"Community has got a hell of a lot weaker": working class and precariat men's search for wellbeing through social prescribing

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Abstract

Despite the growing interest in social prescribing in recent years, both in policy and research, little is known on the experiences of men who are referred to it. Even though recent evidence suggests that men are referred less to social prescribing, there is very little coverage in the literature on social prescribing that specifically focuses on men; this thesis therefore provides a much-needed and timely exploration into men's journey through the policy. Through semi-structured interviews with working class and precariat men (n=14) who have been referred to and used social prescribing in the North of England, and link workers (n=11), the thesis explores men's experiences and perceptions of social prescribing. In so doing, it aims to explore claims that social prescribing can tackle health inequalities and connect people to what matters to them. As a result, this thesis examines if and how social prescribing connects with working class and precariat men, enquiring as to whether it provides men with experiences, access to social capital, resources and relationships that contribute to health and wellbeing. The thesis concludes that men's engagement with social prescribing has mixed success in connecting men to the relationships, resources and activities associated with health and wellbeing.

Table of Contents

Chapter 1: Introduction 10

1.1 What is social prescribing? 14

1.2 The North and men as population and study setting 19

1.3 The origins of social prescribing from Bromley by Bow to policy context: relationships without resources? 21

1.3.1 Social prescribing as developed from the "bottom up" (Moore et al 2022): Bromley by Bow Centre and Sam Everington 23
1.3.2 Visions of social integration: The Big Society as forerunner to social prescribing 26
1.3.3 Theresa May and Social Prescribing: moving beyond the Big Society 28
1.3.4 Social Prescribing in additional Conservative policy networks 30
1.3.5 NHS Long Term Plan 2019 and Social Prescribing 31

1.4 Conclusion 33

Chapter 2: Systematic Review 35

2.1 Introduction and aims of the review 35

2.1.1. Review questions 40

2.2 Eligibility criteria 40

Inclusion criteria 40
Exclusion criteria 40

2.3 Search strategy 41

2.4 "Theoretical relevance" and appraisal of papers 42

2.5 Method of analysis, synthesis and reporting 43

2.5.1 Description of included papers 46
Table 1: Data Extraction Table 48

2.6 Themes and findings 57

2.6.1 Impact at the level of individual and community through social prescribing: inner change and outer impact 57
2.6.2 Theoretical concepts associated with context 60
2.6.3 Theoretical concepts associated with the link worker interaction: mechanisms and agency 63
2.6.4 Theoretical concepts associated with the activities referred to through social prescribing: mechanisms and agency 66

2.7 Conclusion and discussion 68

Strengths and limitations 68
Implications for the PhD study and gap identified in literature: the lack of coverage on men and class in the field of social prescribing 69

Chapter 3: Theory, Social prescribing: Wellbeing and Capital 71

3.2 Wellbeing, humanistic psychology and personalised care 73

3.3 PERMA, Wellbeing science and social prescribing 76

3.3.1 The PERMA Model of Flourishing and the five pillars of Wellbeing theory 76
3.3.2 Wellbeing without antecedent context: contextual determinants of wellbeing 81

3.4 The theoretical toolkit of Pierre Bourdieu and the context, experiences and 82

mechanisms of social prescribing 82

3.4.1 Bourdieu's toolkit and the context and mechanisms of social prescribing 83

3.4.2 Habitus and socialisation into the cultural context of "what matters" 84
3.5 Bourdieu, economic capital and employment as a social determinant of health 87
3.5.1 Economic capital, and psychosocial stress: antecedent contexts that enable or erect barrier to participation in health sustaining activities 88
3.5.2 Integrating Bourdieu and Putnam: social prescribing and social capital 89
3.5.3 Bourdieu, Putnam and "The two facets of social capital" in health research (Rostila, 2010) 89
3.5.4 Robert Putnam, communitarian social capital and norms of trust: bonding, bridging and linking 91
3.6 "Bringing it all together" (Atkinson, 2010) wellbeing and capital: PERMA, Pierre Bourdieu and Putnam 95
3.7 Conclusion 97
Chapter 4: Philosophy of research and methods 98
4.1 Introduction 98
Restatement of research questions 98
4.2 Positivism, critical realism and health research 99
4.2.1 Critical realism, interpretivism and health research 100
4.2.2 Critical realism and stratified ontology 102
4.2.3 Critical realism: context, mechanisms and agency 103
4.3 The use of retroductive reasoning to explore possible mechanisms involved in social prescribing 104
4.4 Covid-19 and adjustment to research design 105
4.5 Study Setting: The North of England and health inequalities 106
4.6 Sample 107
4.7 Ethics 108
4.8 Recruitment and data collection of Link Workers 108
4.8.1 Inclusion criteria for link workers 108
4.8.2 Exclusion criteria for link workers 108
4.8.3 Recruitment of link workers 108
4.8.4 Interviews with link workers: remote interviews through Microsoft Teams 109
4.9 Recruitment and data collection of male users of social prescribing 110
4.9.1 Inclusion criteria for male participants 110
4.9.2 Exclusion criteria for male participants 111
4.9.3 Purposive and snowball sampling and recruitment of men through Northern link workers 111
4.9.4 Remote interviews with the men: telephone 115
4.10 Capturing the experiences and perceptions of working class and precariat men in context: semi-structured interviews 118
4.10.1 Social capital in context and developed through social prescribing 118
4.10.2 Wellbeing in the context, referral to social prescribing 120
4.11 Data Management 121
4.11.1 Transcription 121
4.11.2 Data Analysis: reflexive thematic analysis and critical realism 121
4.11.3 The technologies of coding to highlight the "how" and "why" 122
4.12 Quality and reflexive thematic analysis 124
4.13 The conclusion of analysis and "informational power" (Braun and Clarke, 2021) 125
4.14 Summary of the sample and presentation of findings 126
4.15 Reflexive account 127

Chapter 5: Link worker narratives as enablers of wellbeing and capital 130

Table 2: Link worker participants anonymised (n =11) 131

5.1 Link workers on enabling and empowering users of social prescribing 132

5.1.1 Social prescribing and the social determinants of health: the identification of needs and wants 132
5.1.2 "Empowering" communities? The funding and launching services through social prescribing 136

5.2 Social prescribing as "dumping ground" and link worker as gatekeeper to basic resources 137

5.3 Mental health, meaning and mothering: men and social prescribing 141

5.3.1 Mothering and emotional labour 142

5.4 Link workers and connecting clients to "what matters" to them 143

5.5 Hopes for social prescribing beyond Covid-19 147

5.6 Conclusion 149

Chapter 6: Exploring what matters to men who use social prescribing: an exploration into the cultural context of masculinity, meaning and activity engagement 151

Table 3: Male Participants 153

6.1 Role models and the norms, values, and activities associated with masculinity 154

6.1.1 Virtues of aggression and independence 155

6.2 "Wisdom" and being "respectable": role models outside the immediate family 157

6.3 Role models and the perceived vices of masculinity 160

6.4 Global role models and celebrities as drivers of activity engagement: football, boxing, weightlifting and comedy 163

6.5 State promoted activities: education and national service 168

6.6 Men's narratives of present-day activity engagement: pleasure, mastery or absence 171

6.6.1 Mastery and pleasure through present day activity engagement: rugby, reading, gambling and carpentry 172

6.7 Activities left behind: men and the loss of what matters 174

6.8 Conclusion 178

Chapter 7: Men and the social determinants of health: the context of employment, community and politics 180

7.1 Introduction 180

7.2 Men's narratives of employment and power 181

7.2.1 Meeting the demands of the "higher ups": power denied in employment 182
7.2.2 Hazardous and monotonous employment 185
7.2.3 Post-war economic growth, relative security and choice 186

7.3 Adaptations to power - denying employment: what matters compromised 188

7.4 Searching for power in contexts where the men live and work 191

7.4.1 "It's set up for you to fail innit": Negotiating the Job Centre, suicidal thoughts and being made to feel lacking 192

7.5 Community and social trust: "something missing", stigma and isolation 195

7.6 Politics, democratic engagement and power 198

7.6.1 Men and trade union engagement 199
7.6.2 "No hope": Mistrust, fatalism and politics 200

7.7 Conclusion 204

Chapter 8: Loss and the trigger for the referral to social prescribing 205

8.1 Men and narratives of loss 206

8.1.1 Masculinity and the negotiation of the loss of loved ones 206
8.1.2 Loss of connection: depression, isolation and inequality 209

8.2 Loss of meaning: illness, injury and the breakup of marriage 213

8.3 Responses to loss 219

8.3.1 The search for meaning, understanding and purpose after loss 219

8.4 Connecting to social prescribing after loss 223

8.5 Conclusion 226

Chapter 9: The Two Poles of Social Prescribing 228

9.1 Early conversations with social prescribing link workers 233

9.1.1 "She doesn't really take no for an answer": persistence, pushy or personalised care? 233

9.2 Supporting men through emotional expression with partial success 236

9.3 Meeting the needs of scarcity and safety through social prescribing 240

9.3.1 "Practical stuff" and fish and chips: social prescribing as a gateway to basic needs 241
9.3.2 "There's no judgement being made on you": experiencing safety, engagement and enjoyment 245

9.4 Sharing to create trust in the social prescribing activity and referral 248

9.4.1 Getting past the "awkward" part: sharing images and tales of loss 249
9.4.2 "I didn't think what I was doing was poetry". Sharing and receiving positive feedback to relinquish doubt 251

9.5 Social prescribing as space of enquiry: creating and sharing a safe word to manage discussion and build trust 254

9.6 Receiving, volunteering, and delivering help through social prescribing 255

9.7 The beginnings of bridging/linking social capital: the two poles of social prescribing and connection to others more powerful 256

9.8 "It feels good helping people": The beginnings of new forms of community 259

9.9 Conclusion 262

Chapter 10: Social Prescribing, inequality and wellbeing 264

10.1 Negative pole of social prescribing: positive experiences within a broader context of social inequality 265

10.2 New forms of meaning and engagement within a context of relative inequality 272

10.2.1 Yoga and poetry: the negotiation of masculine norms when participating in new activities 273

10.3 Mission, legacy and "unleashing a beast": partial forms of meaning and purpose 278

10.4 Failed and unsuccessful social prescribing experiences 282

10.5 Conclusion 285

Chapter 11: Discussion 285

11.1 Restatement of research questions 289

11.2 Link workers and male users of social prescribing: agency enablers or swimming against the current? 289

11.2.1 Link workers: stress and low income as barriers to their role as promoters of wellbeing and capital(s) 290
11.2.2 Link workers, "lifestyle drift" and placing sticking plasters on social problems 293

11.3 Original contribution to knowledge: Men and the antecedent cultural context of "what matters" through Habitus and PERMA 295

11.4 Cultural context: class and masculinity, men's norms and values 296

11.5 Cultural context: tracing "what matters" through the men's activity engagement prior to social prescribing..... 298

11.6 Context: men and the social determinants of health, the distribution of capitals and power as barriers to wellbeing 301

11.7 Context: the antecedent context of social capital, trust and power 303

11.8 Original contribution to knowledge: the trigger for referral to social prescribing and men's experience and perceptions of loss 304

11.9 The two poles of social prescribing and the perceived gap in the literature: the cultivation and exploitation of trust in connection to wellbeing and social capital 308

Summary and conclusion of findings: 313

11.10 Practice and policy recommendations..... 313

11.10.1 Link workers need to develop greater awareness of social and political structures: implications for the supply side and delivery side of social prescribing 313

11.10.2 Enlarging, consolidating, and enabling the positive pole of social prescribing and men through a more detailed examination of the strength of informal relationships in services..... 315

11.10.3 Social prescribing needs to develop genuine coproduction through personalised care 317

11.10.4 Social prescribing needs to improve democratic relationships and forms of commissioning services 317

11.10.5 Social prescribers should ensure a greater pluralism/choice of activities are connected to and commissioned 319

11.11 Reflections on methods..... 320

11.11.1 Adaptations made to guidance on critical realist interviewing: men in distress 320

11.11.2 Strengths and weakness of the method 322

11.12 Potential Areas for future research 323

11.12.1 Comparative qualitative study on working class and middle-class men who use social prescribing 323

11.12.2 Discourse analysis: "rational recreation", individual responsibility, and social prescribing 324

11.13 Conclusion 325

Appendices 326

12.1 Appendix A: Ethics 327

12.2 Appendix B: Email to Organisations- for Link Workers 328

12.3 Appendix C: Email to Organisations – for Service Users 329

12.4 Appendix D: Introductory Letter of Thanks to Participants 330

12.5 Appendix E: Poster/Flyer 331

12.6 Appendix F: Participant Information Sheet..... 332

12.7 Appendix G: Consent Form 335

12.8 Appendix H: Confidentiality Agreement for the Transcription of Qualitative Data 337

12.9 Appendix I: Indicative Line of Questioning for Semi-Structured Interviews..... 338

12.10 Appendix J: Model Social Media 339

Bibliography..... 340

Chapter 1: Introduction

It is now theoretically and empirically well established that people's health and wellbeing are determined by a range of resources and relationships (Marmot, 2016). Referred to as the social determinants of health, the relationships and resources deemed vital in supporting our health and wellbeing can be found in the contexts of where we grow, live, work and age (Marmot and Wilkinson, 2005). Examples of some of the goods, resources and relationships associated with the social determinants of health range from access to good education, well designed and health promoting housing, participation in the community, and employment that provides a decent income, meaning and control, amongst others (Marmot, 2015; Marmot, 2016).

Despite knowledge on the social determinants of health, robust evidence demonstrates that within and between countries, those positioned lower down the "social hierarchy" (as measured by social economic status or social class) on average, die earlier and are more likely to suffer from a range of life limiting diseases than those positioned above them (Marmot, 2015, p14). The regularity of this distribution of health is referred to as the social gradient of health (Marmot, 2016) and the lower one's social position, the higher the risk of "just about every disease that's going" (Marmot, 2015, p21). For example, those deemed low in social and economic status are reportedly more likely to report a mental health problem (Lomas, 2014); in addition, those based in more deprived areas report less interpersonal trust and social capital (Wilkinson and Pickett, 2010; Wilkinson and Pickett, 2019), alongside lower paid employment that is often less able to promote wellbeing and a feeling of purpose (Allen et al, 2021).

Recent decades have seen shaper rises in levels of income and wealth inequality (Savage, 2021; Picketty, 2022). This is combined with "regressive" cuts to public health budgets and a reversal in life expectancy connected to the macroeconomic policies associated with neoliberalism and austerity (Marmot et al, 2020, p3).

The explanations cited as the reasons for the social gradient in health (Marmot, 2016) range from those that prioritise psychosocial causes, with inequalities of income and status damaging the ways we relate to one another through heightening self-doubt and fear of others, to those that stress the material causes, like low income, poor housing amongst others (Marmot and Wilkinson, 2005). Both agree, however, that what is causal is the distribution of the above social determinants of health throughout society. It is thought that the lack of material resources, combined with the relational and psychosocial scarring of being at the bottom of the social ladder, denies the presence of control and participation in society (Marmot, 2016). As a result, investment in policies that improve the relational and material conditions mentioned are needed to sustain more equitable forms of health and wellbeing for all (Marmot, 2016).

Following this, the social determinants of health are innately connected to politics and policy, and the distribution of power, goods and resources in societies (Bambra et al, 2021). As Hiam et al (2024, p1) have argued, indicators like declines in life expectancy that demonstrate the worsening of health in the UK are often connected to the "neoliberal focus on individualism". Neoliberalism is primarily an economic doctrine based on a theory of the individual as an economic consumer whose wellbeing is best realised through the pursuit of their own freedom to choose as a consumer in the market place. As an economic doctrine, neoliberalism is most notably associated with the economists Milton Freidman and Friedrich Hayek. In turn, these intellectuals inspired the governments of Margaret Thatcher and Ronald Regan

(Stedman Jones, 2012). Under the assumptions of neoliberalism, governments were encouraged to reduce their regulatory, redistributive, service duties and functions. In turn, the state, according to the neoliberal position, should focus on simply facilitating the transactional exchange of freely contracting individuals (Stiglitz, 2024). Broadly speaking then, neoliberals argue that the regulatory architecture of the state should be weakened so as not to impede the voluntary exchange of individuals. In connection specifically to public health, the term "nanny state" (Hiam et al et al, 2024) is often used by neoliberal oriented thinkers who are against the state impeding in individuals pursuing their own ends, even if these are deemed damaging to others. The dominance of neoliberalism as a philosophy of governance has been connected to widening measures of health inequalities. For example, research has drawn attention to the damaging effects of neoliberalism in widening both income and wealth inequalities (Marmot, 2015; Scambler, 2018). This has had both material and cultural effects, with people at the bottom end of the income distribution experiencing poorer pay, but also less contractually secure work, with the increase in zero-hour contracts. amongst this group increasing (Standing, 2011). While this move to more insecure contracts is legitimated by claiming it creates a more dynamic operational environment for businesses who may need to hire and fire at speed to meet demand, it is also associated with exacerbating stress, lowering the ability of individuals to plan and invest in a future they can control (Standing, 2011).

The widening gaps in wealth and income associated with neoliberalism have been intensified by the economic agenda of austerity. In 2010, the then Conservative and Liberal coalition government implemented policies popularly referred to as austerity, where public spending was cut to pay down the deficit. As a result of austerity, there has been a reversal in the growth of life expectancy, alongside a steepening of the social gradient in life expectancy, with notable indicators on mortality and morbidity widening between those of higher status and those who own less income or wealth education and occupational prestige (Marmot et al, 2020). In

addition, the steepening of the health gradient exposed those positioned at the bottom end of society in greater vulnerability when the recent Covid-19 pandemic hit. Despite the discourse that we 'were all in this together', evidence suggests that death rates from Covid-19 were disproportionately higher in deprived areas, with many of these areas already suffering through the impact of previous rounds of austerity (Bambra et al, 2021). It was also in these areas where many were undertaking the service, logistical, retail and care work that were deemed essential during the lockdown, despite being underpaid and underappreciated for previous decades (Bambra et al, 2021).

In recent years, in an effort to act on some of the above trends and to tackle persistent health inequalities, policy makers and health professionals have invested attention and resources in an agenda known as social prescribing – a policy which has gained interest and momentum in the UK context (Fox and Mason, 2022). Although there are several competing models of the policy, social prescribing usually involves a General Practitioner (GP) referring a patient (or attendee) to a link worker – a person who connects people to social prescribing activities. The link worker then begins a conversation with the individual (known as the service user) on "what matters" to them to understand the root of the social problems that are potentially impacting the individual (Sanderson, Kay and Watts, 2019, p14).

It is claimed that social prescribing represents a reorientation of health services and, in the UK context of the NHS, it aims to make primary care more responsive and preventative in focus (Hardman, 2023). To examine if social prescribing can meet its aims of tackling health inequalities through providing access to the relationships and resources associated with the social determinants of health, this study will purposefully focus on working class and precariat men (Savage, 2015) who have been referred to and have used social prescribing in the North of England. The thesis will examine how the context of their everyday lives interacts with their

social prescribing engagement. In addition, the study will also focus on how the men experience and perceive their social prescribing journey. Firstly, however, the following section will present a definition of social prescribing, before moving on to legitimate the study's focus on men in the North of England in further detail.

1.1 What is social prescribing?

To gain a workable definition of social prescribing, a definition from the health policy network, the Kings Fund, will be used along with support from other sources. In a report titled "What is social prescribing?" (Buck and Ewbank, 2020) defines the policy as follows:

> *"Social prescribing, sometimes known as community referral, is a means of enabling health professionals to a range of local, non - clinical services. The referrals, generally, but not exclusively, come from professionals working in primary care settings, for example GP practices or nurses".*

Buck and Ewbank (2020) go on to state that:

> *"recognising that people's health and wellbeing are determined mostly by a range of social, economic and environmental factors, social prescribing seeks to address people's needs in a holistic way, to support individuals to take greater control of their own health".*

In further developing the detail on what social prescribing is Buck and Ewbank (2020) state that social prescribing schemes involve:

> *"activities that are typically provided by the voluntary and community sectors. Examples include, volunteering, arts activities, group learning, gardening, befriending, cookery healthy eating advice or a range of sports."*

Other definitions have been produced by work by Muhl et al (2023), who hoped to arrive at a firmer definition of what social prescribing is through consultation of an international social

prescribing community. To achieve this aim, the authors used the Delphi method to produce a consensus. The definition arrived at through this method is stated as follows: Social prescribing is

> *"a means for trusted individuals in clinical and community settings to identify that a person has non-medical, health-related social needs and to subsequently connect them to non-clinical supports and services within the community by co-producing a social prescription—a non-medical prescription, to improve health and well-being and to strengthen community connections"* (Muhl et al 2023, p.9).

Whilst the aims of the paper are helpful in generating a firmer understanding of common components of social prescribing, qualitative research on social prescribing has found that even within the same primary care setting link workers, general practitioners and others have different ideas around what social prescribing is (Moore et al, 2022). This difference in understanding and interpretation of those involved social prescribing explored best by qualitative methods.

In addition to the heterogeneity described above, social prescribing is also associated with several broad aims (Calderon-Larranga et al, 2022). The variety of these aims are presented in policy documents, grey literature but also research papers. Foremost amongst these aims are the following: to help people gain access to the social determinants of health, reduce health inequalities and connect users of social prescribing to activities or services that matter to them (Fox and Mason, 2022). This is achieved through a link worker, usually (though not solely) employed in primary care settings, who is placed in charge of connecting people with activities and services either in the surrounding community or commissioned through social prescribing. Moreover, Sandhu et al, (2022) observe that the only direct source of funding for social prescribing is through the employment of a link worker, with it hoped that one link

worker would be employed initially for every primary care network. Recent studies have also suggested that to ensure the long-term sustainability of social prescribing, more detail needs to be considered on how it is financed and funded, with claims made that it is overly reliant on an already under resourced voluntary, community, and social enterprise sector, with the study looking to further explore this (Fox and Mason, 2022).

In addition to claims that social prescribing can help to tackle health inequalities by increasing access to the relationships and resources associated with the social determinants of health, the policy is also driven by an awareness of the health benefits derived from participation in certain activities. For example, it is known that participation in certain activities sustain and enable better levels of mental and physical health. Activities like exercise, cultural activities, mindfulness, meditation, yoga, and sporting participation are all associated with improved levels of wellbeing (Hefferon, 2013; Fancourt et al, 2021). Despite this, however, similar to the social gradients in the social determinants of health discussed above, those of lower social class or social and economic status, typically report less participation in certain forms of cultural activity (Fancourt and Steptoe, 2019) or sport (Scambler, 2022) and exercise (Wiltshire et al, 2019). This is compounded by a social gradient in wellbeing with those lower down the social ladder more likely to report lower levels of subjective wellbeing than those with more income, education, and occupational standing (Jackson, 2016), although some evidence challenges this association (Layard and Neve, 2023).

Whilst social prescribing represents a recognition of some of the social factors that shape levels of health and wellbeing, both commentary and some evidence (Moscrop, 2023; Bickerdike et al, 2017), remain sceptical and unconvinced that it can counteract some of the negative trends identified above. There are therefore calls for further research on social prescribing to be undertaken to explore this (Marmot et al, 2020). As discussed above, the

context of neoliberalism, both in the impact it had on the distribution of resources, but also culturally, is of central importance to understand the broader context of social prescribing. A notable paper by Mackenzie, Skivington and Fergie (2020) has pointed to the danger that interventions like social prescribing, despite their aim to increase social connection, may unknowingly acquiesce in the neoliberal order. Those who have made this argument claim that when interventions and policies fail to acknowledge the material and cultural effects of neoliberalism this can result in the logic of interventions falling into "fantasy paradigms" (Scott Samuel and Smith, 2015; Mackenzie Skivington and Fergie 2020). Those designing and researching interventions like social prescribing often fall back to a "firm commitment to individualised approaches" and neglect their commitment to taking action on the social determinants of health (Mackenzie, Skivington and Fergie, 2020 p2). The over-reliance of individualised approaches has also been identified in the fields of wellbeing, where approaches within the field, and a subdiscipline called positive psychology, have been accused of promoting ideas of human flourishing associated with changing an individual's cognitions to optimism and "grit", without any reference to the context that the individual finds themself in (Lomas, 2023). Key critics of this approach have claimed that these ideas on wellbeing are culturally laden, with parallels again drawn to the individualism of neoliberalism, where the individual is encouraged to become more resilient as a way of improving his productive value as an employee (Lomas, 2023). This focus fails to examine the broader structural issues caused by the design of certain institutions: *"to really enhance happiness, we cannot only focus on helping individuals but must also consider the systematic sociocultural contexts in which they are situated"* (Lomas, 2023 p172). This concern is examined in more detail in the systematic review chapter.

Alongside the connection of neoliberalism with the perceived conceptual inadequacies of some research on health and wellbeing, it has also been identified that the rise of neoliberalism has legitimated unbalanced growth in the UK economy, leading to less inclusive growth and less resilient local economies (Scambler, 2018). One example of this pointed to in the literature is the growth of the City of London, which has crowded in labour, capital, and investment from other regions of the UK, especially the North (Glasman, 2023). The concentration of wealth in the South of the UK has led to the weakening of levels of "social and cultural infrastructure": these are the places, business, rituals, and institutions that support the creation of economic value in the social and cultural sector (The British Academy report on Social and Cultural Infrastructure, 2023, p 3). Other research undertaken in the North of England in an ex-coal mining community has claimed that "left behind places" are subject to "social infrastructure deficits" and that urgent action needs to be taken to remedy this (Tomaney et al 2022, p3). The distribution of this infrastructure across the UK, as coupled with the growth of neoliberalism described above, may impact the ability of social prescribing to create the change it intends in the North of England. Moreover, research on social prescribing has linked the logic of the policy directly to the cuts in public funding associated with austerity, where funding was cut off and diverted away from the public sector, but where individuals and communities were asked to do more with less public sector support and increased strain placed on their services who may not possess the scale or reach to meet this demand (Redmond et al 2019). Challenges associated with this have been identified elsewhere. For example, a recent report published by National Voices, found that "without appropriate investment, social prescribing could exacerbate inequality in a range of ways. Generalist link workers may lack the skills or resources to engage effectively with excluded individuals and communities" (Cole, Jones and Jopling, 2020, p7). In addition, elements of the ways in which this broader macro context may impact the delivery of social prescribing has

been picked up on in research undertaken through a collaboration of international experts within the social prescribing community, who claim that social prescribing cannot tackle health inequalities, but "mitigate them", (Muhl et al 2023, p9). This more cautious position seems to reflect a less optimistic tone than some of the claims made on this in the UK context.

Furthermore, in the UK context, questioning the ability of social prescribing to achieve its aims, as one recent commentator has claimed "social prescribing is no remedy for health inequalities" (Moscrop, 2023). Indeed, Moscrop (2023) notes that claims that social prescribing is equipped to tackle health Inequalities is driven by an inability to understand the structural barriers that certain deprived contexts in the UK face in meeting basic needs and providing access to the resources and relationships associated with the social determinants of health. To explore these concerns further, the following section will explain why the North of England has been chosen as the area of focus for the study, alongside working class and precariat men as the population of interest.

1.2 The North and men as population and study setting

By aiming to explore if social prescribing can help to tackle health inequalities and improve access to the social determinants of health, the North of England is an important setting for the study. As recent data from the "Marmot Review: Ten Years On" suggests that because of austerity, rises in deteriorating health have disproportionately impacted regions in the North of England. As a result, the report argues that it is vitally important that regional inequalities are reduced (Marmot et al, 2020). The report clearly identifies patterns that legitimate the focus of the study: "the most deprived areas and communities, particularly in the North of England, have experienced the greatest declines in funding in almost all social, economic and cultural domains, and poverty, poor health and socioeconomic inequalities have increased" (Marmot et al, 2020, p2). This decline in funding in these areas is as a context that could

potentially negatively impact both the delivery side of social prescribing and the service user experience.

In addition, this contemporary data combines with more historical patterns that suggest that the North continues to need support to recover from the social change associated with deindustrialisation (Groom, 2022). Whilst many Northern cities have experienced regeneration, growth, and cultural renewal, many ex - mining and industrial towns continue to be locked out of this growth and in need of policy solutions. These structural changes have led to the supposed "decline of the working class", (Goodwin, 2023, p17). This is associated with a sense of social dislocation, cultural disenfranchisement, and lack of direction particularly in those Northern towns popularly described as "left behind" (Wood et al, 2023). The cause of this change is associated with the decline of manufacturing, coupled with the comparative economic growth of the City of London and its financial services. Goodwin notes that "those who lived in the small coastal and industrial towns were cut adrift, relegated to second class citizens" (Goodwin, 2023, p41). Furthermore, because of globalization and the rapid movement of capital flows around the globe, coupled with decreased and regressive funding for public services, the needs of men in working class communities, it is claimed, are being ignored (Goodwin, 2023). As a result, Goodwin (2023, p24) argues that "over the last decade men in the least deprived areas of England were living a decade longer (to 83.5 years) than men in the 10 per cent most deprived (to 74.1 years)". Today, average life expectancy for men is eight years lower in areas such as Blackpool, Middlesborough, Manchester and Liverpool than it is in "areas where the new elite live" (Goodwin, 2023, p43). Recent evidence has also found a "gender divide" in participation in social prescribing, with evidence claiming that men are referred to social prescribing less than women, with this concern also shaping the need for the research (Cartwright et al, 2022 p6) This confluence of factors makes the focus on men and North of England of timely and perhaps urgent focus.

Using a qualitative research design, driven by semi-structured interviews, and informed by the philosophy of critical realism, the study will explore the perceptions and experiences of men as they engage and journey through several social prescribing settings sampled. As the urgent need for the focus of the study has now been established, the following will describe social prescribing within a broader context, with this deemed a vital preliminary discussion that will place social prescribing both as a "bottom up" (Moore et al 2022) development and then through the broader policy priorities and agendas that have shaped policy making. As the economist Angner (2023) has argued to understand an intervention or policy, we must understand what it hopes to be the solution to, with the following section examining surrounding discourse on policy and social prescribing to achieve this.

1.3 The origins of social prescribing from Bromley by Bow to policy context: relationships without resources?

The following section will examine the origins of social prescribing and the policy context of the study. This will place social prescribing placed in a broader context and frame, something that is touched upon briefly in the surrounding literature on social prescribing. Whilst a definition of social prescribing has been offered above, recent research has found that practitioners and academics often emphasise different elements of what social prescribing does. On the one hand, some focus on its ability to cultivate behaviour change and self-activation for individuals, whilst others see it as a way of allowing communities to take control of running services and providing control and access to goods and resources associated with the social determinants of health (Calderon-Larranga et al, 2022). As a result, the following section will strengthen the previously offered definition of social prescribing which will be used in the study, by connecting the policy of social prescribing to broader policy discussions with similarities in focus to social prescribing.

The common theme amongst these agendas seems to be the claim that it is no longer enough for the NHS to merely provide curative services; it must now take an active role in cultivating networks and partnerships that can be harnessed towards reducing demand and developing communities (Giddens, 2000; Cottam, 2019; Blond, 2010; Stears, 2021). Nevertheless, research by Garrard (2023) has expressed concern that without a broader redistributive and regulatory role for the state in controlling the accumulation of capital and power at the top end of the income distribution, this renewed focus on community is in danger of shifting the burden of health inequalities away from the state onto communities that do not have the capital or infrastructure to respond to the weight of the challenge. The presence and density of social capital and social entrepreneurship differs in areas, especially those in the North, where the old associations and civic life associated with industrialism have broken down (Goodwin, 2023), with some of the discourse that is presented in the next section documenting this.

This discussion will range from examples of cited pioneering forms of social prescribing to how social prescribing connects with policy aims of the Conservative Party who have been in power since 2010. This will allow a more nuanced understanding of what the aims and priorities of social prescribing are, and how they connect with broader ideological claims made by the incumbent Conservative Party.

Although tracing the beginnings of social prescribing is remarkably difficult, with some claiming "it is as old as the hills" (Fox and Mason, 2022, p5) several sources point to the activity of the Bromley by Bow Centre in East London as the primary example of an early social prescribing initiative. A brief historical documentation of the activities of the community facing activity of the Bromley by Bow Centre (BBBC) will be undertaken, with some of the learning from this example seemingly inspiring the national roll out of social prescribing

(Hancock, 2018). Following this, additional sections will discuss how social prescribing connects to recent efforts by the incumbent Conservative Party to tackle social problems and redesign the role of the state and its relationship with communities, with this return to the social requiring some brief explanation after the declaration of Margaret Thatcher that there is "no such thing as society" (Gamble, 1994, p18).

1.3.1 Social prescribing as developed from the "bottom up" (Moore et al 2022): Bromley by Bow Centre and Sam Everington

As stated, the following section will discuss the development of social prescribing, starting with a supposed pioneer case of social prescribing from the BBBC – a case study which preceded the inclusion of social prescribing in the NHS long-term plan by nearly 20 years (Hari, 2019). The BBBC, established in 1984, is a community facing general practice, offering charities, social enterprises, and voluntary groups the opportunity to link up in partnership with general practice. The BBBC is continually drawn upon as an example of best practice (Buck and Ewbank, 2020). For example, as Hari (2019) has documented, the growth and development of social prescribing in Bromley can best be explored through the testimony of Dr Sam Everington. Everington is the general practitioner who is largely responsible for driving the change in orientation of the BBBC in previous decades, with the philosophy of the centre reportedly built from lessons derived from Everington's clinical experience. In his early years as a practitioner, Everington found himself stuck for a solution to some of his patients' repeated concerns, especially those associated with psychosocial issues. This persisted until an insight alerted him to the shortcomings of his medical training and the application of biomedical diagnostics without a theory of the whole person. Commentary on this insight describes the moment when a male patient entered the consulting room at the BBBC. Following his usual consultation criteria, Everington offered the male patient the option of a referral to a social worker, wherein he replied: "I don't need a social worker, I need a social

worker's wage" (Hari, 2019, p146). It seems it was here Everington realised the shortcomings of his approach: rather than pharmaceutical solutions, his patients had been denied or lost the things that made life worth living (Hari, 2019). As a result of this, Everington set about, with the help of a supportive team, to change the organisational structure and culture of his practice, ushering in several important reforms. Perhaps one of the most important components of these changes was the alterations made to the patient consultation process. When reflecting on this change, Everington claimed that "almost all consultations are, in part, about the emotional health of the patient" (Hari, 2019).

Everington, therefore, set about trying to open his consultation beyond the criteria associated with biomedical symptomology. In doing so, Everington claims he shifted the orientation of his consultancy from "what's the matter with you?" to "what matters to you?" (Hari, 2019), with this phrase later a central part of the branding and delivery of both personalised care and social prescribing (Fox and Mason, 2022). Everington set to reform his practice by having better, more empowering conversations with his patients. Nevertheless, given the focus on efficiency and short-term pressures this was not easy, he realised he had been too quick to offer a pharmaceutical solution to his patients. It was his experience that whilst this often-provided short term results to patients, offering initial hope, the hope was short-lived, resulting in reattendance to his practice. As he noted, "there is no point putting sticking plasters over the patient's pain", stating "what you have to do is to tackle the reasons why they are in here in the first place" (Hari, 2019, p148). An additional component of the subsequent reorganisation centred on readdressing the power asymmetries between physician and user. Everington went some way toward doing this by changing the spatial layout of his consultancy room furniture; indeed, by choosing to sit alongside his patient, rather than directly in front of them behind a desk, Everington believed he lessened the perception that he is the expert that is "supposed to know", in turn cultivating a culture where he is a partner

in a puzzle that both he and his patients can get to the bottom of together (Hari, 2019). Furthermore, patients at the BBBW started to organise a gardening group in the gardens around the building of the GP practice. In time the patients began to renovate and care for the derelict grass and garden areas in the grounds of the practice, transforming them from uncared for spaces, to communal spaces where the group gathered and regularly tended to and maintained the plants and features, they had built and grown (Hari, 2019).

The example of BBBC and Everington, along with the accompanying vignette of change, has offered a brief discussion of the BBBC model of social prescribing. This vignette demonstrates how individual and indeed group change, may occur through social prescribing. The vignette also shows how, through social prescribing, people can build small groups and coalitions that take control and make improvements to the things they care about, cultivating a sense of agency and control. Despite this, however, it is important to note that there was very little discussion from Everington on how broader macro-structural forces are responsible for inhibiting the development of assets associated with the social determinants of health or how these structures might be challenged through the relationships built through social prescribing. For example, it is not all together clear how the vignette of change offered by Everington could combat widening earnings distributions, cuts to public services and shortages of affordable housing amongst other social determinants listed earlier in the chapter. Now that some of the key relational components associated with the social prescribing journey have been described, the chapter will proceed to discuss how social prescribing connects to recent efforts made by the Conservative party to focus on how the state can connect to surrounding communities, with these concerns and assumptions directly related to the focus that social prescribing places on the social as a site of intervention.

1.3.2 Visions of social integration: The Big Society as forerunner to social prescribing

Researchers for example, Redmond et al, (2019) have connected the agenda of social prescribing to recent efforts by the Conservative Party to focus more attention on the space of community. For example, key papers in the field of social prescribing have observed the similarities in focus claiming that, "this model of social prescribing was closely allied to notions of David Cameron's vision of the 'Big Society', which attempted to empower people to play more active roles in their communities, thus developing social capital, improving well-being and reducing social isolation (Redmond et al, 2019, p235). The concept has been identified as marking a departure from a more aggressive variant of neoliberal conservatism found most notably in the Thatcher government, which claimed that society did not ontologically exist (Gamble, 1994). In recent years, to move away from this, some Conservatives drew rhetorical attention to social disintegration and an accompanying retheorisation of society (Maschette and Garnett, 2023).

To legitimate his idea of the Big Society, Cameron drew upon the familiar Conservative disdain for big government (Cameron, 2019). In doing so, Cameron stressed the need to reduce the scale and size of the state to clear the way for a more vibrant civil society; this was despite the fact there is no solid empirical evidence that large welfare states corrode social capital (Rostila, 2007). It was argued that this would reduce dependency on benefits and unleash the dynamism of communities to take control of assets and the delivery of services. This was driven by the need to reduce public spending under the austerity agenda, but was also combined with the notion that the state had corroded civic virtue and the potential of citizens to mobilise resources in communities closer to the everyday life of citizens (Cameron, 2019). Cameron stated he wanted to "show that the Conservative means that had worked so well in delivering prosperity in our economy – decentralisation, choice, competition, transparency,

accountability – could deliver better public services and a stronger society too" (Cameron, 2019, p165). Cameron stressed that businesses and charities now had the chance to deliver public services. Added to this was the promise of "devolving power from Whitehall to cities, communities, families and individuals – a great power giveaway" Cameron, 2019, p165). Indeed, in a speech delivered to the Student Network of Social Prescribing Champions, one member in attendance suggested that: "There is a way in which social prescribing occupies the same space previously occupied by the Big Society. David Cameron's […] attempt to get local people to provide what once had been provided by public services" (Brown, 2019).

One of the key intellectual influences behind the idea of the Big Society, Philip Blond (2010, p156), shared this vision of a renewed theorisation of society and how this linked with perceived criticisms of the welfare state and the NHS. For Blond, the swelling in size and scale of both state and market associated with both Thatcherism and New Labour, had proved disastrous for the space of community and other intermediary institutions that help check the power of business and state. In the words of Blond, worth quoting at length,

> *"We no longer have, in any effective independent way, local government, churches, trade unions, cooperatives, publicly funded educational institutions, civic organisations, or locally organised groups that operate on the basis of more than a single issue… these associations helped to give form and direction to human beings...Nowadays, however, all such sources of independent power have been eroded; instead, these civil spaces have either vanished or become subject domains of the centralised state"* (Blond, 2010, p137).

In response to this vacuum, Blond argued that health workers, including GPs, could "spin out" new social enterprises to solve social problems in the surrounding areas, competing for contracts out of the purchaser - provider mix (Blond, 2010). Despite this perceived lack of

community and intermediary resources outside the state and market, a notable historian of community and social capital development in the UK claims this lack of social infrastructure is a persistent problem, with this proving problematic for social prescribing (Lawrence, 2019).

The following section will continue the renewed emphasis placed on community in recent Conservative policy discourse, focusing on how this looks to repair some of the social damage that has resulted from decades of neoliberalism, with Theresa May explicitly referring to social prescribing as a means of remedying loneliness and disintegration.

1.3.3 Theresa May and Social Prescribing: moving beyond the Big Society

In a continuation of David Cameron's efforts to soften the Conservative brand post -Thatcher, Theresa May's brief spell in leadership furthered Conservative efforts to cultivate a compelling message on the place of society, as an area separate, nonetheless interdependent, on market and state. May, drawing upon the "One Nation" (Hickson et al, 2020) integrative brand of Conservatism, supported the need for a more proactive state to that envisioned by the previous Conservative government. Evidence of this can be found in May's Speech, The Shared Society (May, 2017):

> *"It means developing policies that give a fair chance to those who are just getting by, as well as those who are most disadvantaged. Because people who are just managing – just getting by – don't need a government that will get out of the way. They need an active government that will step up and champion the things that matter to them"*.

Importantly, May makes use of the concept of social prescribing in a number of her speeches and publications. For example, 2018 saw the publication of any Government's first loneliness strategy, with the release of a report titled, 'A Connected Society: A strategy for tackling loneliness" (HM Government, 2018). In the preface, Theresa May stated "Loneliness can

affect anyone of any age and background - from an older person mourning the loss of a life partner to a young person who simply feels different and isolated from their friends. Furthermore, as our society continues to evolve, so otherwise welcome advances can also increase the risk of loneliness" (HM Government, 2018, p2). Further to this, May argued that the dynamic, but often destructive, forces of the market need to be tempered by a greater social ethic and indeed (although somewhat vague) regulation from the state.

In their efforts to combat social isolation and loneliness, a greater preventative role for the state was envisioned, with social prescribing outlined as a salient feature of the changes required to public sector delivery:

> *"Part of the work we have to do is to change the way we think about public services. For example, the expansion of social prescribing across the country will change the way that patients experiencing loneliness are treated. Recognising that medical prescriptions alone cannot address the root causes of loneliness, it will invest millions of pounds in ways of connecting people with community support that can restore social contact in their lives. As such, it will also play a critical role in the prevention of ill health which I have made a key priority for our long-term plan for the NHS"* (HM Government, 2018, p2)

As demonstrated earlier, social prescribing shares similarities with notions of the "Big Society", May's mentioning of the policy is accompanied with a more activist vision of the state like the above. The following section builds upon this discussion by presenting references to social prescribing in other Conservative policy discourse.

1.3.4 Social Prescribing in additional Conservative policy networks

The reinvestment of society, with added attention, has recently emerged as a key part of the work of a Conservative think tank called the Social Covenant Unit. The think tank recently produced a report stressing the importance of the UK's network of civil associations in renewing public service delivery. Commentary from the think tank emphasised the importance of civic associations and a need to move "beyond the Big Society" (Baille et al, 2021, p2), with the latter criticised for its focus on relationships at the expense of resources. A recent report produced by the think tank also states that, "trusting the people means giving people real control over the way that local services are run. It means trusting communities to come together to tackle previously insoluble challenges, and putting money into the hands of local groups so that they can develop new solutions and develop local infrastructure" (Baille et al 2021, p6). Moreover, to concretely identify these changes in public service delivery, examples of social prescribing are offered from the North of the UK, where:

> *"GPs, health and care services are working with local community groups to create a better service for local people. This partnership approach has led to residents being encouraged to take part in activities from sport, singing and mental health sessions to proactively managing their health and preventing illness from developing. This approach has now been championed by NHS England as part of its Long Term Plan for the future of the NHS"* (Baille et al, 2021, p7)

Going further, it added that "Increasingly, the NHS has recognised the power of so-called "social prescribing" which encourages residents and patients to take part in community powered services from physical activities, befriending services, and voluntary action" (Baille et al, 2021).

The report also contains a more explicit understanding of why social prescribing may need a more adequate theory of inequality, proceeding to describe the inequalities of social infrastructure and social capital in more deprived areas of the country. In doing so, they draw attention to this project's study setting, the North of England suggesting that inequalities in income and wealth may pose a problem for policies that provide communitarian bottom-up solutions (Baille et al, 2021). That is, policies like social prescribing must contain an adequate understanding of how the distribution of power and wealth can have corrosive effects on the health of communities. The area of the North is highlighted, going on to describe these problems in the following way:

> *"These places are concentrated in the North of England, with the North East having the highest concentration of left-behind areas. This is not just an isolated finding... research found that those places which had a higher density of charities, pubs, churches and other civic institutions were located in the commuter belt around London with a lack of institutions in our industrial towns, ex - mining villages and coastal communities."* (Baille et al, 2021, p9)

The above identifies the inequitable distribution of social infrastructure in the North of the UK, arguing that an understanding of this must accompany all efforts of public service reform, like social prescribing, that aims to bring services closer to communities. This again will inform the focus of the broader thesis.

1.3.5 NHS Long Term Plan 2019 and Social Prescribing

Launched in 2019, with subsequent iterations and revisions in the following years, the NHS Long Term Plan is driven by the goal of modernising the NHS, bringing it in line with patient demands of the 21st century. As part of this, the plan identifies several institutional changes, including a prioritised focus on "integrated care systems" where primary care, social care and communities are less siloed and make stronger connections to one another sharing data,

resources, and learning (NHS, 2019, p3). Moreover, the plan highlights a need for a more proactive and preventive vision of care. As part of this, the plan states that more power and staff resources should be wrapped around communities, creating a more supportive infrastructure of health, not one that simply intervenes once the patient has become ill. Part of this model of integrated care takes the form of a more empowered primary care network, where GP's can procure and purchase services from the local providers, providing a more decentralised form of decision making (NHS, 2019). But also, and perhaps more importantly, a continued stress on increasing the responsiveness and choice that the service offers to ensure that the NHS can provide a service suitable for the 21st century. A central element of the agenda is the NHS personalised care model, which is described as a significant transition in the way that front line health professionals work (Fox and Mason, 2022). The central mechanism behind this change in working is the conversations that front-line professionals have with patients. This is described in the plan's policy document, with the following passage repeating the phrase used by Everington, as documented earlier in the chapter:

> *"the NHS needs a fundamental shift in how we work alongside patients and individuals to deliver more person-centred care, recognising… the importance of 'what matters to someone' is not just 'what's the matter with someone,'* (NHS, 2019, p2)

A central component of this is the policy of social prescribing with the report earmarking the hopes, goals and vision for the service.

> *"As part of this work, through social prescribing the range of support available to people will widen* […] *Primary care networks will work with people to develop tailored plans and connect them to local groups and support services. Over 1,000 trained social prescribing link workers will be in place by the end of 2020/21 rising further by*

> *2023/24, with the aim that over 900,000 people are able to be referred to social prescribing schemes by then."* (NHS, 2019, p7)

The previous sections have offered a vignette of change through Dr Sam Everington's early model of social prescribing. It has also presented the aims of social prescribing within recent efforts of the incumbent Conservative Party to reinvest energy in the space of the social. It is hoped that this section will have provided a clearer picture on what the aims and agendas of social prescribing are whilst also discussing some of the challenges it may face. The challenges, as noted by discourse surrounding the Social Covenant Unit, are identified as potentially salient in the North of England where economic and social change have left much of the social infrastructure in certain areas weakened. The study will look to explore the opportunities and problems identified in the previous section through data.

1.4 Conclusion

This chapter has laid the foundations of the study. Firstly, the chapter described and legitimated the focus of the study. Secondly, it offered a detailed vignette of change through social prescribing by examining the BBBC and Sam Everington, before connecting social prescribing to broader discourse around the aims and agendas of the Conservative Party on the state and community. To reiterate, the aim of the thesis is to examine if social prescribing can meet its' aims of tackling health inequalities through providing access to the social determinants of health; the study will purposefully focus on working class and precariat men (Savage et al, 2015) who have been referred to and have used social prescribing in the North of England examining how the context of their everyday lives interacts with their social prescribing engagement. In addition, the study will also focus on how the men experience and perceive their social prescribing journey The following chapter builds upon this by providing a

systematic review of the literature on social prescribing informed by the guidance on critical realism.

Chapter 2: Systematic Review

2.1 Introduction and aims of the review

In order to ground the study in the current literature on social prescribing, this chapter presents a systematic review which synthesises and critically analyses theoretical concepts in the field of social prescribing. The focus of the review is driven by the following areas of concern. The previous chapter, through discussing the impact of neoliberalism, highlighted the finding that there is a recent history of failure in policies that aim to tackle health inequalities (Scott Samuel and Smith, 2015; Mackenzie, Skivington and Fergie 2020). Alongside this, research has argued that even when the discourse on an intervention recognises the need for action on improving the social determinants of health, the focus of the intervention drifts towards a focus on making impact at the level of the individual, impacting the individuals' emotions, cognitions and behaviours. This shift towards the individual level has been termed "lifestyle drift" (Williams and Fullagar, 2018). A similar trend has been identified in literature on wellbeing (Lomas, 2023), with the improvement of the individual's emotional wellbeing a concept often associated with the goals of social prescribing. On this drift towards the individual, critics from within the field of wellbeing have argued that whilst the focus on the individual is often needed, more durable theoretical connections need to be made to the surrounding context or structures the individual finds themselves situated in (Lomas, 2023). It is argued that better theoretical connections here could help in understanding the prior needs of the individual, in relation to the social determinants of health, before engaging in the intervention (Lomas, 2023). Alongside the lack of focus on context, the bias in focus towards impact at the level of the individual may sometimes overlook the impact that may occur through the intervention at the level of the broader system the intervention is delivered within. An example of how this concern could be associated with the impact made through

social prescribing could be the way in which changes in the individuals' emotions, cognitions and behaviour may be connected to their further participation in deciding where money with a service is spent, the formation or commissioning of a group, or their move from a user to provider of a service through social entrepreneurship. Whilst this change is unlikely to occur without changes at the inner level of the individual, and their emotional wellbeing, the changes at this level of the system may lead to changes at the level of institutional design or service delivery. For example, critical commentary within the field of wellbeing has argued that the overwhelming focus in much evaluation of impact has been at the level of the individual, overlooking if any impact has been made to the "social- ecological" level through the intervention (Lomas, 2023, p137). Alongside the gap identified in the pre-existing context, this literature review will identify if the literature on social prescribing contains concepts that analyse and describe the impact at the various levels of analysis discussed in the previous section.

To understand how successful the literature on social prescribing has been in making these connections, the central aim of this review is to explore the theoretical concepts used in the literature on social prescribing. Undertaking a review with this focus enabled the development of the research questions underpinning the broader thesis. These questions were formulated on the perceived gaps in the literature as this pertains to the theories used in the social prescribing literature.

This systematic review uses critical realist methods (Edgeley et al, 2016). The following section will describe the reasons why critical realism was chosen as the approach to the review taken and how the strengths it offers fit with the focus of the. Firstly, in relation to the focus on the theoretical concepts within the review, critical realism claims that our relationship to reality is always discursively constructed and why that reality may exist, we need to scrutinise and think

critically about our theories that we use to assign meaning and causality to reality. Moreover, critical realism as a review methodology "eschews cookbook approaches" (Edgeley et al, 2014), allowing for more recursive development of focus and questions with this more appropriate for complex emerging literatures like social prescribing. In addition, critical realists believe in a deeper level of reality than other methodological approaches. Critical realism as a method assumes that most of the analysis contained in fields of study focuses on a different level of reality that can be directly observed. This is referred to as the "empirical" (Bellazzecca et al, 2022). In exploring the deeper level of reality, critical realists explore the concepts and analysis contained in papers which it is assumed exists at the empirical level of reality to make inferences on the "actual" (the unobserved but existing) in the papers to get at the (unobservable but existing) "real" (Edgeley, et al, 2014).

Following guidance on this method, "a critical realist review is a review of literature; it is not an empirical review of an intervention" and its aim is "conceptual and theoretical development to the issue under analysis" (Edgely, et al, 2014 p 322). Moreover, the primary aim of a critical realist review is to analyse the "assumptions" or "ways of seeing" (Edgely, et al, 2014 p 322) contained in the literature, with critical realists believing that knowledge creation is always value laden. It therefore follows that it is best to bring our values under conscious awareness rather than pretending they do not exist. As such, researchers are encouraged by Edgely et al (2014, p321) "to think about the concepts associated with the topic they have chosen. What concepts crop up, what appears to be implied but not stated and what seems to be missing?". This suggestion will be drawn upon to assess the patterns, gaps and perhaps silences analysed in the papers contained here. Critical realism then provides the tools to offered a detailed critical reading on the concepts used in the literature on social prescribing. Dragana et al (2021 p5275) argue that "social prescribing as a field of study is

underdeveloped in both theoretical and methodological aspects […] thus, the literature on social prescribing should be considered to be at its inception".

Following this, the aim of the review is to identify areas in need of improvement in the early theoretical connections made within the field, which will then be built upon in subsequent theoretical chapters of this thesis.

As stated in the previous section, the field of social prescribing is in the early phases of its development. The relative youth of the field of social prescribing is further substantiated through reference to recent reviews on specific populations or social problems as they pertain to social prescribing. These reviews contain only a small number of papers. In a review on older adults, Grover et al (2023) found only nine papers worthy of inclusion (n=9). Reinhardt et al (2021), who focused on social prescribing's ability to tackle loneliness, found only eight relevant papers (n=8). As a result of this, whilst the focus of the broader PhD project is on working class and precariat men and their referral and engagement with social prescribing, after a scope of recent reviews and the included papers, it was deemed that there was not an adequate amount of data included in the primary papers on either men, class, or inequality to conduct a synthesis directly on this focus. Whilst the review questions explore the connections made in the field on class and gender, this is an exploratory secondary focus of the questions that will be posed rather than the primary driver

As a result, the review, informed by critical realist guidance on conducting reviews, will explore the analytical or what are sometimes referred to as "second order concepts" (Britten et al, 2017) contained in the literature as they relate to impact of social prescribing on users' health and wellbeing as described or analysed conceptually. That is, it will explore the patterns of change – positive and negative - that the policy may create through how this impact is analysed conceptually in the papers. Following this, the further exploratory focus will examine

if (as it cannot be assumed it does *a priori*) and *how* the social prescribing literature reports contexts associated with the broader PhD study. In connection to the working class and precariat men as the primary groups of interest to the main PhD study, this focus on context will explore if the discussion or conceptualisation of contexts within the papers is associated with the social, cultural economic status, class and gender of service users and how or if these interact and shape the impact of social prescribing.

Alongside this, the review will explore the analytical concepts that may be used in the literature to explore mechanisms "Mechanisms can be described as natural, social or individual powers that generate tendencies in events. While they may not be observable, their influence can be retroduced from what is observed" (Spacey et al 2022 p347) For example, a mechanism that may come into play through social prescribing could be the social trust formed in the users towards link workers. In addition, through using the critical realist concept of agency, the review will focus on the way in which this has been discussed conceptually in the papers. For critical realists, agency refers to the "powers of individuals to engage in meaningful action" that is separate from structures and mechanisms (Spacey et al 2022 p347). In relation to social prescribing, although an individual is referred, unless this referral is fully aligned with the reasoning and decision making of the individual it is unlikely to be sustained or change further social structures.

To achieve the focus desired, the review is driven by three questions focused around the theoretical concepts associated with the user/client experience of social prescribing in line with the primary focus of the overall thesis.

2.1.1. Review questions

1) Does the social prescribing literature use theoretical concepts to describe clients'/users' accounts of its impact, and, if so, are these made with any connection to the context of class and gender?

2) Does the social prescribing literature use theoretical concepts to describe the antecedent contexts of clients'/users' engagement that interact with the intervention (for example, material, political, cultural), and if so, do any of these concepts connect to class and gender?

3) Does the social prescribing literature use theoretical concepts to describe and explain the mechanisms and agency in play for clients'/users' in social prescribing components (referral, link worker relationship, activity referred to) and, if so, how they relate to the contexts of class and gender?

2.2 Eligibility criteria

Inclusion criteria

Qualitative, mixed method and quantitative peer reviewed papers on social prescribing that focus on impact, experiences, and perceptions of clients/users of social prescribing.

Exclusion criteria

- Papers that focused solely on the perceptions of General Practitioners in the delivery of social prescribing
- Papers that focused on reducing NHS workload or attendance rates alone
- Papers that focused on financial and environmental sustainability or that focus on economic evaluations and cost benefit
- International studies on social prescribing outside the United Kingdom
- Papers that focussed on children or adolescents <18

- Grey literature and opinion pieces
- PhD studies or dissertations
- Papers not published in English

2.3 Search strategy

As per critical realist Edgeley et al (2014), the search approach was iterative, like the development of the question. Firstly, an initial search was undertaken to retrieve recently published reviews on social prescribing. This was achieved by a simple search in Google and the university library database. This returned several systematic reviews for the field of social prescribing (Calderon-Larranga et al, 2022; Husk et al, 2019; Tierney et al, 2020). After consulting these reviews, it was deemed that the review could not focus solely on the thesis's population of primary interests - men positioned lower down the social ladder (Marmot, 2015) with less relative income, wealth, occupational prestige and status than others. Rather, it was deemed best to focus on the concepts used in the social prescribing literature that focused on both men and women, whilst asking more exploratory questions on how the concepts used to discuss populations included in the papers may relate to working class and low socio-economic status men.

After consulting the above reviews, a list of databases targeted in the reviews was consulted. The databases targeted were informed by Calderon-Larranga et al (2022) and were, PUBMED, EMBASE, CINAHL, PsychINFO and Scopus. The Cochrane databases and grey literature databases such as The Kings Fund were not used as they did not meet the inclusion criteria or the focus of the review. The decision to exclude grey literature was to ensure that only peer reviewed literature was included.

As the inclusion criteria for this review was not focused on international papers on social prescribing, there was no need to used alternative synonyms like community connector as this is associated with international models of social prescribing. Following this, long search strings connected with Boolean operators like "community connector OR", were not included.

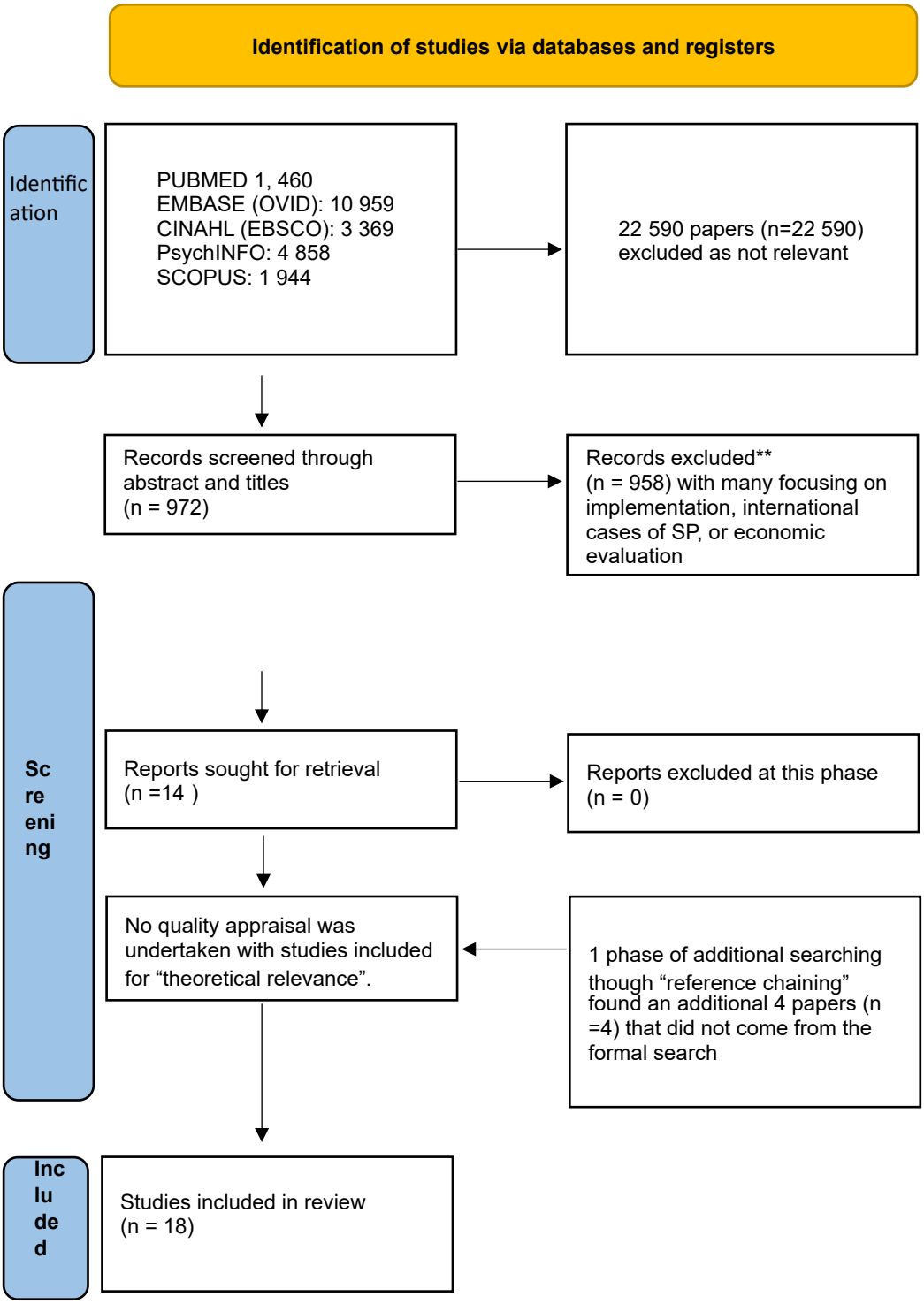
The search terms were the following, with some adjustment made to the various database interfaces: "social prescribing OR social prescription".

Truncation social prescri* was trialled but added no additional papers.

Moreover, though the most recent growth of social prescribing is sometimes connected to the 2018 speech by Matt Hancock (Hancock, 2018) that launched the National Academy of Social Prescribing, several papers pre-existed this date when the policy was launched. The papers identified were around the year 2010. As a result, this year was used as the search limiter.

2.4 "Theoretical relevance" and appraisal of papers

Following other critical realist and similar reviews, the papers were not quality appraised. The central focus of the review is conceptual, theoretical, and not methodological. Following Bellazzecca et al (2022, p4) papers were included for their "theoretical relevance" even when not "methodologically robust".



2.5 Method of analysis, synthesis and reporting

Thematic synthesis, as developed by Thomas and Harden (2008), was selected as the method to synthesise the findings of the paper. The step-by-step outline of the process of thematic synthesis is well suited and versatile enough for the synthesis of complex and emerging fields

like social prescribing. Whilst the guidance on the steps to be taken are presented in a linear way, the process itself is more iterative and recursive. To analyse the papers, hard copies of the 18 papers were printed out. In following the first step of thematic synthesis, and using the logic of descriptive coding, papers were coded line by line. The aim of this step was to look for mentions in the text of any theoretical concept or surrounding commentary associated with the questions guiding the review. During the reading of the individual papers, when a theoretical concept was encountered, a descriptive code was marked in the righthand margin of the hard copy of the paper. For example, if the concept of "flow" was used to describe the engagement in the referred to activity of social prescribing, then this information was also marked in the margin alongside "inner pleasant state used to describe the activity engaged in after referral".

Following this, a second phase of analytical coding took place. Here the disciplinary home or paradigm associated with the theory was coded. Using the above example again of flow, the analytical code "positive psychology" was used to demarcate the associated disciplinary home of the concept. If this was not clear from reading the text, the reference was consulted in the bibliography. In the final phase, the descriptive and analytical themes from above were synthesised into higher order themes. These themes identified patterns of meaning in the use of theoretical concepts across the individual papers. To facilitate this synthesis of codes, patterns were formed by using plain coloured post-it notes. The descriptive and analytical codes that resulted from the phases described above were noted down on a post-it note with the note containing some supporting quotes that surrounded the concepts from the individual papers along with the descriptive codes. The aim of this was to explore patterns of meaning that went beyond the theoretical concepts contained in the individual papers. These notes were then re-arranged and clustered together around three ideas. Firstly, if they discussed similar theories; secondly if the theories connected to similar parts of the policy of social

prescribing. Lastly, then connecting to impact, context, mechanism and agency as the critical realist components described above and in reference to the questions driving the review.

Some of the post-it notes that contained descriptive/analytic codes, with the supportive quotes, were then compiled together to explore patterns of connections through themes. For example, quotes that connected to flow, emotional change, motivation or psychological control as central change of social prescribing within the papers were grouped together around a new sticky note titled "inner impact". Those that described "networks" or some form of social connection, were grouped underneath a title post–it note referring to "outer impact". Codes that for example described "trust" or related through the link worker connection were grouped together. Sometimes the codes created in reference to the theoretical concepts were connected to theoretical concepts in the individual papers that required more deliberate decision making. For example, the codes developed were often connected to theoretical concepts like interpersonal trust. Sometimes the use of this concept within the individual papers described both impacts, but also a possible mechanism. This is common when dealing with realism and critical realism as identified in the guidance (Pawson, 1999). When this occurred, guidance suggests that an interpretive judgement must be made on the place of such a concept. Following this guidance, the researcher made judgement based on his interpretation of the central aims of the paper and the centrality of the theory within it in relation to a purported mechanism or impact.

Although the analysis and synthesis of the papers was driven by Thomas and Harden (2008) on thematic synthesis decisions on when to conclude the analysis of the papers was driven by more recent guidance by Braun and Clarke (2022 p 148) on the conclusion of sampling in qualitative orientated research. In opposition to ideas of "informational saturation", and exhaustion of all possible information, they argue that an interpretive judgement be made on

"informational power" in the analysis. When the researcher felt like some reasonable answers had been given to the aims of the review and the questions raised at the outset, analysis and synthesis was concluded. Alongside this judgment, the conclusion of the analysis was also driven by the fact that social prescribing is a new but growing field and there was only a relatively small amount of peer-reviewed qualitative papers available. This resulted in four themes with two subthemes.

2.5.1 Description of included papers

Fifteen of the 18 papers were qualitative, with 13 of the papers involving some form of interview method; a further two papers were primarily observational with ethnographic research designs. Three additional papers were mixed methods, combined some form of survey designs with qualitative semi-structured interviews. Whilst quantitative papers were part of the inclusion criteria, many of them that were scanned for inclusion were from local evaluations that were not published in peer-reviewed journals. The theoretical coverage contained in these papers was not sufficient for that required in answering the research questions.

It was deemed that only two out of the 18 papers contained sufficient analysis on class and gender. This was even though all but two papers reported some form of area deprivation and how this effects people in their description of recruitment or study setting. This lack of coverage seems problematic given the rhetorical claims made within the social prescribing reportage suggesting it can help to tackle patterns of health inequalities and improve access to the social determinants of health (Calderon-Larranga et al, 2022). Added to this, is the continuous implicit recognition across the papers that the social prescribing pathway contains both an activity arm (for example, "ping pong") combined with an arm more squarely associated with other areas of the public sector (such as debt advice, food insecurity and

benefit advice) without enquiring as to if these two things should be combined or be a part of social prescribing. Furthermore, no analysis included in the papers enquired as to if and how social prescribing may merely be servicing poverty, deprivation and indebtedness that are a result of system level macro-economic conditions and policies, where indebtedness is welcomed for many, and stigmatised for some. Of central interest to the study setting of the broader PhD study, 10 of the included papers were based in the North of England with the other eight focused in the Midlands and South of the country, with one paper based in Glasgow, Scotland. In addition, none of the papers focused on men as a population alone who use social prescribing with this legitimating the exploratory nature of the review.

All but four of the papers focus on impact at the level of the individual with behaviour change, cognitive change, positive emotion and the development of skills, purpose and meaning covered across most papers. As a result, the analysis lacks well-formed micro, meso and macro links. When the papers do focus on outer change at the meso-level of developing community assets or social capital, it is with cursory reference to theories that stress social integration or "social self-efficacy" (Carnes et al, 2017) where social prescribing is positioned as the "social cure" (Kellezi et al, 2019). These are weak on the distribution of power and resources in society and in reference to the "social cure" (Kellezi et al, 2019) under examine who is complicit in fostering the social pathology and how it connects to upstream macro - structural influences. This is both analytically and normatively problematic. Further to this, only two papers report how social prescribing connects to policy agendas.

Table 1: Data Extraction Table

Authors	**Location**	**Programme (content of referral)**	**Sample and research design**	**Reported Impact**	**Analysis on social class and gender contained in papers.**
Bertotti et al (2018)	Hackney and City in London	Not specified but mild to moderate mental health needs, debt and employment stated	N = 17 (but only 5 vignettes presented) Gender of participants not reported Gender neutral descriptor 'service user' used across the dataset with no disaggregation between male and female Participants described as 3 out of 5 lived alone; only small number in employment; experiencing mild and mental health problems and social isolation. Qualitative face to face interviews, with some telephone interviews with 'patients'	Noted that social prescribing improved wellbeing outcomes for people with mild mental health problems and isolation Increased self-esteem. Renewed sense of purpose Connections made to cognitive/ behavioural self-efficacy theory, and "motivation"	Analysis starts at the stage of "referral process"; does not discuss the antecedent contexts of class and gender and how they interact with social prescribing. Participants described as experiencing 'health inequalities'
Carnes et al (2017)	Hackney, London	Varied pathways listed including "exercise and ping pong", but reported that no solid data could be captured on participation of classes	N = 20 Gender of participants not reported Participants = 'more likely to be living alone and unemployed'; 'extreme range of socioeconomic deprivation' Mixed methods. Randomly assigned control group from neighbouring areas from people not involved in social prescribing; triangulated with a phenomenological approach to capture the impact of social prescribing from a "patient perspective" through "beliefs and opinions at one point in time"	Study reports no improvements for control or treatment group in general health, wellbeing, and mental health or "positive and active engagement" The quantitative analysis in the study also reports "a reduction" in activities participated in in the intervention arm. This was in contrast to qualitative data with a different sample that demonstrated "powerful" impact	No analysis of class, inequality or gender

Cheshire et al (2022)	Not stated	Yoga 4 Health through social prescribing	N = 22 All female Qualitative interviews and focus groups. Three "time points" Before, during and two months after engagement in social prescribing	'Perceived benefits spanned psychological, physical and social domains'; self- management skills; enjoyment and sense of social connection	No analysis on class, inequality or gender but study argues that: 'yoga as an intervention may be less acceptable to men with long-term conditions, which should be explored with future research'
Dayson et al (2020)	Rotherham	Nothing specific stated, but noted that "sustained engagement in community activities, including participation in peer-to-peer support, networks and volunteering"	N = 20 Gender of participants not reported Qualitative case study of one mental health social prescribing service, with "three nested case studies" of social prescribing providers Semi-structured interviews carried out	Activities provided environmental mastery, "confidence" and "lifeline" with some connection to theories on "flourishing" and "hedonic" positive affect and wellbeing Social wellbeing discussed as "social contribution and "integration"	No analysis on class, inequality or gender
Gibson et al (2021)	North of England	Not specifically stated, but examples of social prescribing through reference to "gym referrals, benefits, housing advice and community classes".	N = 23 Clients experiences of social prescribing captured through ethnography between November 2019 and July 2020 Four case studies/participants (n = 4) used to draw out findings from a larger ethnographic dataset (n = 19)	Paper reports contrary to rhetoric stated in policy documents, social prescribing and personalised care cannot tackle health inequalities	"Bourdieusian" theory of class used to discuss the connection of social prescribing to "everyday contexts" Gender and class discussed through the case of "Eddie" whose lack of economic capital erects barriers to him participating fully in social prescribing

Gibson et al (2022)	North East England	States that social prescribing pathway is heterogenous, "ranging from benefits advice, fitness classes and social groups". As well as "gardening"	N = 19 Class and gender reported (7 men and 12 women) Participants = aged 4074 Ethnographic study conducted between November 2018 and July 2020. "Longitudinal" ethnography. 200 hours over 20 months spent with the participants Participants sampled for diversity and ranged from being close to discharge from social prescribing or in "active participation". Adapted to "remote methods" during pandemic	"temporal" elements of the social prescribing intervention often rubbed against the grain of some of the working class men who were sampled. Economic need and shift work often prevented impactful experiences of social prescribing	Some discussion of "marginalised communities" Class and gender discussed in detail. Specifically, through Bobby and Warren who suffer from "time poverty... a regular feature of working class employment which denies "temporal autonomy"

Hanlon et al (2021)	Glasgow, Scotland	Not specified claiming that no "prespecified" activities were designed in the social prescribing pathway but that these were added on after a personalised consultation	N = 12 Participants = 6 male "Patients with complex needs in areas of high socioeconomic deprivation", progressing to make claims about social gradients, stating "People living in more socioeconomically deprived areas are also more likely to experience combined physical and mental health problems" Thematic analysis of semi-structured Interviews	Out of n = 12, 4 described no overall improvement related to self-determination theory and its associated needs: "relatedness autonomy and competence" 6 described moderate or major improvement and 2 described slight improvement	No analysis of class, inequality or gender
Hassan et al (2020)	North West UK (two locations)	Life rooms provides either "learning opportunities or social support". "free courses on topics such as wellbeing, understanding the management of mental distress and other social and creative offerings". "housing, debt…and volunteering" and library facilities	N = 18 Participants = "two thirds were female" but no disaggregation in analysis 6 semi-structured focus groups with mental health service users Aim to get at "service users experience" Section on recruitment identified that mental Health problems "disproportionately affect those from a poorer socioeconomic background; associated with exposure to "poverty, unemployment, low educational attainment, and poor housing"	Can impact social determinants of health; all participants reported that social prescribing positively impacted their mental health, plugging the gaps in service and offering 'a sense of purpose by participating in meaningful activities'	No analysis on class or gender but some cultural analysis on "street drinking", homelessness and social exclusion issues Study notes that 'the majority of participants came from disadvantaged backgrounds' No specific mention of issues pertaining to gender

Howarth et al (2020)	North of England	Nature-based social prescription; RHS Bridgewater Wellbeing Garden Gardening case study, but refer to social prescribing activities as pertaining to, "Exercise classes, yoga, knit and natter groups, gardening or arts based activities"	N = unknown Specific number of interviewees not stated, with the proviso that the paper positions itself as in progress through "findings thus far" Gender reported with use of 'him' Mixed methods research design, before and after survey using SWEMWBS Focus groups	Study reports improved self-confidence and reduced social isolation	No analysis on class, inequality or gender.
Kellezi et al (2019)	East Midlands	Self-care management, VCSE referral but no specific pathway mentioned	N = 19 No specific reporting on the number of male participants, but noted that less men recruited than women Interviews all clients/service users Mixed methods Qualitative interviews and quantitative longitudinal component	Impact identified through the theoretical use of the 'social cure', where social prescribing connects people to groups to tackle social isolation	No analysis on class, inequality, and gender

Moffatt et al (2017)	Newcastle	Long-term condition management e.g. physical activity, weight management, healthy eating, welfare rights advice, benefits advice, learning and employment assistance (e.g. CV writing), voluntary work Community activities: quiet art therapy, gardening, fishing, crafts	N = 30 16 men, 14 women Semi-structured interview Data on occupational social class obtained, based on current or previous employment Setting for study in an inner-city area or high socio-economic deprivation in North of England	Impact reported as control self-confidence, reduce isolation, weight loss, healthier eating, increased physical activity	Study notes: "Long term health problems were linked to a range of social and economic factors including relationship breakdown, job loss, income reduction, debt and housing problems".
Payne et al (2020)	Sheffield	Advocacy (welfare, benefits advice) Physical (health trainer, swimming) Wellbeing (yoga, pain management, walking) Social (social café) Creative (art, craft, modelling, cooking) Volunteer (applied to all)	N = 17 Participants = 6 males. Data disaggregated into male and female Majority of participants lived in areas of 'high socio-economic deprivation' 9 participants located in the most 10% deprived areas of the UK; 14 lived in the most deprived 30% Combines realist 'deeper mechanisms' and 'lived experience' Qualitative study on perceived benefits of social prescribing and "experience of change" Combines realist "deeper mechanisms" and "lived experience"	Learning new skills Engaging with others, followed by purpose, and developing a positive outlook	No explicit analysis of class or gender but some analysis commented on reasons for referral with benefit advice and social isolation listed

Redmond et al (2019)	South West England	"creative arts" programme (Airlift); patients engage for 8 to 10 weeks Drawing, mosaics, painting, and creative writing	N = 1297 (large qualitative sample) No participant information on class or gender Qualitative methods and thematic analysis from feedback from an open-ended questionnaire on self-reported benefits of the arts referral programme Longitudinal collection of a whole patient cohort other 7-year period	The study identified impact through terms like "empowerment" "wellbeing" and "self-discovery" as linked to self-determination theory "Creativity" and development of skill in art	No analysis containing class or gender but some commentary on supply side and issues that social prescribing 'offers an opportunity to plug some gaps' in statutory services experiencing cuts from "austerity"
Stickley and Eades (2013)	Nottingham	Arts on Prescription for "people with mental health problems"	N = 10 Participants disaggregated in a table with gender; 7 men Follow up study from first study two years earlier. Qualitative "in depth" one to one interviews	Increased self confidence Improved social and communication skills Increased motivation and aspiration "both hard and soft outcomes identifiable but most were soft outcomes" Soft outcomes = "raised confidence and self-esteem" Hard outcomes = "educational achievement and voluntary work"	Some discussion of how social prescribing connects with policy agendas, including New Labour and "Coalition government" but no discussion of the context of class or gender

Stickley and Hui (2012)	Arts on Prescription for City Arts, Nottingham.	Arts on Prescription for 'people with mental health problems".	N = 16 (8 men) Participants disaggregated in a table with gender First study with part 2 following two years later Qualitative "in depth" one to one interviews; "narrative enquiry process"	Increased self confidence Improved social and communication skills Increased motivation and aspiration "both hard and soft outcomes identifiable but most were soft outcomes" Soft outcomes were described as "raised confidence and self-esteem" Hard outcomes were described as "educational achievement and voluntary work"	No mention of class, inequality, or gender.
White et al (2022)	North of England	No activities listed; study focused on the use and experiences of social prescribing in social work referrals	Full sample N = 10 Men N = 7 No disaggregation between male and female 'clients' "service context" is located in an area of "higher than average social deprivation indicators" Qualitative study; semi structured interviews with range of stakeholders, including clients Thematic analysis	Self-referral often does not work in contexts of deprivation, with more intense support needed.	No analysis of gender and class But a context of loneliness, isolation is noted

Wildman et al (2019)	North East England	Ways to wellness social prescribing offers services on from "weight management, welfare rights, and arts- based activities"	N = 24 13 men Data disaggregated between male and female "40 most socioeconomically deprived areas in England"; higher-than average proportion of the west Newcastle population have LTCs and are in receipt of sickness or disability related benefits Semi-structured follow up interviews	Reported reduced social isolation, improvements in condition management and health related behaviours. Other reported "set backs" due to multi morbidity, family circumstances, and social, economic, and cultural factors	Some analysis describes how structural factors associated with inequality lead to 'setbacks' but no analysis of gender or male specific issues Also of interests was a noted lack of "suitable and accessible voluntary and community services for onward referral"
Wood et al (2021)	North of England	Most SP programs	N = 35 Interview phase: N = 15 clients N = 5 men Focus group phase: N = 5 clients N = 2 men Qualitative data collected through semi - structured interviews and focus groups High socio-economic deprivation; study focused on "predominantly white working-class council estates"	Salutogensis, wellbeing and coherence Social prescribing as addressing the "wider determinants of health" Discussion of how personalised care may "disadvantage" those whose sense of "coherence" is so low that they may be unaware of how or what to change Noted that the "wider determinants of health may "constrain the effects of the SP intervention"	Some analysis of inequality in context with "social needs" including "housing, benefits and lack of support networks"; claiming "many are isolated" No specific analysis of gender and class

2.6 Themes and findings

2.6.1 Impact at the level of individual and community through social prescribing: inner change and outer impact

This section will answer the first question of the review: "does the social prescribing literature use theoretical concepts to describe clients'/users' accounts of its impact on health and wellbeing and, if so, are these made with any connection to the context of class and gender?". In response, many of the papers included describe the impact of social prescribing at the level of the individual. Most described changes at the inner level through concepts associated with behaviour, attitudinal, or cognitive change associated with health and wellbeing. In addition, despite claims in some papers that social prescribing is associated with the social determinants of health and health inequalities, there is very little coverage of individuals' class or gender. Some of the examples of the prevalence of the concepts in the papers focusing on inner change can be found in the following examples. In several of the papers included they used concepts from the discipline of psychology to describe inner change through social prescribing. More specifically, some drew on concepts associated with the fields of humanistic and positive psychology (Stickley and Hui, 2012; Hanlon et al, 2020; Howarth et al, 2020). These papers describe cognitive and experiential impact of social prescribing, using concepts like the experience of positive emotion and "flow", as a state of full engagement (Howarth et al, 2020, p296) when engaging in an activity associated with social prescribing, alongside the cultivation of intrinsic motivation through the development of "self-determination" and "control" (Hanlon et al, 2020, p175). Lastly, some refer to the concept of "coherence" as associated with the theory of inner control and balance associated with salutogenesis, with this concept prioritising change at the inner level (Wood et al, 2021, p5). In addition, papers also described the impact resulting from participation in social prescribing as a "hiatus" and

"space" from everyday life and the "mundane", claiming this may often be connected to a more developmental "form of healing" and a "better psychological state" (Redmond et al, 2019, p239-240). Many of these concepts in the papers are from the field of psychology with little well-developed connection of how impact of individual level relates to the contexts of class and gender.

Despite this noted gap in the concepts contained in the literature, a paper does focus on how the focus on inner change alone may be problematic, identifying why this may need correction with more concepts that focus on outer change (e.g. on how social prescribing creates forms of "social capital" (Carnes et al, 2017, p8) when measured through association in networks and resources, not just changes at the inner level. This is especially the case given that some of the papers identify settings of deprivation (Hassan et al, 2020; Hanlon et al 2020), in contexts associated with a lack of access to resources, relationships and goods associated with the social determinants of health.

Moreover, commentary on concepts in papers claims that the focus on inner change may be too simplistic and that the "theoretical assumptions" contained within the social prescribing literature (that it can help change individual mindsets and behaviours) may be "misguided" (Carnes et al, 2017, p8). In contrast to this focus on inner change, Carnes et al (2017, p8) suggest a "better conception is to give value to self-efficacy and social capital" whilst also considering other forms of outer impact. Whilst there is some commentary that argues for the need of a more nuanced understanding of social change through social prescribing, these are rare in the papers included.

For example, whilst one paper claimed that social prescribing has the potential to increase access to the wider determinants of health (Hassan et al, 2020) only one paper contained commentary on how the impact that social prescribing may make needs to be understood

within the broader political contexts of the austerity agenda and how this context may shape the changes made through social prescribing (Redmond et al, 2019). Moreover, one paper included described outer impact that moves beyond behaviour or individual cognitive change by stating that social prescribing "provided resources that supported individuals to reconnect with the things they used to do, for example presenting, [and] running workshops" (Hassan et al, 2020, p6). None of the papers in the review, however contain concepts or discussion which reflect on how volunteering and running workshops may be problematic for those in deprived contexts with low levels of wealth, income, or power as associated with concepts of class or other concepts associated with inequality. Moreover, another paper contained conceptual coverage on how social prescribing can create "social networks". In doing so the authors point implicitly to the sustainably of social networks created through social prescribing as part of the impact, describing this as "the development and improvement of locally based social networks that can continue beyond the purpose of the socially prescribed activity" (Redmond et al, 2019, p234). This does not discuss as part of the intended impact how social prescribing or the groups it supports can be sustainably financed under the current fiscal challenges or an economic model that has created widening inequalities of wealth and income.

In summary, whilst many of the papers contain commentary that discuss deprivation, none use concepts to discuss how deprivation is connected to policy and asset flows at macro level and if the impact achieved through social prescribing beyond at the outer level can help offset or mitigate this. As a result, many of the concepts pertaining to impact and the surrounding commentary are weak on how impact relates to broader structural trends associated with health inequalities. As a result, the papers lack adequate theorisation on the distribution of power, income, and wealth in society. In conclusion to the first question posed then, papers in the social prescribing literature discuss impact mostly at the individual level through use of

concepts derived from psychology. Whilst there is some links made on how the changes made at the individual level connect to context, in answer to the exploratory questions posed, there is little conceptual coverage on the concepts of class and gender.

2.6.2 Theoretical concepts associated with context

Following the metatheoretical framework of critical realism, the following section will discuss the concepts and surrounding commentary in papers that focus on the antecedent structural contexts that exist and are encountered prior to social prescribing. Whilst there has been some discussion of this above in relation to how the impact of social prescribing connects to inner and outer change, this section will answer in more detail the second question of the review, that is: "does the social prescribing literature use theoretical concepts to describe the antecedent contexts that interact with the intervention (for example, material, political, cultural) and if so, do any of these concepts connect to class and gender?" The first of these subthemes on context will discuss the coverage of concepts in related to the social and economic context as discussed in the papers. The second sub –theme will discuss the coverage of the cultural context, with both sub-themes providing an answer to the second review question.

1) <u>Social and Economic context</u>

Many of the papers included are undertaken in areas of deprivation, with studies based in some of the most deprived areas of the United Kingdom (Moffatt et al, 2017; Hanlon et al, 2021; Hassan et al, 2020). Nevertheless, in reference to the review's questions, only three papers included in the review refer explicitly to social class (Moffatt et al, 2017; Gibson et al, 2021; Gibson et al, 2022).

Papers describe the context of inequality by claiming that poor mental health is connected to inequality. For example, Hassan et al (2020, p1) argue that poor mental health is "associated with socio-economic factors such as poverty, unemployment, low educational attainment and poor housing which are also linked to physical health problems" (Hassan et al, 2020, p1). They add that people have "complex needs" claiming that integrated care and social prescribing can help get to "the root" of health issues (Hassan et al, 2020, p2). Other papers draw attention specifically to the social gradients found in antecedent structural contexts. For example, Moffatt et al (2017, p9) describes the social gradients in the following way "people from lower socio-economic groups experience higher levels of chronic disease, and have poorer condition management, worse health outcomes and higher mortality. Behavioural risk factors for long-term conditions include poor diet, smoking and physical inactivity, all of which are socioeconomically patterned". Whilst this discussion of context does not directly discuss the context of class and gender, it offers some coverage on contexts associated with these concepts. Some papers also use concepts to describe how social prescribing can "reach into communities that are difficult to access" (Redmond et al, 2019, p234), but with little description or analysis on why communities are difficult to access, for whom, and what this says about the distribution of power, income and wealth across society. Moreover, many of the papers describe social prescribing as offering "debt and employment" support (Hassan et al, 2020, p3) and "benefit advice" (Wood et al, 2021, p1) in deprived areas. As stated, because the papers often lack adequate coverage of the context, few of them described how this type of support, when disconnected from efforts to tackle drivers of these social patterns of the macro level, may mitigate the structural causes of indebtedness but not get to the root causes of these social problems. In addition, other papers describe the antecedent contexts of social prescribing by discussing how people who participated in social prescribing in deprived communities in Glasgow, had a "lack of supportive relationships," being "unable to mix with

others". For example, Hanlon et al (2021, p180) describe experiences of clients in the following manner, with clients reported to possess "little control over their own activities and unable to engage with the wider community". This coverage draws attention to concepts that describe contexts of deprivation were the people who reside suffer from addiction and a lack of "self-regulation" (Hanlon et al, 2021, p175).

Despite this lack of analytical coverage of antecedent context for social prescribing three of the papers included used concepts like "social class", providing an adequate theorisation of relational context through examining the "classed processes" (Gibson et al, 2021; Gibson et al, 2022, p1156) and contexts of those who engage in social prescribing. Gibson et al (2022) use a Bourdieusian informed understanding of class, describing how the stocks of economic, cultural, and social capital that working-class populations possess may prevent them from investing in the opportunities for health associated with social prescribing. Moreover, the authors use concepts that explore the temporal assumptions contained in social prescribing; that is, the availability of support and activities at the same weekly time during the day may erect barriers for working-class people (both men and women in the paper) in accessing social prescribing. Although the paper includes data from both men and women, the paper describes how working-class employment, historically associated with men, often leads to time poverty, with shift work often erecting barriers to men taking part in social prescribing in a "linear" way (Gibson et al, 2022, p1150).

In answer to the second review question, there are only three papers included that use concepts to describe how the contexts of class, inequality and gender interact with what is on offer in social prescribing. As will be discussed in the conclusion, this is a gap that the PhD study will look to fill.

2) Cultural context of social prescribing

The following section will continue to offer a response to the second question. In contrast to the previous focus on the social and material context. This section will now discuss how the cultural context is described and analysed in the included papers.

In addition to discussing the antecedent structural contexts, among the papers in the review there is little use of concepts that describe the antecedent context of culture, particularly that which pertains to men, and the norms, values and activities they engage with, and how it intersects with social class and gender. There is only one exception found in the sample of papers where there is a reference to "street drinking" (Hassan et al, 2021, p1), as a cultural activity associated with deprivation. In response to the questions posed then, as stated in the last theme, then, much of the literature seems to begin the analysis at the beginning with individual referral or engagement without any discussion of the surrounding context and how these contexts interact with the intervention. Similar findings have been acknowledged in other reviews informed by critical realism, but not on social prescribing, that claim much of the literature included was "decontextualised" (Bellazzecca et al, 2022, p8).

2.6.3 Theoretical concepts associated with the link worker interaction: mechanisms and agency

The following section will discuss how, in relation to the supporting metatheory of critical realism, research has discussed and used theoretical concepts to examine mechanisms and processes involved in the link worker interactions, and if these concepts report agency for those who pass through the policy. It will therefore offer a response to the third review question: "Does the social prescribing literature use theoretical concepts to describe and explain the mechanisms and agency in play for clients/users in social prescribing components

(referral, link worker relationship, activity referred to) and if so, how do they relate to the contexts of class and gender?"

Commentary in papers describe that, through working under the auspices of personalised care, the link worker acts as a pivotal relationship in the social prescribing process. Their roles seem to range from "straight forward signposting" to a more "intensive coaching style" (Carnes et al, 2017, p6). They are reported as carrying out, "a mutually determined wellbeing action plan" with the aim of improving "patient wellbeing" (Carnes et al, 2017, p7).

Commentary in a number of the papers reports that a major strength of the relationship is that it offers an alternative to the relationships associated with professional expertise. For example, Redmond et al (2019 p233) argues that "services run by community organisations…based on relationships that are other than the professional patient model seen in statutory organisations". Moreover, itis reported that this sometimes makes these interventions more accessible to communities in deprived areas that would otherwise "reject" similar types of professionally led health interventions, with previous rounds of engagement with "statutory" services leading to disengagement (Redmond et al, 2019, p233).

As discussed earlier, social prescribing and the link worker relationship has been associated in the literature with several theoretical connections. Commentary on the link worker role that describes this as one of the key mechanisms involved in social prescribing are connected to several concepts. Like the previous section, these concepts manly stress how the relationship with the link worker is associated with individual level mechanisms or processes. For example, papers describe the link worker relationship as "person centred" and "holistic" (Redmond et al, 2019, p234), and associated with the therapeutic work of Carl Rogers, "Humanistic" and "positive psychology" (Stickley & Hui, 2012, p574). Moreover, others describe it as connected to the "biopsychosocial model" (Carnes et al, 2017, p1), which looks to move beyond the

medical model. Several papers have drawn upon concepts that describe the way that link workers support the agency of service users to "voice their priorities and have control over what goals were set" (Hanlon et al, 2021, p182). Going further, it is suggested that this relational space that looked to offer patient or client choice and "control" were different to "many of the other interactions they experienced in other areas of their lives" (Hanlon et al, 2021, p182). In contrast, other papers reported no analysis of a supportive link worker or relational component of the social prescribing pathway. When discussing referrals that demonstrate no evidence of this, Carnes et al, 2017, p7) describe "patient evaluation" where no active discussion or conversation took place between the patient or client and the GP or link worker. In doing so, the authors describe a referral process of "parentalism", where the referral mechanism has no real element of engagement with those who are referred to social prescribing (Carnes et al, 2017, p5). Others mirror this analysis this by claiming that conversations with link workers on "what matters" has its place, but that it may have a negative impact in deprived contexts, where it "may disadvantage those whose sense of coherence is so low that they cannot recognise or articulate the need to change" (Wood et al, 2021, p5). White, (2022, p8) claims that social prescribers and researchers, may be at risk of underestimating the amount of support required to increase agency. Consequently, it is advised that concepts that describe agency through social prescribing, "such as choice, independence and empowerment are not over simplified" (White, 2022, p8). This concern also ties to the previously identified lack of adequate theoretical and conceptual discussion of context, without which researchers cannot understand if social prescribing can adequately provide agency to those who engage with the intervention.

In addition to concerns documented on the link worker relationship enabling agency, others comment on the heterogeneity in the level of support that the link worker offers. One paper describes how the nature of the support provided by the link worker needs to be intense for

many, given the prevalence of social isolation, multimorbidity's and other associated problems associated with deprived areas, and the socio-economic problems that accompany them (Moffatt et al, 2017).

In summary, in response to the third review question, the commentary in the social prescribing literature focuses upon the link worker role as a key mechanism in the journey of social prescribing. This commentary is connected to theoretical concepts that describe agency through choice and the voicing of priorities as two examples. These mechanisms sometimes do not seem well connected to context, and therefore there is little discussion of class and gender, for example how choice or the voicing of priorities may be absent for men in certain occupational contexts associated with class.

2.6.4 Theoretical concepts associated with the activities referred to through social prescribing: mechanisms and agency

The following section offer a further response to the third review question: "Does the social prescribing literature use theoretical concepts to describe and explain the mechanisms and agency in play for clients/users in social prescribing components (referral, link worker relationship, activity referred to) and if so, how they relate to the contexts of class and gender?" Like the broad and varied range of support associated with the link worker role, there is a heterogenous, and sometimes conflicting, range of activities on offer through social prescribing. For example, Carnes et al, (2017, p4) states "the community organisations referred to were diverse and reflected the different interests of people, for example, exercise classes, cookery lunch clubs, library visits, religious groups and ping pong". In addition, Redmond et al, (2019, p239) refers to an example of an arts pathway referred to through social prescribing. In relation to an "art class" pathway that provides a 10-week course, it is described that "those that attend are not required to have any particular history of, or skill with, their

particular art media; and are provided with required materials, and training to develop their skills in that media throughout the course and beyond" (Redmond et al, 2019, p239). This led to the cultivation of "new and rediscovered skills and hobbies" (Redmond et al, 2019, p240). Whilst the studies included in the review convey that this is sometimes the case, hardly any of the papers discuss how the contextual levels of economic, social, and cultural resources and experience may interact with social prescribing offering. Put simply, people's pre-existing skills, income, and social ties, especially in areas of deprivation, may lead to a lack of experience in art or crafts. There is no discussion of this in the literature included apart from a small sample of papers informed by the social theory of Pierre Bourdieu. One of these papers uses the concept of "hysteresis" as developed by Bourdieu, when describing social prescribing (Gibson et al, 2021, p2). This concept is used to describe a heightened emotional reaction that may occur if a health intervention asks too much from individuals by misaligning with their previous skills, interests, and capacities. For example, although not reported in many of the papers, men may feel threatened by being asked to do art, dancing or cooking classes as an offering that does not fit with their previous experiences both in employment and leisure. In addition, research discusses how social prescribing can help support people through "debt advice", "food insecurity" or "homelessness" (Carnes et al, 2017, p3) without questioning if this is a legitimate focus for social prescribing. For example, unless the policies practice of asking "what matters" to people (Howarth, et al, 2020, p 265) means what basic goods do people need to survive, then some of the provision may be more suited for better resourced areas of the public sector. Arguably, this positions social prescribing as not being about engaging in a social activity to improve wellbeing, but instead about assisting with basic economic, dietary, and housing needs.

2.7 Conclusion and discussion

In relation to the review questions, theoretical concepts contained in the papers that focus on the impact of social prescribing mostly focus on easily observable forms of experiences, or mindset and behaviour changes. Much of the concepts and discussion contained in the papers relate to the field of psychology, with concepts drawn from humanistic, positive psychology, self-determination theory, and the more behaviourist oriented self-efficacy theory. Despite many of the papers discussing study settings of deprivation, the analytical coverage of context is sometimes under-developed in the papers with only a small number of papers using concepts from sociology and political science to make connections on the impact of the social prescribing as connected to the macro or meso-level of analysis. Very few of the papers assesses if this individual level of impact can be connected to other forms of outer impact that could help transform the negative elements of the context associated with the identified deprivation. This identified gap will help inform the selection of theories that inform the broader thesis as documented in the following chapter.

Strengths and limitations

To the author's knowledge, this is the first systematic review of social prescribing to use critical realism as a review method, where the "ways of seeing" (Edgeley et al, 2014) and the theoretical concepts in the papers are scrutinised. It is also the only review that has an exploratory focus on if, and how, the literature on social prescribing uses analytical concepts pertaining to the antecedent contexts of the intervention. 18 papers were included after a comprehensive search process, the number of papers included is a comparatively sizeable amount compared to other recent reviews on social prescribing. However, given the emerging nature of the field of social prescribing it is possible that some papers were missed.

Implications for the PhD study and gap identified in literature: the lack of coverage on men and class in the field of social prescribing

There is only a small coverage of men and social class in the literature and no article specifically focused on men's experiences of engaging with social prescribing. The PhD study will look to plug this notable gap in the literature. Added to this, the theoretical connections made in the papers between micro, meso and macro levels of analysis are weak, as is their coverage on the social and cultural contexts that precede and interact with the intervention. Lastly, only a small number of papers connect social prescribing to political issues, that is either informal politics concerned with power in everyday life, as having the power to lead a life that one has reason to value, or the politics associated with political processes, policy making and representative democracy (Savage and Miles, 2017). This seems an important insight as much of the social prescribing agenda through personalised care refers to "empowering" people (Sanderson, Kay and Watts, 2019, p 14). It follows from this that if empowerment is needed, then power may be absent and is lacking for some. Of course, power can come from becoming more aware of one's emotions, from exercising choice, and other more inner orientated ways. It can also come from reflecting critically on the outer barriers to power and how the impact made through social prescribing could connect to this. From the papers included and analysed for this this review however, there seems little connection to this. As a result of the perceived gap in the literature the PhD study will be informed by the following research questions:

1) **What cultural, social, and material contexts do working class and precariat men report and how do they relate to need and referral to social prescribing?**
2) **How do these men perceive and experience social prescribing and why?**

It is deemed that these questions will ensure sufficient leverage on the perceived gap identified in the field.

Now that the literature in the field of social prescribing has been reviewed, with critiques and gaps, identified that the PhD study, will look to address, the next chapter will describe and explore the theories that will be used to inform the study.

Chapter 3: Theory, Social prescribing: Wellbeing and Capital

3.1 Introduction To understand and explore both the antecedent contexts of the men's lives and their journey through social prescribing, the study will primarily draw upon two theoretical sources or traditions. The first theory is associated with the emerging field of wellbeing science and positive psychology (Seligman, 2011; Layard and Neve, 2023); the second is associated with the concept capital and is informed partly by the French social theorist Pierre Bourdieu and his theory of habitus and capitals, along with the work of Robert Putnam on social capital. (Bourdieu, 1977; Wacquant, 2023; Putnam, Leonardi and Nanetti, 1993; Putnam, 2001; Putnam and Garett, 2020). The theories selected were informed by some of the gaps identified from the systematic review completed in the previous chapter. On some occasions, papers referred to social prescribing's ability to foster "wellbeing" through participation and "meaning" and, on lesser occasions, cultivate "social capital" (Stickley and Hui, 2012, p5; Tierney et al, 2020, p12), this chapter will deepen these connections. As discussed earlier, positive psychology and wellbeing studies are often criticised for their exclusive focus on the inner life of the abstract individual, without any focus on the surrounding context. This concern is of interest when identifying if social prescribing can impact the social determinants of health given that many of the determinants are associated with the qualities of places, or social infrastructure, for example the availability of public green space, rather than in individuals (Marmot, 2015; Tomaney et al, 2023) In contrast, however, the second theory that will be used, mainly Bourdieu's theory of capitals, has been criticised for the primary focus of the structures that enable or block individual agency, overlooking more nuanced descriptions and analysis of the experience and inner life of individuals and groups (Sayer, 2011; Archer, 2007). However, when using PERMA, it is important that this analysis does not overly focus on the psychological life of the individual at the expense of the

social determinants of health and wellbeing. That said, both theories will be used as a corrective to the blind spots identified by others in the individual theories. In deepening the theoretical connections within the field of social prescribing, the aim is to improve the analytical coverage between the micro, meso and macro level analysis as concluded in the review.

As stated then, the first strand of theory is focused on wellbeing. The field of "wellbeing science" is focused on finding what mindsets, behaviours, relationships, resources, and institutions best explain and predict wellbeing (Seligman and Cszikzhentmihalyi, 2000; Layard and Neve, 2023). The chapter will draw on the theory of PERMA, as developed by Martin Seligman (2011), to understand if social prescribing can connect working class and precariat men to the experiences, relationships and activities associated with wellbeing. The second theoretical tradition focuses around Bourdieu and Putnam. Bourdieu's model of conflict theory frames society like a competitive game of sports (Savage, 2021). In contrast to wellbeing science that looks to understand what helps us flourish, Bourdieu's primary focus was on the social, cultural and political mechanisms that sustain and reproduce social and material inequality (Bourdieu and Wacquant, 1992). The most notable components of this model are the unequal distribution of capital and resources across society or "social space" (Bourdieu, 1977, p13), sometimes referred to as the capital and resources model (Savage, 2015, p21).

Both traditions of theory will be used and synthesised to describe and explain the contexts and mechanisms associated with working class and precariat men, alongside the experiences, perceptions, processes, and mechanisms associated with the journey through social prescribing. The following section will offer a more detailed introduction of the theories which have been selected, before separately discussing concepts from each later in the chapter.

3.2 Wellbeing, humanistic psychology and personalised care

As stated, social prescribing is associated with an agenda referred to as personalised care (Fox and Mason, 2022). The personalised care agenda aspires to democratise relationships formed within health consultations and move the NHS towards a more collaborative responsive culture. Literature on social prescribing has connected the assumptions of the personalised care agenda with a therapeutic model called "person - centred" care (Redmond et al, 2019, p234). This model of therapy was developed by Carl Rogers, who was an early member of the humanistic psychology movement. In opposition to Freudian models that focused on the unconscious and a therapeutic relationship based on neutrality, Rogers believed that attention to the client's world from the "inside", along with empathy, was key to the therapeutic relationship (Rogers, 1947, p17). This involved a deeper level of attention on the "perceptual" field of the client, with the aim of recognising the client as a choosing and agentic force (Rogers, 1947, p19). This vision of human nature contrasted with the classical psychoanalytic model that viewed the agent as motivated by unconscious drives and desires (Lomas, 2022). Moreover, rather than helping the client accept that pleasure had little part in mature forms of functioning, humanists believed that humans flourish given the right circumstances (Lomas, 2022).

Alongside informing some of the assumptions of personalised care agenda and the connection social prescribing makes to what matters to people, this early wave of humanism associated with Rogers, along with thinkers like Abraham Maslow, provided the intellectual foundation for a new field of study called positive psychology and wellbeing science (Kaufmann, 2020; Lomas, 2022). The founding of Positive Psychology is associated with the American Psychologist Martin Seligman (2019), but has spread to British academic and policy contexts through the academic and policy work of Richard Layard (2011), amongst others. Both have worked to shift economic and psychological disciplinary focuses away from the negative, to

the positive: Seligman (2019) for example, has looked to shift psychology away from a focus on psychopathology and disorder towards what helps individuals and communities flourish. Moreover, Layard, along with notable others (Sen, 2022), has worked to attempt to shift social and economic performance away from measures of gross domestic product (GDP), and the aggregate output of goods and services, towards more developmental measures of wellbeing within the economy. These disciplinary shifts have parallels with the shift social prescribing looks to make in health care, by moving consultations away from what is the matter with the user of social prescribing, to what matters to them. The aim of this shift is to "put the patient at the centre of a more holistic vision of healthcare…this is person centred care, with the individual at the centre of everything and co -creating with health professionals and others their own individualised pathway to health" (Fox and Mason, 2022, p5).

Whilst this focus on the positive has been refreshing and to have been productive, it seems to sometimes have come at a cost. That is, to identify the experiences, states, mindsets associated with flourishing, the institutions, structures that enable some to maintain often unjust economic and political power over others, reproducing persistent patterns of health inequalities, are sometimes removed from the analysis. The following commentary on social prescribing offers an example of this issue. In establishing the legitimacy of social prescribing Fox and Mason (2022) state that at the 3rd International Social Prescribing Network Conference in March 2021 that within some deprived areas of the UK, up to half of all patients sought appointments for a social not medical problem. Fox and Mason (2022) describe, loneliness smoking and alcohol consumption as three possible social problems. The question of why these social problems is disproportionately found in deprived areas is not discussed. For example, more sociologically orientated work partly informed by Bourdieu, refers to how widening health and income inequality, along with the reversal of life expectancy, can be partly explained by how elites at the top end of class structure are "strangulating the flow of assets"

associated with the social determinants of health and wellbeing (Scambler, 2018, p14). The main processes theoretically pointed to as responsible are the rigging of the rules of political and economic game by elites who are corrupting the democratic process to stack the rules of economic life in their favour. Without this connection to the drivers of inequalities at the top end of society, both the literature on social prescribing, and practice, risks offering only a partial analysis. As noted in the review, the literature on social prescribing is often weak on context and seems to place focus on the individual user of social prescribing, with the analysis often only beginning at the time of referral. This analysis risk removing the journey through social prescribing out of the contexts concerning distributions of power, psychosocial support, wealth, and income within society. Often this is the case with empirical work and theory which seems to promote understanding of the human agent as unencumbered by power constraints or impingements. For example, Seligman (2011, p16) argues that the theory of wellbeing that he in part developed is driven by a "theory of uncoerced choice" with its five elements of wellbeing offering a model of "what free people will choose for their own sake", without enquiring as to why certain groups are freer from economic compulsion than others.

In summary, often, these theories lack an adequate understanding of the social determinants of our health, flourishing and indeed "freedom" and the "collective action" needed to secure these elements at the level of the individual (Marmot, 2016, p161). The following section will discuss some of the key elements of Seligman's wellbeing theory and how they relate to both the context that may pre-exist working class and precariat men's engagement with social prescribing and the processes and mechanisms experienced through social prescribing. The second section of the chapter will then unpack and describe Pierre Bourdieu's theoretical toolkit, whilst also integrating Bourdieu's theory of social capital with as different reading of the concept derived from the political scientist, Robert Putnam.

3.3 PERMA, Wellbeing science and social prescribing

To understand the claims that social prescribing makes towards improving users' levels of wellbeing (Stickley and Hui, 2012), the following section will outline the PERMA model of wellbeing theory associated with Martin Seligman (2011).

3.3.1 The PERMA Model of Flourishing and the five pillars of Wellbeing theory

The PERMA acronym stands for "positive emotion", "engagement" "relationships" "meaning" and "achievement" (Seligman, 2011). Although some components of the model are of more interest than others for the present study, the following section will proceed by describing each component to gain a fuller appreciation of the ingredients of wellbeing theory (Seligman, 2011). In doing so, the following will ground each component with examples of how they pertain to a hypothetical journey through social prescribing.

As stated, the P in the acronym PERMA refers to the experience of positive emotions and the cognitive, subjective appraisal of "how happy" the individual feels in their day-to-day life (Seligman, 2011, p7). Alongside seeing positive emotion as an end, others in the field of positive psychology have used the experience of positive emotions as a mechanism encouraging and rewarding expansive participation in challenging activities. Here, the positive feedback derived from the experience of positive emotion enables us to "broaden and build" in our engagement with others and meaningful activities (Frederickson et al, 2001, p1367). For example, in relation to social prescribing, if someone reports experiencing pleasure, happiness, or joy, from taking part in the activities referred to, or relationships involved throughout, this could act as an internal reward whereby the individual feels positive emotion associated with the engagement. This could relate to trying out a new activity, mastering a new skill or cultivating new relationships.

In addition, the next component of the PERMA model, namely, the presence of engagement and interest as a component of wellbeing, are associated with exploring if people take pleasure from learning new things (Seligman, 2011), combined with if they feel a sense of participation and tackling something personally derived as meaningful. This element of the PERMA model connects squarely with the aims of social prescribing, with the policy driven by the idea that participating in meaningful activities is good for our health and wellbeing and that we must offer and cultivate these opportunities within healthcare, moving the focus away from curative models of health to preventative ones.

The relationships component of wellbeing theory refers to the presence of supportive and loving others. Seligman claims that "very little that is positive is solitary. Other people are the best antidote to the downs of life and the single most reliable up" (Seligman, 2011, p20). Social prescribing actively looks to connect people to others, with sociability to others a key component of the policy's logic from the initial conversations with link workers, to the groups, support and activities referred to.

The 'M' in PERMA refers to the cultivation of meaning, described as "belonging to and serving something that you believe is bigger than the self" (Seligman, 2006, p31). The presence of meaning has a subjective component which links to positive emotion, sometimes referred to as the hedonic component of wellbeing theory. This is operationalized by asking simple questions on how we feel in terms of emotion and how this connects to various forms of engagement (Layard and Neve, 2023). Interestingly, however, Seligman believes there is also an objective component to meaning. It is this objective dimension to meaning that can help obviate the biases of subjective reporting and retrospective memory, with Seligman claiming that "meaning is not a solely subjective state" and that it gains objective value by the judgement and validity of others (Seligman, 2011, p23). In contrast to the hedonic utilitarian

scale, this reading of wellbeing is connected to the philosopher Aristotle and "eudemonia", with the concept associated with balance, virtue and meaning (Jackson, 2021, p79). This Aristotelian tradition of thought is also drawn upon by political thinkers not simply interested in wellbeing, but the renewal of a deeper from of citizenship in community that transcends the neoliberal model of transactional behaviour (Glasman, 2022) and can foster social capital (Putnam, Leonardi and Nanetti, 1993)

Moreover, Sayer (2011) has used Aristotelian informed virtue ethics to broaden out Bourdieu's thought beyond the strategic acquisition of capital, to lay normativity. In connecting this back to wellbeing, Seligman argues, for example, that a night spent drinking and smoking marijuana with friends may be seen as meaningful at the time, but "when you remember the gist years later and are no longer high on marijuana, it is clear that it was only adolescent jibberish" (Seligman, 2011, p17). Further to this, as an American academic, Seligman points to the life of Abraham Lincoln to draw out the difference between subjective and objective distinction in meaning. He argues that although Lincoln suffered from low mood and a melancholic disposition, his life was judged as profoundly meaningful despite the negative emotion and suffering that accompanied many of his achievements. Meaning, then, Seligman argues, is often pursued for its own sake, and cannot be reduced to hedonic or pleasure-seeking motives, claiming "there are effortless shortcuts to feeling positive emotion, which is another difference between engagement and positive emotion…you can go shopping, take drugs, or watch the television" (Seligman, 2011, p12).

Others working in the field of wellbeing, have claimed that this more objective reading of meaning, associated with the Aristotelian tradition, is liable to abuse and goes too far towards associating wellbeing with virtue or a higher good rather than pleasure or satisfaction (Layard and Neve, 2023). Whilst others have claimed that the pleasure domes of shopping centres and

commercial culture no doubt provide subjective positive emotion, but unless we can move towards a more developmental understanding of wellbeing, we risk legitimating transient pleasure in our measures (Pilgrim, 2021, p561). In relation to social prescribing, the meaning component of the PERMA model connects to one of the central aims of the policy: to connect people to what matters to them (Fox and Mason, 2022), and, elsewhere, with this being possibly operationalised by asking questions on how and if the social prescribing journey enabled a feeling of purpose. This research will be informed by both readings of this component of wellbeing at this point, to see how these competing ideas connect with social prescribing in the analysis.

In addition, the qualitative distinction between subjective and objective forms of meaning has been scrutinised by theorists of a more critical orientation. Primarily, they argue that this objective form of meaning has led to accompanying conceptions of "higher" and "lower" forms of social and cultural participation (Snape, 2019, p16). They argue that elites who consciously or unconsciously aim to reproduce their power, use this distinction to dominate and contain those positioned lower down the social structure, whose leisure activities are often seen through the oppositions of "hedonistic", or "chavs, slags and slobs" (Marquand, 2015, p164) in comparison to highbrow forms of engagement and wellbeing. It is argued that this often legitimises corrective intervention with the aim of civilising and reforming to reach a state of health and wellbeing (Snape, 2019). This critique is often framed without reference to the economic constraints that those positioned lower down in social space face, both in terms of income, psychosocial stress, and health - damaging employment, and how these contexts interact with choices that subsequently shape social and cultural participation. This also overlooks elements of the cultural life associated with these communities. This will be discussed in more detail in the following sections when the theoretical work of Pierre Bourdieu is discussed.

In addition, Seligman (2011, p47) claims that the "meaningful life consists in belonging to something and serving something that you believe is bigger than the self, and humanity creates all positive institutions to allow this: religion, political party, being green, the Boy scouts, or the family". This points to social elements of meaning as founding in groups and participation beyond the individual, which again maps on to the social elements of social prescribing. Moreover, researchers have cited that connection to "meaning" and "hope" are key ingredients to a successful pathway through social prescribing (Tierney et al, 2020, p7). In reference to Seligman's example, social prescribing may accommodate the cultivation of meaning and belonging in similar forms to religion or boy scouts. In the above quote, however, we also see some of the normative slippages in Seligman's work. Through the lens of sociological theory, Seligman's assessment that society creates institutions that provide meaning lacks a critical understanding of how the distribution of power and resources in society may corrode the foundations of wellbeing (Jackson, 2016). For example, whilst there are institutions that serve our needs for belonging, offering functionalist solutions to problems, there are also institutions that sever our ties to others (Alexander, 1997). For example, more critically orientated scholars, who look to challenge the assumptions that legitimate current the current order, point to the institutional and cultural institutions associated with neoliberalism, with the scarring effects surveyed in the introduction, as rewarding the disavowal of our interdependency on others, combined with an ethic of greed. This economic model has widened income and wealth inequalities in the UK (Savage, 2021; Picketty, 2022).

The "A" in PERMA refers to accomplishment or achievement. It is operationalised as peoples need to gain competence and mastery but also social recognition for their efforts (Seligman, 2011 p 20). As discussed earlier in the thesis, class and social position is often associated with less rewarding, and lower paid employment, with less autonomy (Marmot, 2016). These

conditions may enact barriers, both culturally in terms of psychological recognition of achievement, but also materially in terms of pay, to the experience of achievement. Through participation in social prescribing, men may achieve some form of achievement in the pleasure associated with the relationship or activity. They may also receive interpersonal recognition for their efforts.

3.3.2 Wellbeing without antecedent context: contextual determinants of wellbeing

There is very little understanding in this theory of how the history of individuals and their lack of support from certain social, relational, and economic determinants may impact the agent in achieving wellbeing. There is an absence then of an analysis of the generative mechanisms of the flourishing society, or the social determinants of health. Following this Calderon Larranga et al (2022) claim that if interventions drift towards focusing on the individual then this may be problematic. Drifting to a focus on the individual may slip into an overemphasis on the subjective level of cognition or choice, or without an adequate awareness of the "legacies" of our lives (Pilgrim, 2021, p567). Pilgrim (2021, p565) notes that, "later corrective relationships (which are found in our networks or sought out in personal therapy) may permit us to gain trust and confidence in others and find new meanings within them. They cannot alter the past, but they might offer us new ways of construing past-present links, learning new ways of coping and envisioning more optimistic personal futures". In addition, alongside the neglect of historical context, this bias in focus towards individual wellbeing, also obscures the development of flourishing communities in at a higher level of analysis than the individual (Atkinson, et al, 2019).

In continuation then, there is little focus within the theory of how the agency, choices, needs and wants of individuals may be impacted by this distribution or their position in social space. This can be seen most clearly when Seligman claims that the PERMA model is informed by

individual choice with its five elements of wellbeing offering a model of "what free people will choose for their own sake" (Seligman, 2011, p16). These critical qualifications aside, the theory provides an important insight into theorised components of wellbeing, which will be drawn on throughout the thesis to make analytical sense of the data and draw conclusions on the ability of social prescribing to connect men to what matters to them (Sanderson, Kay and Watts, 2019, p14), introduce them to goods and experiences associated with wellbeing and ultimately improve their reported wellbeing.

3.4 The theoretical toolkit of Pierre Bourdieu and the context, experiences and mechanisms of social prescribing

As the concepts associated with the field of wellbeing have now been outlined, the following section will provide an accompanying theory to the more humanistic and agency focused theories of wellbeing described above, with the theoretical toolkit of Pierre Bourdieu drawn upon. Like PERMA above, this theory has implications both for the antecedent context of men's social prescribing referral, along with the journey through the policy. Bourdieu's conceptual tools will provide a lens to understand the context of class, income, wealth, and relational inequality and how these then interact with the social prescribing processes, along with the ingredients of PERMA described above. Added to this, through using Bourdieu to understand and explain the mechanisms and processes involved in social prescribing, the research will explore power and resources at a social level, beyond the psychosocial resources associated with PERMA.

Bourdieu's work is complex, with him often using his own concepts inconsistently and demonstrating conceptual slippage (Atkinson, 2010). As a result, an element of simplification is needed to make his concepts operational. The central concepts drawn upon here will be "habitus" and "capitals" and whilst this is only a partial selection of Bourdieu's rich conceptual

toolkit, this eclecticism has been recommended (Wacquant, 2023). The work will also draw on the more phenomenological reading of Bourdieu (Atkinson, 2010). Whilst the PERMA model was interrogated for its lack of understanding of the distribution of power in societies, and its optimistic view of human choice, Bourdieu's theory has often been criticised for its lack of focus on the power of human choice and reflection. In combination with these claims, he is also said to have disproportionately focused on the unconscious motives of agents and their quest for domination over others and resources (Sayer, 2011). The phenomenological reading of Bourdieu used here will help offset some of these shortcomings of Bourdieu. Like PERMA theory, Bourdieu's work will be critically analysed and synthesised with approaches that have looked to rework his toolkit and compliment the blind spots identified.

3.4.1 Bourdieu's toolkit and the context and mechanisms of social prescribing

The work will mostly draw on habitus, social, economic and cultural capital. In its simplest form, social space is where all members of a society are distributed in relation to three axes of capital (Bourdieu, 1977; Atkinson, 2010), with capital designated as a bundle of goods and resources and relationships. All forms of these three capitals have institutional, material, and embodied qualities. For example, cultural capital is institutionalised in the schooling system, made material through books, artefacts, technologies, and equipment, and then embodied as skills, knowledge and know how (Prieur et al, 2023). The following three capitals will be used to understand the context of the men's lives and how they possess or lack certain goods and resources associated with health and wellbeing, but these will also be used to see if social prescribing can repair and cultivate the capitals that may be compromised by an unfair distribution throughout society, impinging on the context of men's lives. The main capitals discussed are as follows:

(1) Economic capital which is described as "wealth, income and property". (Savage, 2015, p33)

(2) Cultural capital, that is "signifiers of cultural competencies" (Atkinson, 2010, p46)

(3) Social capital which Bourdieu defined as "the sum of resources, actual or virtual, that accrue to an individual or group by virtue of possessing a durable network of more or less institutionalised relationships of mutual acquaintance and recognition" (Bourdieu and Wacquant, 1992, p67).

As the three main capitals pertaining to Bourdieu's work have been discussed in the previous section, the following section will describe Bourdieu's concept of habitus. Moreover, whilst data was collected on all three capitals, the thesis focus is on economic and social capital. Cultural capital is discussed in relation to how impacts the formation of social capital both in context and through referral and participation in social prescribing.

3.4.2 Habitus and socialisation into the cultural context of "what matters"

The habitus has been described by Bourdieu as "a system of dispositions, that is of permanent manners of being, seeing, acting and thinking or a system of long lasting (rather than permanent) schemes or schemata or structures" (Bourdieu and Wacquant, 1992 p187). This describes the way in which we internalise and store in various forms of memory elements of the social structure, which in turn shapes both thinking and action on the agency side of the habitus (Lizardo, 2016). In relation to the concept of social class, the habitus analyses how members of society are socialised into a certain position in social space. This position exposes the working class to space that is closer to the "demands of necessity" (Bourdieu, 1977 p6; Atkinson, 2010). Put differently, those positioned lower in social space or a "social ladder" (Marmot, 2016, p5) possess a scarcity of economic resources, relative to others. As a result of

this, the working class feel the "urgencies" and emotional demands of material scarcity with greater force than those positioned above them with greater economic capital (Atkinson, 2010 p17). This socialisation into primary social position is sometimes referred to as the "primary" (Wacquant, 2015) or first habitus (Freidman, 2013). Moreover, it is argued that these conditions help shape working class cultural and social participation, hobbies, and practices, with this in turn shaping their patterns of health behaviours and lifestyles (Singh, Manoux and Marmot, 2005). This second, more active form of participation is often referred to as the "secondary habitus" (Wacquant, 2014, p9).

Following the impingements of the economic context, Bourdieu and subsequent work informed by him, has found that the working class cleave towards cultural participation that values functionality (Bourdieu, 1977). The reasons for this are associated with the economic context of class, with low income and low control, often described in association with a hedonistic lifestyle, with short term pleasures like gambling and smoking theorised as offering some pleasure and relief, but also mastery, form the demands and low pay of the economic context (Mckibbin, 1990; Snape, 2019) This may preclude some of the eudemonic elements of wellbeing theory and the space to indulge in the more reflective forms of cultural taste and appreciation (Bourdieu, 1977). It seems reasonable, that in order to tackle health inequalities in morbidity and mortality, as surrounding rhetoric, and discourse in social prescribing claims, then an understanding of socialisation into the context of multidimensional inequality is important.

Alongside this, Bourdieu's theory offers an understanding of why there are social gradients in the engagement in some protective health behaviours and activities (Wiltshire et al, 2019). Bourdieu himself was inconsistent with his use of the habitus, with further methodological complexity arising when he pointed to both the cognitive and embodied or "corporeal" (Bourdieu, 1990) content of the concept. For example, Bourdieu used the concept to describe

socialisation at both the level of language and discourse and the words people use, but also at the level of embodied skills and routines. This adds further methodological complexities as embodied forms of skill are stored in procedural memory (Lizardo, 2022). This is a form of implicit memory not easily available to conscious retrieval (Panksepp and Biven, 2012; Siegel, 2020); for example, the method of the semi- structured interview cannot easily get at this, whereas, autobiographical memory is stored in declarative memory and is more easily accessible through interviews. To circumvent these problems, notable work from the likes of Atkinson (2010) has promoted a phenomenological reading of the concept habitus, integrating it with the phenomenological work of Alfred Schutz. When moved away from its predominantly unconscious and strategic orientation, the habitus is opened out to the cumulation of learning both conscious and unconscious. Elements of this connect with other claims to broaden out the habitus to explore people's emotional life (Reay, 2017) along with the lay normativity (Sayer, 2011), and with its "active" components (Wacquant, 2023). These other readings of habitus have often developed in response to criticisms of the concept, with other thinkers like Archer (2007) claiming the habitus privileges an overly socialised vision of the human agent with norms, values and activities merely "transmitted" and then "sedimented" into the agent like a machine routinely stamping a product on a production line (Atkinson, 2010, p26). Following criticisms of this reading of habitus, however, men's values and norms will be examined along with their emotional life, examining how their habitus and socialisation is never merely passive, but always concerns securing things we have reason to value (Sayer, 2011).

It should also be noted that researchers have recently argued that socialisation into class no longer has explanatory power. Those who make this argument point to the social changes of increased choice and diversity, and pockets of social mobility associated with late modernity (Archer, 2007). This is combined with an increased level of choice that has emerged through

the growth of neoliberalism (Atkinson, 2010) now render some of Bourdieu's claims obsolete. Such is the power and plurality of choice, we can no longer read from our socialisation what type of activities we will participate in, with choice, self - awareness of identity and plurality overpowering the habitus and our primary socialisation. Observations of similar forms of social change are not new. Classical observations on "changes in working class life", noted in the 1970s that "prosperity... removes old fears and increases confidence; it increases the power to make choices of one's own because the straight jacket of poverty has been loosened. It increases the feeling of individuality, of being a person with individual wishes and decisions" (Hoggart, 1973, p11). Whilst there are merits to this claim that more focus needs to be placed on choice, with efforts to rework Bourdieu through more conscious forms of choice and commitment integrated here, empirically the evidence seems to remain with Bourdieu and the continuing power of socialisation into scarcity shaping our early forms of cultural engagement (Bennett et al, 2008; Atkinson, 2010). The patterns associated with social class and social gradients in cultural participation, exercise, and physical activity, as discussed in the introduction, and of interest here, remain notable regularities identified in the literature (Fancourt and Steptoe, 2019; Wiltshire et al, 2019; Scambler, 2022).

3.5 Bourdieu, economic capital and employment as a social determinant of health

The following section will offer some discussions on how Bourdieu's concepts will inform the focus of the work in the context of employment as a social determinant of health and wellbeing (Marmot, 2016; Layard and Neve, 2023). In doing so, it will move beyond a sole focus on the output of employment as merely income, wealth and economic capital, by combining this with an examination of the psychosocial conditions of men's occupational histories. The antecedent context of employment is also of added cultural importance to working class men who have been noted as cleaving to ideas of being a good husband and

breadwinner (Dolan, 2011). Efforts to achieve this will follow Atkinson (2019, p152) who claims that Bourdieu can help health inequalities scholars "bring it all together" by synthesising the material and psychosocial contexts and mechanisms that scholars discuss as the drivers that continue patterns of health inequality on some of the indicators of morbidity and mortality discussed in the introduction. Moreover, now that the key concept of habitus has been explained, the following section will discuss in more detail the concept of capital.

3.5.1 Economic capital, and psychosocial stress: antecedent contexts that enable or erect barrier to participation in health sustaining activities

Following other scholars who have connected Bourdieu's toolkit with health research, it is not merely through lack of income, wealth, or "economic capital" (as income and wealth) that people face structural barriers to participation in practices and activities that encourage health and wellbeing. Barriers to participation are also erected through long - term exposure to adverse psychological conditions and contexts of work. This type of employment is associated with "lower grade" occupations (Siegrist and Marmot, 2004) which are disproportionately associated with low levels of power and task control within the workplace, and a lack of actual and perceived control, reciprocity, and reward (Marmot and Wilkinson, 2005).The long-term exposure to adverse work conditions can cause significant health problems at a deeper embodied or ontological level that transcend the lack of income or time afforded for wellbeing - sustaining activities. Following the deeper ontological focus that critical realism allows, these conditions can sediment under our skin (Siegrist and Marmot, 2004; Wilkinson and Pickett, 2019) causing long - term exposure to chronic stress, sometimes leading to an institutionalised and embodied form of fatalism (Marmot, 2016; Scambler, 2018)

Of central importance to the focus here, exposure to these conditions can influence the quality of engagement in health-sustaining activities outside of work. As Sayer (2011, p118) notes,

"The effects of quality work carry over into individuals' capacities in leisure time too, thereby further widening inequalities in terms of capacity for enjoyment for internal goods". This deeper ontological focus suggests that the effects of lack of democratic control may persist beyond the life of paid employment. If the work life has been filled by compulsion, stressors, and unrelenting demands from others, then people may have very little experience of reflecting on questions of what matters to them (Fox and Mason, 2022). Bourdieu's conceptual toolkit has been extended to understand the lack of democratic control at work, and how this may provide structural barriers unacknowledged to the effectiveness of social prescribing in connecting working class and precariat men to what matters to them, alongside reducing health inequalities. Moreover, as discussed, the structural barriers discussed here are often underappreciated in theories that place more primacy on the individual, abstracted from structural or cultural contexts, like the PERMA model above.

3.5.2 Integrating Bourdieu and Putnam: social prescribing and social capital

As noted, whilst this thesis is reliant upon several of Bourdieu's central concepts, it will be, effort of "synthesis", (Wiltshire and Stevinson, 2018, p51) combining Bourdieu's conceptualisation with that of the strengths of Robert Putnam. Use of the concept, examining if the social capital that social prescribing may cultivate can be connected to health sustaining activities. The following section will focus on the concept of social capital, the different facets of the concept and how they relate to the current research questions.

3.5.3 Bourdieu, Putnam and "The two facets of social capital" in health research (Rostila, 2010)

Social prescribing as an intervention looks to connect people to others, and develop groups, communities, and networks. To understand this process, and to describe this potential impact of social prescribing, research has pointed to theoretical concepts of social capital (Tierney et

al, 2020). Social capital research is split amongst different traditions of social theory, with these different theories containing competing assumptions about the way societies work. Related to this, those who have used social capital in work related to questions of health and wellbeing note that researchers often choose between the work of Pierre Bourdieu or Robert Putnam when using social capital to understand questions of health and wellbeing (Wiltshire and Stevinson, 2016). Moreover, in addition to the different theoretical traditions that pertain to social capital, the concept has been operationalised and used in different ways: these different uses have ranged from different units of analysis, with some focusing on social capital as a product of the individual through cognitive forms of interpersonal trust, to others who prefer to view social capital as a structural outcome of the number of associations in each society (Rostila, 2010).

Recent research within the field of health inequalities has described a social gradient in trust across society. Those in more deprived areas are less likely to report high levels of interpersonal trust (Wilkinson and Pickett, 2019). Bourdieu helps us understood why social capital and social trust are distributed across social space. Moreover, his work can also help us to understand why social networks are not just good in and of themselves for health, but also allow us access to certain goods, resources, and relationships. Following this, in aiming to empower people (Sanderson, Kay and Watts, 2019, p10), social prescribing may be informed by pre-existing context of social capital. This is a context where some are empowered by their social networks and some excluded from these networks. In Bourdieu's reading of social capital our networks and connections to one another expose us to access to certain goods and resources that could not be drawn or mobilised without our membership in said networks. This reading of social capital contrasts to those like Putnam's (Putnam, Leonardi and Nanetti, 1993) who see social capital and the norms of trust that result as a net good for society. Those who fail to look at the way in which networks and associations reproduce power overlook that

connections are often "a means of allowing the privileged and powerful to use their connections to help each other and protect their interests and thereby shut out those who lack such social capital" (Savage, 2015, p145). For Bourdieu, our socialisation into certain relations based on income, status, and power, lead members of society to probabilistically connect with people who share a similar social class. Ties to others similar in class are further reinforced through institutions like schools, employment, and leisure activities. Moreover, in relation to the antecedent context of social prescribing, our ties to others then can shape how much control and power we have in our lives, with the lack of control and power to do otherwise in certain contexts cited as a primary theoretical cause for the persistence of health inequalities (Marmot, 2015). With other large empirical studies informed by Bourdieu, that conclude that the, "the British working class is not inclined to join in the associational activities of civil society" (Bennett et al, 2009, p19).

3.5.4 Robert Putnam, communitarian social capital and norms of trust: bonding, bridging and linking

Robert Putnam, a political scientist based at Harvard, offers a different interpretation of social capital to Pierre Bourdieu. As we have seen, Bourdieu's readings of social capital are derived from a tradition of social theory referred to as conflict theory. In contrast, for Putnam, social capital is more of a net good for society at large, with our associations with others tacitly building norms of trust and reciprocity with others (Putnam, Leonardi and Nanetti, 1993). Although in later work Putnam has become more alert to how the countervailing forces of an unbridled neoliberalism can impinge upon our sociability, his earlier work on institutional reform in Italy, framed social capital as a primarily bottom-up phenomena, independent of political and institutional support that can enable or constrain the formation of social capital (Putnam and Garrett, 2020). But also, crucially, Putnam found little evidence that social capital was inversely correlated with the income or wealth inequality of Italian regions (Putnam,

Leonardi and Nanetti, 1993). Whilst Bourdieu informed readings of social capital would claim that this approach is naïve on how power reproduces and operates within society, it is argued here that the following conceptual nuances of social capital enrich the project. The following section will describe the variations of social capital as "Bonding", "Bridging" and "Linking" social capital (Layard and Ward, 2020, p152), offering examples of how they relate to social prescribing and later findings chapters.

Bonding social capital: within networks

Those that have utilised Putnam's conceptualisation of the concept have used this analytical taxonomy to add greater detail to social capital theory (Layard, 2019). Bonding social capital refers to an association or network of people who are all similar in either, class, status, ethnicity, and so on. In offering examples of this type of social capital, some have described golf clubs as viewed within the cultural context of the UK (Layard and Ward, 2020). Golf clubs, historically, tend to be an example where people with similar class, wealth ethnicity, gender and status, amongst others, gather. This type of social capital has been described as "inward looking" and tends to "reinforce exclusive groups and homogeneity" (Rostila, 2011, p111)

Bridging social capital and social capital between networks

In contrast to the bonding social capital of the golf club (Layard and Ward, 2020), bridging social capital is described as a network or association of people that are more diverse in class, wealth, ethnicity, gender, and status gather. For example, a political party like the Labour Party, has a long history of members of different positions and roles in society coming together, from workers, academics, and trade unions. It has been argued that these networks have better democratic potential. They are referred to as more "outward looking" (Rostila, 2011, p111) as they consist of more diverse members and offer more hope for tolerance, public discussion, and robust forms of trust to emerge. In addition, some have described bridging social capital

as "probably more valuable for the creation of collective resources as they facilitate cooperation between dissimilar people in a given social structure" (Rostila, 2011, p112). Others seem less convinced, claiming that bridging social capital consists of "loose ties" of individuals with similar levels of power (Szrter, 2002), meaning it shares more similarities to bonding social capital than the next nuance of social capital theory to be discussed, namely linking social capital.

Linking and institutional social capital through social prescribing

In contrast to both bonding and bridging social capital, scholars have discussed a further variant called linking social capital. Linking social capital is described as "respectful and trusting ties to representatives of formal institutions – e.g., bankers, law enforcement officers, social workers, health care providers" (Szreter, 2002). Others, like Adams (2019) emphasise that this more institutional reading of social capital, moves the concept away from a sole focus on community, where the state and powerful institutions are bracketed off from an analysis of social capital. The emphasis on institutional and linking social capital allows the researcher to focus on "state - society linkages in health interventions" (Adams, 2019, p97). Linking capital is of added importance as social prescribing is focused on creating partnership between the NHS and the VCSE sector. As described in the introduction in relation to the Big Society, this connects to several policy agendas that hope to move public service delivery and the welfare state closer to communities and individuals (Blond, 2010), but also from other parts of the political spectrum who have reached similar conclusions (Cottam, 2019; Stears, 2021). In terms of the mechanisms and processes involved in social prescribing, linking social capital will help us understand if and how social prescribing link and connect men to resources and relationships associated with the determinants of health and wellbeing (Marmot and Wilkinson, 2005; Seligman, 2011) and perhaps challenge the reproduction of the current

economic model that has been identified by scholars in the field of health inequalities as under developing the assets associated with health (Scambler, 2018).

Social prescribing, social capital and habitus

One of the ways in which it is theorised that social prescribing will enable positive change towards improved health and wellbeing is by bringing people together to engage in activities associated with wellbeing (Hefferon, 2013). This is achieved through connecting people to groups and sources of social capital. This also leads to the formation of positive networks associated with, for example, participation in a cultural activity or sport through participation in "community assets" (Tierney et al, 2020, p7). As stated before, at the level of the individual and through the habitus, activity engagement is stored in the body, changing the neural structure of the brain (Atkinson, 2010; Siegel, 2020). There are sunk costs to the habitus, with those who have gained skills and competencies in certain fields developing an inbuilt structure that point them towards further engagement in certain activities. As Bottereo (2018, p203) states, "bodily lifestyles are not simply a reflection of social location, and the material circumstances which contextualise people's lives, shaping what is available to them; they also reflect a habitus of deeply ingrained habits, tastes and predispositions which are shaped in childhood which are moulded by our affiliations and intimate relationships". Research informed by Bourdieu, health interventions should move away from the ontological individualism associated with the voluntary choosing of PERMA and behaviour modification, where the intervention focuses on changing individuals' behaviour or motivations.

Some who have used habitus theory to understand the cultural and social context of working-class men's lives have pointed attention to the way in which risk, danger and emotional denial are a part of the collective ends of this culture (Dolan, 2011). Men will have gained experience and competence. Failure to mould the mechanisms and pathways involved in social

prescribing around areas where men have received esteem may mean that social prescribing fails for men. For example, a social prescribing link worker may encourage a working-class male client to notice when he receives cues and cravings to smoke, advising him to supplement his response to this cue with another behaviour, like chewing replacement gum. This analysis may fail to understand that smoking for this man is a ritual form of collective bonding in the context of his employment in "low grade" position in the manufacturing sector. During his smoking breaks he bonds with other men, sharing stories about his weekend and wrestling back some control under the perceived lack of reciprocity in the workplace. Bourdieu's concept of habitus suggests that our participation in activities is always partly determined by our socialisation (habitus) and possession of capitals, which may exclude us from certain activities whilst predisposing us towards others. The added focus on the power of structure and socialisation helps balance some of the more humanistic visions of the voluntary choosing actor associated with PERMA.

3.6 "Bringing it all together" (Atkinson, 2010) wellbeing and capital: PERMA, Pierre Bourdieu and Putnam

For Bourdieu, the concept of social capital focuses on the instrumental effects of the phenomena and from what we can get by association from others. As a result, social capital is always a means to an end of agents gaining power relative to others (Bourdieu and Wacquant, 1992). For example, people coming together in groups through social prescribing could only be interpreted as an explicit or implicitly motivated strategy to gain certain resources, positions, or goods and capitals. Whilst this focus is important in helping the researcher move beyond a naïve humanism, whereby the romantic motives of agents are taken at face value (with some elements of this described in the criticisms of wellbeing theory above), Bourdieu's conflict theory often downplays the powerful affective and emotional ties, both conscious and unconscious, that bring people together.

For example, those who make friends in the activities they engage in through social prescribing may as a result accumulate goods, and resources, but the friendship may also be a good in and of itself. Often, we connect with friends through the positive emotion and "inner" rewards of love, and "commitment" (Sayer, 2006; Sayer, 2011). Furthermore, often people stand up for their friends at the risk of losing material goods and resources, with Bourdieu saying little on these types of moral and emotional commitments to others. Moreover, we may be drawn to others because their very presence feels restorative and well attuned to ours. Whilst this can be read as a form of capital, it is a capital that is gained through a connection to the effect it has on our body, and the emotions and pleasures it releases not to something external like money, status, and power. Here, the focus on wellbeing derived here from PERMA combined with Bourdieu and Putnam, offers useful accompanying analytical lenses. This corrective of Bourdieu's blind spots shares similarities to other critical users of Bourdieu's work (Lamont, 2019; Skeggs, 2003; Reay, 2017; Rosa, 2019). Whilst there are differences in this work, similarities can be gleaned from the way in which they move Bourdieu from an exclusive focus on "having" resources, relationships, and capital to one of "being", with greater emphasis on the quality and nuance of experience (Lamont, 2019, p661). This move is complimentary to the two theories offered in the analysis, allowing the researcher to integrate Bourdieu's theory with the theory of PERMA alongside Robert Putnam.

In combining these theoretical concepts, it allows us to understand experiential and relational forms of wellbeing combined with Putnam and Bourdieu's conceptual toolkit, with this enabling us to understand how "rounded conceptions of wellbeing" which relates to being able to deploy the economic, social and cultural resources necessary to journey towards a good life (Savage, 2021, p322).

3.7 Conclusion

The chapter has presented two traditions of theory focused on the concepts of wellbeing and capital. The first, derived from the emerging field of "wellbeing science" (Layard and Neve, 2023), has noted implications for both the analytical focus on the contexts of the men's lives and in theorising the mechanisms and processes involved in social prescribing. In particular, the PERMA model enables us to explore and assess if social prescribing can connect people to the determinants of wellbeing.

The second tradition of theory, orientated around Pierre Bourdieu and Robert Putnam, is orientated around capital and its distribution in society. Like PERMA, this theory also has implications for the context of the men's lives in addition to the mechanisms and processes that come into play during the men's experiences and reports of social prescribing. The chapter has also looked to combine and integrate the two theories in line with perceived shortcomings identified in the theories selected. The following chapter will now discuss the methodological choices made for the project.

Chapter 4: Philosophy of research and methods

4.1 Introduction

Restatement of research questions

As defined in response to the gaps identified in the literature at the end of the systematic review in chapter two, the study will answer the following research questions:

1) What cultural, social and material contexts do working class and precariat men report and how do they relate to need and referral to social prescribing?

2) How do these men perceive and experience social prescribing and why?

To achieve this, the stratified ontology of critical realism was deemed appropriate to examine the antecedent contexts of working class and precariat men's social prescribing experience. Associated with Roy Bhaskar (1979; 2009), critical realism was formulated to place social scientific research on firmer philosophical ground. Bhaskar's goal was to chart a middle way between two competing paradigms of social enquiry, namely, positivism and interpretivism. Both philosophies of social science had underpinned social research for much of the twentieth century. The following section discusses the assumptions that underpin the philosophy of critical realism and its' relationship to positivism and interpretivism. Following this, the second half of the chapter will discuss the methods, processes and procedures orientated around semi-structured interviewing as the method chosen as best suited to tackle the research questions guiding the research. In addition, the section will also document in detail the process of recruiting the participants and the approach taken to analyse the data collected.

4.2 Positivism, critical realism and health research

Through discussing critical realism in relation to positivism, this section will explore the central critical realist concepts of "transitive" and "intransitive" levels of reality (Anderson, 2021, p12). The transitive level of reality is that which is conceptually dependent and is a product of human theorisation; whereas the intransitive level of reality refers to a deeper level of reality that exists whether we theorise it or not. In contrast to critical realists, positivist orientated health researchers focus on "tracking correlations" (Anderson, 2021, p45), using statistical methods and techniques to describe or explain relationship between variables. Although they do often ask questions on how and why certain regularities and associations exist, especially through more advanced forms of multivariate analysis (Goldthorpe, 2016), the casual questions and mechanisms inferred from positivists often must be observable. This focus is similar to the "transitive" level of critical realism. Whilst this approach is understandable, it can often prevent a deeper ontological focus on the underlying generative mechanisms at the intransitive level of reality (Anderson, 2021).

The differences between positivist orientated research and critical realism can be seen in the following example taken from literature that describes and explains the social gradient in cultural participation; research has shown that lower socio–economic status groups, on average, participate less in certain cultural activities (Fancourt and Steptoe, 2019). Whilst this association has rightly been held under scrutiny by work informed by Pierre Bourdieu (Atkinson, Roberts and Savage, 2012), the evidence of a social gradient in some forms of cultural participation is of direct relevance to the context of social prescribing as the intervention is based on referring people to cultural participation. In reference to this pattern, Fancourt & Steptoe (2019, p2) note that "this gradient is thought to be in part due to logistical factors, such as higher levels of disposable income and closer proximity to cultural venues". Whilst these causes could certainly be responsible for a social gradient in cultural

participation, making appeals to this type of explanation offers an example of positivist-oriented explanations in health research. The examples of income and proximity can be easily measured in a standardised way, but may neglect some of the unseen causes or those less neatly measured through the tools of positivist research. For example, work by Atkinson, Roberts and Savage (2012) claims that those who study this social gradient in cultural participation sometimes overlook historical accounts of social change. That is, due to a history of not feeling welcome in certain spaces, it has been demonstrated that the cultural life of the working class is much more orientated around the home and close forms of kinship than public forms of cultural participation (Atkinson, Roberts and Savage, 2012). Further to this, critical realists have claimed that positivist orientated research may be studying the association between two effects (Anderson, 2021). In reference again to the above example, rather than logistics and income (Fancourt and Steptoe, 2019), the social gradient in social and economic status and cultural participation caused by underlying generative structures like the historical legacy of various policies. Through this interpretation, both logistics and income as associated with the social gradient of cultural participation are effects of a deeper cause.

4.2.1 Critical realism, interpretivism and health research

The term interpretivist is a simplistic descriptor used to describe a broad range of approaches that focus on culture, language and meaning making. These range from approaches associated with the poststructuralist movement who denied reality beyond its textual form, to a softer version that believes that though reality may exist, it is dependent on the concepts that we use to theorise it (Geertz, 1971). Much of interpretivist research is also sympathetic to the claims of German sociologist, Max Weber's philosophy of social science (Scambler, 2022). In contrast to a positivist orientated social science that focuses on tracking and describing associations, prediction and explanation, Weber argued that social science should aim for

"verstehen" or understanding (Scambler, 2022 p24). In a criticism that has some resemblances to the above criticism of positivist orientated research, critical realists have claimed that interpretivist research, broadly conceived, is guilty of committing the "epistemological fallacy" (Scambler, 2018, p32).

Through this reading, critical realists claim that interpretivists have reduced social analysis to a focus on what we can say about the world, (epistemology) as opposed to ontology (being), with some interpretivists claiming that the gap between human subjective experience, language and reality may be unbridgeable. For example, staying with the social gradient of cultural participation example from the previous section, an interpretivist research design may focus on the perceptions and experiences of low social economic status individuals as a way of capturing the meaning and experiences associated with perceived barriers to cultural engagement. Added to this, interpretivists may look at the way in which language and discourse around cultural participation is politically loaded and is itself an oppressive technique of exclusion and power. However, in contrast to critical realism, some interpretivists may be hesitant to comment on the way in which certain patterns of cultural participation may affect the material and embodied being of individuals and certain actual material structures may impinge or otherwise on health and wellbeing.

Whilst some critical realists accept that our theorisation of reality is always concept dependent, many would claim that it is not reality that is social constructed but our theorisations of reality (Anderson, 2021). With this touched upon earlier in reference to the critical realist term, the transitive level of reality, which, for critical realists is always concept dependent. Now that critical realism has been discussed in relation to two dominant methodological approaches to social science, enabling elements of its' distinctiveness as an approach to be explored, the following section will discuss further features of critical realism as they relate to the research.

4.2.2 Critical realism and stratified ontology

As discussed in the previous section, most critical realists, broadly conceived, are committed to studying ontology. Along with transitive and intransitive forms of reality, the critical realist focus on ontology is notable for its depth, possessing different levels. Some of the levels are available to our sensory field, whilst others are not. This is often referred to as stratified ontology (Anderson, 2021; Danermark et al, 2019). The following section will discuss these layers in more detail, before relating them to the current research project.

1) The "empirical" domain of stratified ontology refers to "observed experiences and events". It is also referred to as "things that really exist and are captured in the data and noticed by the researcher" (Wiltshire and Ronkainen, 2021, p173). In relation to the projects focus and research questions, the empirical level pertains to the "experiences" and "perceptions" of men who have engaged with social prescribing.
2) The domain of the "actual" contains "unobserved but occurring experiences and events." This is also described as "things that really exist but that may not be captured in the data or noticed by the researcher" (Wiltshire and Ronkainen, 2021, p174). The actual may be the broader social events, culture and institutions that are involved or associated with social prescribing, for example, the National Health Service.
3) The domain of the "real", consists of "things that are not observable, but have the power to produce events" (Wiltshire and Ronkainen, 2021, p176). This refers to the mechanisms that exist that are responsible for explaining men's experiences and perceptions at the empirical level, along with the some of the events, culture, and institutions at the level of the actual. The level of the real could apply to the unseen presence or absence of power and trust.

Researchers in the field of critical realism have used the image of a flower to unpack stratified ontology, with the following worth quoting in length:

> *"the soil in which the flower is growing and the nutrients that it contains (the real domain) are out of the reach of our visual field. This means that we can only know anything about its predisposed properties – such as the quality of the soil – by observing the real effects that they have on the flower and building a theory about it* [...] *In the context of qualitative data analysis, the assumption of ontological depth suggests the need for researchers to engage in empirical as well as highly theoretical and speculative activities"* (Wiltshire and Ronkainen, 2021, p154).

As the stratified ontology of critical realism has now been unpacked, the following section will further develop critical realism to the current research project, before the next section moves onto the application of this philosophy to the research for the thesis.

4.2.3 Critical realism: context, mechanisms and agency

The primary analytical focus of the study will be on the way in which contexts associated with health and social inequalities interacts with social prescribing. Contexts have been described by Greenhalgh and Manzano, (2021, p591) as "spaces and social, geographical and historical settings, with norms, values and interrelationships found in underlying social, cultural, economic or legal contexts". Mechanisms can flow up from the individual or down from social structures and relationships involved in social prescribing (Scambler, 2022). Following this, possible mechanisms may range from individual forms of motivation and positive emotion triggered by social prescribing, to forms of choice and decision making. Examples of mechanisms that may be involved at the meso-level of social prescribing could include reciprocity, trust, and psychosocial safety. Examples of mechanisms at the macro-level could

be the generative mechanisms of neoliberalism described as "strangulating the flow of assets" associated with the social determinants of health with this caused by a small number of elites who are strategically eroding the social contract (Scambler, 2018).

From these examples, then, we can see how the use of critical realism enables an investigation into the way in which this context may be carried with working class and precariat men, and how it may interact with the processes and mechanisms of social prescribing. Lastly, agency refers to the way in which the social mechanisms that may be in play through the intervention are used and interpreted by individuals, although, it could also be said, that these are cognitive mechanisms (Anderson, 2021).

4.3 The use of retroductive reasoning to explore possible mechanisms involved in social prescribing

In addition to the contextual mechanisms, the analysis will also use retroduction to explore the mechanisms that may come into play during the social prescribing experience and that could cause the patterns of experience men may report to occur. Retroduction is defined as: 'the move from knowledge of phenomenon existing at any one level of reality, to a knowledge of mechanisms, at a deeper level or stratum of reality, which contributes to the generation of the original phenomenon of interest' (Jagosh, 2021, p121). Retroduction, then, is driven by questions such as, "what is it about x that matters?", "why do things appear as they do?" (Jagosh, 2021, p121). Following critical realism, these mechanisms exist at the level of the real and are the drivers and enablers of any experiences, positive or negative, that are reported through social prescribing. The analysis will also theorise how the mechanisms interact across various levels, for example, how a positive or negative experience and perception reported by the individual connects to meso and macro political and economic contexts. The following section will now discuss the methods used: this will range from a discussion of how the

research was adjusted because of the Covid-19 pandemic, to recruitment, data collection and analysis.

4.4 Covid-19 and adjustment to research design

Prior to Covid-19, the initial research design proposed that several qualitative methods would be triangulated. Alongside semi - structured interviews, the original design included ethnographic observation and fieldwork. The hope was to observe men participating in the activities referred to through social prescribing. This would help gain a dynamic understanding of men's referral and participation into social prescribing. As a result of the social isolation of Covid-19 this element of the research design was deemed unworkable. Adaptations were thus made to the design with it then solely focused on remote semi - structured interviews, with the men interviewed twice to facilitate a deeper exploration into the antecedent context of the intervention, and how this led to the referral or interaction with social prescribing. The use of a semi-structured interview also allowed the participants to discuss topics of interest in their own way, using language and concepts they felt familiar with, before a more theory-informed form of questioning, with the open-ended nature of the semi- structured interview demonstrative of the versatility of the method (Bronnimann, 2022). Another adaptation made to the research design because of Covid-19 was the sampling approach. Whilst it was always the intended aim to recruit men and link workers in the North, in the initial months of lockdown, there were concerns that not enough interest was forthcoming from the North. To cast a wider net, it was decided that a national sample of link workers be approached from up and down the UK. As the months passed, more link workers from the North replied to calls to participate in the research. As a result, the initial concerns that the Northern focus would have to be widened were removed. The data collected from link workers outside of the North was used to understand broader patterns of link worker views on social prescribing with the link workers then who participated in the North used as the key conduit to connect to the men

and to deeper understand the study settings of the North. The link workers from the North were recruited from five social prescribing settings, with this explored in more detail in subsequent sections.

4.5 Study Setting: The North of England and health inequalities

Prior to contacting the link workers, websites of social prescribing settings in the North were consulted in the initial recruitment efforts. All websites contained addresses and postcodes that were then cross referenced with the Index of multiple deprivation (hereafter, IMD) scores for the prospective social prescribing settings (Ministry of Housing, Communities and Local Government, 2019). Similarly, when link workers were referred to the study information was searched for on the area the link worker and social prescribing setting was based in and cross referenced with IMD scores. When referring to the summary statistics on the areas through the deprivation score of the local authority the social prescribing setting was in, only one of the settings recruited from was not placed in the lowest decile on scores of deprivations. This confirmed where the men were recruited from was of interest to the study with men in these areas likely to have lower levels of education and income typically have poorer health. In addition, to further ensure the men in the areas were of interest, especially in the setting not in the lowest decile, to the study, conversations with link workers confirmed that the men who were referred to their social prescribing setting were of theoretical interest.

Whilst it was initially hoped that more settings across the North could be recruited from, efforts to recruit in greater numbers were constrained due to the pandemic. Despite these constraints, it was the intention to try and recruit men and link workers from different types of social prescribing pathways to offer some diversity and variation in the accounts. For example, three of the settings recruited from contained a link worker employed in a primary care setting, receiving referrals from seemingly regular attenders to primary care. One setting sampled offered a model of social prescribing where a local council had contracted in the

services for social prescribing, receiving referrals from primary care, police and fire services amongst others. Lastly, one other setting was a hybrid of a VCSE run social prescribing and primary care network, with the link worker roaming between two settings.

All the settings recruited mentioned receiving pockets of funding or revenue used to run classes and activities with this contributing to running social prescribing. Moreover, one of the settings had received sustainable funding to run their arts on prescription, although no detailed accounts of this funding came forth in the accounts from the interviews.

4.6 Sample

As stated, to capture the experiences and perceptions of men positioned lower down the social ladder (Marmot, 2015), and understand their experiences during social prescribing, both a sample of link workers and a sample of men based in the North of England were recruited. The sampling strategy looked to recruit men from two of the seven classes mapped through the process of the Great British Class Survey (GBCS hereafter) (Savage et al, 2015). These are the "traditional working class" and the "precariat" (Savage et al, 2015, p14). The "traditional working class" are described as having "low economic capital", measured as levels of income and wealth (Savage et al, 2015, p170). This class is heavily based in the "industrial North", often associated with employment, or previous employment, in manufacturing, construction and transportation. (Savage et al, 2015, p170). In addition, 9% of the traditional working class are of ethnic minority (Savage et al, 2015, p170).

The other measure used to theoretically inform the sampling was the measure of the precariat (Savage et al, 2015, p96). According to the GBCS, this group had the lowest measure of all capitals. The precariat has an average age that is slightly younger than the traditional working class at 55 years of age. This class has by far "the lowest household income has little if any savings and is likely to rent property. It also has the smallest number of social ties […] with its

cultural capital more limited than any of the other classes" (Savage, 2015, p171). The precariat is represented by 13% ethnic minority.

4.7 Ethics

Once ethical approval was confirmed by Lancaster University Faculty of Health and Medicines research ethics committee, data collection commenced. Ethical approval was gained from Faculty of Health and Medicine's Research Ethics Committee on the 30th of September 2020 (Appendix A).

4.8 Recruitment and data collection of Link Workers

The following will discuss the criteria and process of link worker recruitment, before describing the interview process with the link workers.

4.8.1 Inclusion criteria for link workers

- Employed in social prescribing within the United Kingdom at the time of interviewing

4.8.2 Exclusion criteria for link workers

- Employed in any other health worker or public facing role not associated with social prescribing
- Employed in social prescribing outside the United Kingdom

4.8.3 Recruitment of link workers

To explore possible patterns associated with male use of social prescribing, a group of national link workers were first recruited. It was hoped that a national sample of link workers would offer a broad picture of the complex policy of social prescribing. No real criteria on class were stipulated for the link workers, nevertheless, the GBCS of "emerging service worker" was possibly identified as providing potential theoretical insight (Savage, et al 2015, p62).

The link workers were recruited via Twitter, LinkedIn or email (Appendix B, E & J). When the flyer for the advert was posted on Twitter, it generated responses and replies from link workers. This commenced a conversation and the beginning of a series of communications with the link worker. On other occasions, however, link workers were emailed or messaged via social media directly by the researcher (Appendix B, C, E & J). When this was the case, the conversation included the attachment of sending of the flyer for the study (Appendix E). Through this process, the link workers were informed, either from reading the flyers and posters discussed or through our conversations, that they would be offered a £15 "Love to Shop" voucher in recognition of their time and expertise. As the link workers were all in paid employment, the voucher's value of £15 was not deemed coercive or compromising the principles of free and informed consent (Head, 2009).

In both types of connection, when the researcher was contacted or the initiator of communication, an information pack was sent with more detail on the study. This included a topic guide and list of interview questions along with a consent form (Appendix F & G). After reading this pack, if the link worker continued to express interest in taking part in the study, the researcher requested that they send the consent form back through the post through the pre-paid envelope contained in the pack; or, if it was preferable, through an online form of consent form, accompanied by an electronic signature.

4.8.4 Interviews with link workers: remote interviews through Microsoft Teams

Once the written form of consent was received, the interviews were arranged. The interviews were undertaken through Microsoft Teams. Interviews with link workers commenced in 15th January 2021 and finished in May 2021. When a date and time had been arranged, the link workers were reminded of the ethical processes involved in the interview and that ethical

consent was a dynamic process and could be removed at any time during the interview. Moreover, the link workers were reminded that the interviews would be recorded, with them asked again for consent on this.

The link worker interviews were designed to gain an exploratory overview of the possible patterns associated with male users of social prescribing. In the first part of the interview, the questions were aimed at capturing the link workers' experiences of working in social prescribing. The questions examined if the link workers were satisfied with their employment in social prescribing and if they felt adequately supported, with these questions designed as a way of exploring if the link workers were aware of or impacted by structural factors like income, time pressure, stress and funding cuts to services. Finally, the interview questions focused more specifically on the problems the link workers perceived and experienced with men through social prescribing and how they go about resolving them. Final questions then explored how link workers connected men to solutions and practices and how these may or may not support health and wellbeing.

4.9 Recruitment and data collection of male users of social prescribing

Now that the link worker recruitment and interviews have been outlined, the following section will discuss the criteria, recruitment, and interviews of the male participants.

4.9.1 Inclusion criteria for male participants

- Male UK resident, currently receiving, or previously received, support from social prescribing in the North of England
- Above the age of 18.
- Retired, employed or unemployed but with a history of employment in manufacturing, construction, logistics, transportation as defined by the "traditional working class" measure in the GBCS

- Or employed in service sector in "low skill" low paid, insecure contracts as per the precariat in the GBCS

4.9.2 Exclusion criteria for male participants

- Males based outside the UK.
- Adolescent males
- Men not theoretically of interest with higher levels of economic, social and cultural capital than traditional working class and precariat

4.9.3 Purposive and snowball sampling and recruitment of men through Northern link workers

To gain access to the men of interest, a purposive sampling strategy was developed. As discussed above, using indices of multiple deprivation, this targeted areas of deprivation in the North of England. In addition to this, and largely because of Covid-19, other participants were recruited through snowball sampling (Kircherr and Charles, 2018). Snowball sampling involves a chain of referrals to the study where those who are initially approached to being involved pass on the study details to others. When this type of sampling was used, the initial link workers in the sample offered connections to other link workers in their network, asking them if they would participate in the study. Whilst snowball sampling is identified as an approach that is especially appropriate in gaining access to "hard to reach" or "concealed populations" (Kircherr and Charles, 2018, p2), it also contains some potential challenges. Snowball sampling, dependent as it is on chains of communication between gatekeepers, may exclude the voice of those least willing to participate within the hard-to-reach groups often left out of the research (Kircherr and Charles, 2018). Similar trade-offs to this will be discussed in more detail in a later section of the chapter on the uses of link workers in the recruitment.

To gain access to the men, as stated, the researcher first interviewed a national sample of link workers based in various locations across the UK who were working in social prescribing. This national sample contained some link workers employed in the North of England. These link workers based in the North were the interviewed and consulted further to gain access to the main sample of focus. Link workers that were based in the North were asked if they knew of any men from their caseload who may be interested in taking part in the study. As mentioned in the previous section, and as part of an initial screen, a brief discussion of the inclusion criteria for the men was discussed. The researcher briefly described to the link worker that the study was interested in the way that social prescribing could help tackle health inequalities. It followed from this that the further description that certain men in the population who earn less income, possess less wealth, whose occupational conditions are not necessarily conducive to health, often have worse physical and mental health outcomes than others. It was then stated that research can help establish how these patterns can be avoided. Moreover, it was described that the cultural norms associated with masculinity often combined with these social and economic factors making health seeking harder for many men (Lomas, 2014).

It was then added that the study was interested in recruiting men who have experienced these types of conditions. After confirming that these trends were consistent with the issues they experienced with men in their Northern based role, the link workers consulted their case load to find men that may be interested in participating who fitted the population of interest. After consulting with the men and gaining their consent, the link workers sent contact details and addresses across to the researcher. From this, an information pack containing details of the study was then sent to the men's home address and email address when possible. This included general information about the study, a participant information sheet (Appendix F) an interview topic guide (Appendix I) and a consent form (Appendix G). The envelope containing

the information pack also contained a pre-paid envelope to send the documents back at no charge to the participant. When the men returned the envelope with a signed written consent form, further conversations then took place on the time and on the scheduling of interviews. Similar to the link workers, the men were offered a £15 "Love 2 Shop" voucher in recognition of their time and expertise. Whilst many of the men reported low levels of wealth and income, the value of £15 voucher was deemed appropriate in rewarding the men for their participation. This amount was deemed not to be coercive or threatening to freely informed consent. Although Head (2009) argues that the use of vouchers may lead to participants telling the researcher what they felt the researcher wanted to know, to the researcher's knowledge there was no evidence of this effect. Whilst no explicit data was gathered on the men's motivation for taking part, many of the men claimed they enjoyed telling their story with the added acknowledgement that in the last years and decades of their life, their account may add to the public good and improve our knowledge on men's health.

To further confirm the men met the inclusion criteria, the initial phases of the interview were used to discuss the men's occupational history, with some connection often made to levels of economic capital (income and wealth) they possessed. Discussions of these conditions as pertaining to the concepts of capitals and class and precariat were first done in an exploratory and open-ended way, giving the men the space to present a narrative of their life in relation to these questions. This was deemed a subtler way to gain access to information on class and is supported in guidance (Laurea, 2021). As a result of this screening, only one male (ex-university lecturer) who was passed on by the link workers to participate did not meet the theoretical conditions of interest, with him reporting moderate to high levels of income and wealth. In doing so he was thanked for his time and a £15 voucher was sent to him anyway.

The use of the link workers as gatekeepers proved an essential recruitment tool, especially during Covid-19. Nevertheless, this does have its associated risks too and this is worth discussing. Whilst it has been identified that gatekeepers are often a vital conduit in connecting researchers to participants, the researcher was mindful that this method of recruitment also has potential problems that require further examination. For example, literature has drawn attention to how the scarcity of funding and subsequent competition for commissioning of services influenced researchers in a similar project (Dogra et al, 2021) These conditions can influence the recruitment of participants in the following ways. Firstly, to give the best impression of their work, link workers as gatekeepers may cherry pick the men, they feel have gained the most from social prescribing. This is Identified in literature on researching "hard to reach" groups as "social desirability bias" (Wood et al, 2023, p1174) with the link workers perhaps unconsciously motivated by the power of social norms, but also conditions of scarcity identified previously, to look and feel successful in their work, only referring men to the study likely to support this. Secondly, perhaps unknowingly, the link worker may select men for recruitment who they have forged the strongest relationship with at the expense of those they have not. These concerns associated with link workers represent a form of selection bias (Kay, 2021), and, if not accounted for here, could threaten the validity of subsequent findings. Nevertheless, as noted by Bashir (2023) link workers as community gatekeepers are an essential component of research for communities that are underrepresented in health research. Consistent with Bashir (2023) many of the link workers who participated and subsequently facilitated the research were from the local areas. Their knowledge of the social, cultural, and historical problems men in the area faced and how this interacted with social prescribing was often indispensable in terms of gaining access to the men of theoretical interest to the study.

Moreover, whilst diversity of the men's age and ethnicity was not the explicit aim of the research questions developed, the men recruited presented diversity of problems faced through social prescribing. These problems ranged from mental health, to loss and bereavement. This diversity provided a rich insight into the specific problems of working class and precariat men through social prescribing.

Young men were not deemed of interest to the study. The exclusion of them resulted from conversations from link workers who stated that adolescent and younger men had little to no involvement in their social prescribing caseload. In addition, whilst ethnic diversity was again not an explicit aim, a small number of the men sampled were from ethnic minority populations with this again providing some diversity of the analytical claims made.

4.9.4 Remote interviews with the men: telephone

Interviewing of the men began on the 26th of February 2021 and concluded on the 18th of February 2022. The interviews lasted between 45 minutes to 1 hour 30. As a result of Covid-19, all the interviews with the men took place through a remote interview over the telephone (King et al, 2018). As noted in the literature, remote interviews have been identified with several weaknesses. Some notable examples of these are the concern that the lack of face-to-face contact of remote interviews may threaten the development of rapport, cause participant fatigue or lead to a superficial transactional conversation (Keen, Rodrigues and Joffe, 2022). Whilst these concerns are important to take note of in the design of remote interviews, overall, the men interviewed over the phone seemed to be forthcoming in sharing their thoughts and experiences. Moreover, alongside their identified weaknesses, remote interviews also possess their strengths. This is especially the case when dealing with participants who may be suffering with mental health problems (King et al, 2018). When conducted over the telephone, remote interviews remove eye contact and physical proximity

from the interview process. Whilst removing eye contact can be problematic for some, in those who have experienced trauma etc the absence of face-to-face contract can be a welcome relief, offering more control (Van Der Kolk, 2015).

Moreover, given some of the discussions with link workers, some of the men to be recruited were likely be suffering with various mental health problems. The interviews were designed to ensure a feeling of safety for the interviewee. The remote interview would also allow the interviewee to leave the interview at any moment by simply placing the handset down. In addition, some have suggested that there may be a level of tacit anonymity in the telephone interview which encourages more free flowing responses (King et al, 2018).

The participants were reminded of the ethical components of the interview and that in addition to the signed written consent form, a further request for verbal consent was requested. Moreover, once this was given, a further confirmation was undertaken that asked if the interviewee was okay for the interview to be recorded through a handheld audio device.

The interviewee was then reminded that consent is dynamic and can be withdrawn at any stage during the interview. Prior to the first interview commencing, after the men agreed to a time to be interviewed, a telephone call was made from the researcher to the participant. An introduction was designed to generate a basic level of trust and rapport. A summary of my motivation to research the topic was given and this was connected to my own personal experience. Elements of this described my own history with mental health, and a chronic condition called Crohns' disease, along with my use and attendance of the NHS. This was also combined with some brief history of my occupational trajectory as playing semi -professional rugby league before working in construction and then returning to education via an access course, with this included to build rapport. This seemed to work well given some of the later feedback from the men interviewed.

In contrast to the link workers who were only interviewed once, all the men recruited were interviewed twice. This was deemed important in enabling the researcher to really capture a detailed and rich set of data. The first interview was designed to capture the social and cultural context of men's lives, with only some of the interview aiming at social prescribing experience. Following this, it was then envisaged that the second interview would recursively circle back towards the experiences, perceptions and possible mechanisms involved in social prescribing. Following Lareau (2021, p29) probes were used to dig deeper into some of the men's responses. These are questions that ask interviewees to reflect on certain topics of interest in further detail were used to add detail to some of the men's responses, with this versatility a central reason on why semi-structured interviews were chosen as the method.

The first part of the interview topic guides was driven by the stated aims of social prescribing, most notably the aim of social prescribing to connect users to what matters to them (Fox and Mason, 2022). The primary aim of the first interview questions were to explore the cultural context on what did matter, or, perhaps, previously mattered, to working class and precariat men in terms of their participation in hobbies and activities. Following guidance on critical realist interviewing, the questions on social prescribing were designed to move from more descriptive questions on events, patterns, and regularities before digging deeper into questions of "how" and "why" (Bronnimann, 2022, p12) certain experiences and possible patterns had occurred both in the antecedent context of the lives of working class and precariat men and in their journey through social prescribing. Following this, the interview questions focused on the referral, relational components, and participation in activity as processes contained in social prescribing, and how these possibly interacted with the context.

4.10 Capturing the experiences and perceptions of working class and precariat men in context: semi-structured interviews

The men were interviewed twice to deeply understand both the context of their lives and their social prescribing journey. Semi-structured interviews allow in-depth exploration into contexts and processes (Bronnimann, 2022). Moreover, following Baldwin and Stears (2024, p 247) in terms of capturing what matters to working class and precariat men, it was deemed important to let the "working class…speak for themselves", in an inductive way whilst also asking very focused theoretically informed questions. The method of semi- structured interviews is very well suited to this aim. Moreover, as noted in literature on wellbeing interventions, and the key findings of the systematic review, the surrounding context of interventions identified as historical, cultural societal and political influences are often under-analysed within the field of social prescribing. The versatility of semi-structured interviews allows for a more thorough and deeper exploration into context. This was further strengthened by interviewing the men twice, where the development of rapport over time could provide the scope necessary to understand if the context the men described was consistent with literature on the contexts that are responsible for causing health inequalities and why.

4.10.1 Social capital in context and developed through social prescribing

The interview questions were designed to proceed with caution when discussing the context of class and inequality (Appendix I). As mentioned previously as part of the recruitment, the interviews questions enquired about occupation, which subtly led into discussions prompted around income and wealth, community, and power, hobbies, and meaningful participation in activities prior to social prescribing engagement. The decision to frame the questions in this manner resulted from commentary and findings in recent work on class and health inequalities. This research has argued that whilst objective patterns of income/ wealth are widening, and progress on narrowing health inequalities reversing, efforts to discuss these

structural forces can be emotionally painful. This can sometimes cue defensive responses from those being interviewed (Laureau, 2021). The interviews were designed to build rapport around the participants' interests and life history before discussing areas of economic and relational inequality. This followed methodological guidance on analysing the habitus and participation in activities in context (Wacquant, 2015) and how they relate to levels of capital as discussed in the previous chapter, economic, social, and cultural (Bourdieu, 1977; Atkinson, 2010).

The interviews used questions derived from social capital research to understand the two types of social capital (Rostila, 2011). These two types will be examined in the presence of interpersonal trust in the context of the men's lives and the development or cultivation of trust through the social prescribing experience. Trust can further be conceptualised following Lizardo and Stoltz (2018, p237) as an affective and embodied felt sense of trust, in addition to a deliberative and more cognitive appraisal of the situation i.e., "it was in my interest to trust x". Although the more embodied forms are harder to capture in non-observation, the description of "felt experience", can be used to explore this. Moreover, the second facet of social capital is more structural than cognitive and relates to the level of association with others (Rostila, 2011); this level of association is related to the participation in activities and association in the antecedent context of men's lives as well as the development or cultivation of participation in associations and activities through social prescribing. Further questions explored if and how the forms of social capital associated with social prescribing are associated with bonding, bridging, and linking forms of social capital discussed in the previous chapter.

4.10.2 Wellbeing in the context, referral to social prescribing

In addition, to explore the processes and mechanisms involved in the referral, relational components and activities connected to social prescribing, questions related to how wellbeing is discussed conceptually in different forms, as discussed in chapter three (Layard and Neve, 2023). These questions were designed to understand how social prescribing was experienced and how and why this was the case.

This was conceptualised through using interview questioning that asked how certain events or patterns described in the context evoked positive or negative emotion. For example, questions like "how do the activities you reported participating in (prior to social prescribing) make you feel?". These questions focused upon retrospective accounts of feeling as associated with certain key events and experiences of interest where then applied to the social prescribing experience. This focus on pleasant or unpleasant emotions, or a "hedonic" orientation of questioning, was combined with more eudemonic forms of questioning, which related more to life's purpose and meaning, rather than emotion as by Pilgrim (2021 p55) in context: "Do you feel your life has purpose?" and, in reference to social prescribing, "what activities that you have participated in through social prescribing have given your life direction?". These were combined with questions like "how has social prescribing enabled you to find meaning and purpose, if it all?".

The time between the men's first and second interviews ranged between one week and six weeks. A central concern here was ensuring that the men felt comfortable and empowered in their participation, with the data collection through interviews proceeding at a pace that was comfortable for them. This was especially vital given the Covid context. Some of the men who decided to be re-interviewed a week after often remarked that the interview provided a much-needed form of communication when this occurred during the lockdown. Others who waited

longer between were sometimes ill with Covid-19 or wished to wait a few weeks before being contacted again. In either instance, the gap between interviews allowed for a familiarisation with the data which then shaped elements of the second interview. This was done through either listening to the recording of the interviews or reading the transcriptions. This allowed the researcher to revisit certain parts in the first interview, probing for more detail into certain responses.

4.11 Data Management

4.11.1 Transcription

After the completion of the interviews, the files were downloaded onto a portable hard drive. After this, the interviews were transcribed by the researcher. This was opted for to aid a deeper from of familiarisation with the data. All data and personal information about study participants was securely held. All electronic data was encrypted and stored securely (on One drive) and analysed on the researcher's password-protected personal laptop, accessible only to the researcher.

4.11.2 Data Analysis: reflexive thematic analysis and critical realism

In analysing the data, guidance on reflexive thematic analysis as developed for realism and critical realism was used (Wiltshire & Ronkainen, 2021). Following this, interpretation is always filtered through and shaped by some of the researchers' assumptions; efforts towards this not happening unknowingly are improved using reflexivity where the researcher reflects on their background and assumptions and how this may impact the research. The link worker data and data from the men were coded separately. This offered the benefit of comparing if the problems the link workers discussed in their role when dealing specifically with men were confirmed in some of the men's data. This added to the validity of the analytical

interpretations. Another possible approach could have seen the link worker and men data analysed together and then presented together as findings. Following this strategy could have disrupted the perception that the link worker and men were of different social classes. For example, both the men and link workers reported structural conditions like poor pay, resulting stress, and other structural issues. These findings could have been combined with inferences made on how social prescribing interacts some of the issues listed previously.

4.11.3 The technologies of coding to highlight the "how" and "why"

In terms of the "technologies of coding" (Braun and Clarke, 2022, p111), this involved printing out each transcript, familiarising myself in the data through reading them, then coding with pen in the right-hand margin when meaning was assigned to the data. Despite the overlapping nature of the data collection, the link worker and men's transcripts were coded separately. Coding the datasets separately did not prevent the later comparison of the candidate themes which improved the quality of the analysis.

Moreover, the coding only concerned data from the interview that was relevant to the research questions. For example, some of the early phases of the interview were spent talking about Covid-19 and various topics and experiences associated with lockdown and the virus. Whilst these conversations were very useful in generating empathy and rapport, they were of no consequence to the research questions and were not systematically coded. To visually exclude this data, it was struck through in red pen on the printed hard copies of the transcripts The data left over from this initial sift was approached through an inductive, or data driven orientation, coding line by line and assigning descripting forms of meaning. In this part of the process, as best as possible, the data was approached at the level of generating descriptive and "semantic" codes (Braun and Clarke, 2022 p119). As a draft of the systematic review had already been written, it was important in the first inductive phase to try to stay as detached

as possible from some of the theories used in the social prescribing literature. This ensured the initial coding for semantic meaning stayed as close to the participants accounts as possible. For example, codes like, "men and worry", "men and enjoyable activities" and "link worker on dealing with men who lack money" are just three examples of codes that were written in the right-hand margins on the printed transcripts. In addition, the codes were tagged and identified as referring to different levels of analysis. So, for example, some of the codes pertain to individual level phenomena related to embodied experiences and emotions, feelings, or the more cognitive, attitudes and perceptions. Whilst others pertained to levels of political or sociological phenomena like, political parties, policies, schools and income inequality

Once codes were assigned in the right-hand margins of the transcripts, a further stage of more deductive and retroductive analysis occurred (Wilthsire and Ronkainen, 2021). The aim here was to develop more analytically informed themes. In doing so, the researcher reflected on the use of theories in the social prescribing literature from the review, alongside others, developing candidate themes through assigning more analytically informed interpretation for each individual transcript. Plain coloured post-it notes were used to experiment the connection with different themes. Meaning previously identified in a line-by-line way was condensed and connected to potential themes, with these potential themes written down on a post-it notes, for example, descriptive codes like "men and worry", "men and fear", were condensed into a candidate theme like "men, barriers to wellbeing and negative emotion" and then physically moved around in ways that resembled the clustering of themes into potential chapter contents. Although the link workers were interviewed first and analysed separately, some of themes developed with this data were used to compare with the men's data and inform some of the analytical claims made on the men's data. After a first exploratory round of this, the candidate themes were then fixed into a more permanent

structure. It was also noted when a smaller number of the participants accounts diverged from the patterns of meaning, providing negative cases.

Similar to the codes, the themes were developed at different levels of analysis following Wiltshire and Ronkainen, (2021) and further refined into the following which map onto the stratified ontology of critical realism described earlier in the chapter:

(1) experiential themes, referring to "subjective viewpoints such as intentions, hopes, concerns, beliefs and feelings captured in the data" (Wiltshire and Ronkainen, 2021, p14).

(2) Inferential themes, "referring to inferences and conceptual redescription using more abstract language" (Wiltshire and Ronkainen, 2021, p15).

(3) And, "dispositional themes" referring to themes about properties and powers that must exist to produce the phenomena being studied (Wiltshire and Ronkainen, 2021, p16).

The following section describe the processes associated with quality in the use of reflexive thematic analysis.

4.12 Quality and reflexive thematic analysis

In an effort to move away from a "positivist creep", key guidance from authors associated with thematic analysis (Braun and Clarke, 2023, p268) caution against the smuggling in positivist and post - positivist notions of validity, reliability and rigour. Rather, Braun and Clarke (2022, p4) advise that, "for us, quality depends not on notions of consensus, accuracy or reliability, but on immersion creativity, thoughtfulness and insight". Despite this, however, Braun and Clarke (2022, p269) do offer a 15-point checklist to guide the researcher, although they stress that even following this does not necessarily lead to high quality reflexive thematic analysis.

Although the details of the checklist are too numerous discuss here in full, a summary of its focus is worth inclusion: the checklist stresses that a clear and consistent audit trail from transcription to analysis is important, documenting in detail the process from raw data to analysis; in order to achieve this a research journal which was completed regularly and especially when key analytic insights felt like they were made; moreover, Braun and Clarke (2022) stress that a thorough and slow immersion in the data and analysis is vital. Again, this is to ensure premature analysis does not take place and superficial theme development is avoided. Lastly worth mentioning is the importance placed on reflexivity, with a reflexive account of the researcher's position discussed at the end of this chapter. Reflexivity was used an ongoing process throughout the data collection and analysis, where the - researcher acknowledges their position in interpretation of the data to ensure that these assumptions do not unnecessarily impinge upon the analysis. This was again covered in the research diary, where frequent efforts were made on how the researcher's positionality and normative beliefs may impact my interpretation and analysis of the data.

4.13 The conclusion of analysis and "informational power" (Braun and Clarke, 2021)

In adherence to Braun and Clarke (2021) rather than claiming a level of "data saturation" an interpretive judgement call was made on the conceptual depth of the data. Like the previous section on quality, Braun and Clarke (2022) argue that too often claims to saturation adhere to positivist understandings of generalisability and probabilistic logic. In contrast, in reflexive thematic analysis, if both the data collection and analysis is more open, fluid, organic and recursive coding, then data saturation can never be conclusively reached, as we never fully know if the next data collected will not generate interesting and novel findings in relation to the research questions (Braun and Clarke, 2021). Personal transcription of early interviews and familiarisation with the data was ongoing alongside later data collection and interviews.

This allowed for continuous reflection as to whether more data collection was needed to provide a rich answer to the research questions posed. In describing this process Braun and Clarke (2021) argue that conclusion of data collection and analysis in reflexive thematic analysis may be better described as being driven by a subjective feeling of "informational power" (Braun and Clarke, 2021, p201). It is also noted that the practicalities of deadlines in research projects also drive the conclusion of analysis. As the project was carried out during the Covid- pandemic, the constraints placed on contacting and talking to people most certainly impacted the ability to recruit people to the study.

4.14 Summary of the sample and presentation of findings

The sample contained 10 link workers, 13 male users of social prescribing from across the North of England, and 1 man who had been both a user and now deliver of social prescribing. In total 24 participants were interviewed, with 38 interviews completed in total. A more detailed tabulation of demographic information and data associated with the samples are presented in the introductions of chapters five and six. To protect anonymity, the men's data has been aggregated. The table includes information on age, location and, for the men, social class and capitals as pertaining to the Bourdieu informed GBCS (Savage et al, 2015). The findings from the study are presented in chapters five to ten. In terms of presentation of the data within the chapters, it is hoped that the reader can follow elements of the individual arc of the men's lives through the presentation of the findings across the patterns presented. In addition, in the reporting of the data, the terms interviewee and participant are used interchangeably to avoid repetition. When the presentation of the data documents questioning and dialogue between the researcher and the interviewee, the data will be presented in the following way to identify the question and response:

Researcher*:*

Male Participant/ Link worker participant:

The following section will now progress into a reflexive account. Following reflexive thematic analysis (Braun and Clarke, 2022) this account is deemed vital to ensure that the author's socialisation, values, and beliefs do not unduly impact the analysis that follows. The following section will therefore discuss three key areas of the researcher's social trajectory that have shaped the focus of the study.

4.15 Reflexive account

As central to the guidelines on reflexive thematic analysis (Braun and Clarke, 2022), this brief reflexive account will be undertaken through a discussion of the background and context of the researcher, with particular attention given to elements of the context that interact with the focus of the analysis. After returning to education through an access course, my first degree was in History at Edge Hill University and allowed me to examine some of the problems associated with inequality. My BA dissertation focused on labour politics and the working class in Wigan and Leigh in the North West of England which gained a first, with my interest in the North of the UK and inequality shaped in this study. After this I pursued my MA at the University of Nottingham, where I developed a more specific interest in health policy, with changing policy approaches in the delivery of health policy the focus of my MA dissertation. This gained a distinction and stimulated my interest in further study. It was during this period that I was diagnosed with an autoimmune condition called Crohns' disease. As a result, I continue to attend NHS hospitals every eight weeks. Throughout this experience I have continually asked questions of how to reform the health service.

After my MA, I spent time employed in the Voluntary Care and Social Enterprise sector (VCSE) in St Helens. This was in one of its most deprived wards, Parr, which is also the area that I

attended secondary school. Working for a social enterprise that delivered employment support and low-level psychoeducational interventions, it was this experience that alerted me to the issues that many men in the area were experiencing. During my employment, there were numerous cases of suicide and self-harm alongside a lack of engagement reported by the men.

All of the above experiences have therefore shaped the research questions and some of the theories selected for this study. Politically, and in terms of policy output, I am concerned with how, during a phase of political economy loosely referred to as neoliberalism, the distribution of power, control and resources associated with health have been redistributed towards a rentier (Sayer and McCartney, 2021) and monopolist elite, at the expense of labour (Piketty, 2022). I am also interested in how these distributional struggles interact with people's everyday life. Along with concerns of the ways in which changes to the economy have impinged upon people's sense of agency, I am also interested in how the public sector needs to change some of its assumptions to combat some of the social problems of the 21st century. I am especially interested in how top-down policy making seems to omit this focus. This drew my interest to social prescribing as a health policy that seems to have a better developed sense of how the context of people's everyday life interacts with service delivery. In many ways, I am sympathetic to currents of social democratic thought that are proud of the NHS, and wish to defend it, but that nevertheless view it as cutting off the rich connections of social capital that pre-existed the welfare state.

In that sense, I locate my own beliefs within the tradition of "ethical" social democratic thought, combined with a rich tradition of social liberalism, which has seen recent iterations referred to as a socialism of "the everyday" (Stears, 2021). At the centre of these beliefs is a commitment that it is our interdependence that allows us to flourish as individuals and communities and that neoliberalism has rewarded the collective denial of this

interdependence. The following chapter is the first findings chapter. It presents data from interviews with the link worker's sample. In the table that presents the men's data, some information on capitals is presented with some data from the men presented on this in the latter columns.

Chapter 5: Link worker narratives as enablers of wellbeing and capital

This chapter presents data on the perceptions, experiences, values and practice of a sample of link workers interviewed employed in social prescribing. The data presented concerns link worker experiences and perceptions of social prescribing along with narratives of their work with men through social prescribing. Subsequent chapters will focus on the men users of social of social prescribing who were interviewed, their accounts and experiences of social prescribing. The following table contains data on the sample of link workers.

Table 2: Link worker participants anonymised (n =11)

Name	**Location**	**Data coded on occupational/volunteering history prior to link worker role (when given)**
Andy (Male)	Based in the North	Used social prescribing, then volunteered through it and other sources before gaining employment in social prescribing
Ben (Male)	Based in the North	Previous job as personal trainer then health trainer for the NHS
Connor (Male)	Midlands	Training in psychology and counselling, before working in care roles in the NHS.
Deepti (Female)	Based in the North	History of volunteering before taking a role as link worker
Ellie (Female)	Based in the North	Higher education in psychology before taking a link worker role
Freya (Female)	Based in the North	N/A
Gillian (Female)	Based in the North	Higher education in sports and exercise science, previously worked as a health trainer before working as a link worker
Harry (Male)	Midlands	MA in health psychology
Izabelle (Female)	London	N/A
Jasmine (Female)	Based in the North	Previous roles in NHS
Katarina (Female)	Based in the North	History of roles associated with physiotherapy before link worker role

The chapter proceeds through four themes. Firstly, it will examine how, through working under the policy of social prescribing, many of the link workers report enabling and empowering their clients as part of their role; through this, the link workers often present nuanced understandings of their client's needs. Secondly, despite this, the chapter will explore how social prescribing is often experienced as under resourced to meet the scale of the local operational realities in the context of where link workers work; thirdly, it will examine how link workers describe meeting men's needs in novel and innovative ways, but again how this is coupled with descriptions of contexts of deprivation. Finally, the chapter will look at the way that link workers communicate optimism for social prescribing in helping to reintegrate communities post- Covid-19.

5.1 Link workers on enabling and empowering users of social prescribing

This theme documents two ways in which the link workers describe new ways of working through two subthemes. The first describes how social prescribing enables link workers to work towards practices they loosely associate with the social determinants of health perspective; secondly, it explores how social prescribing was often described by the link workers as "empowering" with examples derived from generating new funding streams for activities in the community, helping to launch activity classes.

5.1.1 Social prescribing and the social determinants of health: the identification of needs and wants

Often the link workers report accounts of practice that contain sophisticated understandings of the social determinants of health, recognising how identifying certain deficits in clients' needs is an important element of their practice. The link workers' awareness of the social determinants of health ranged from an explicit well-developed theory, to a more implicit

understanding and perhaps even contradictory understanding of them. For example, some of the link workers interviewed claimed that changes to behaviour that may improve health (like the cessation of smoking) cannot be achieved until other issues associated with historical or contemporary stressors were tackled. These were often identified by words like "root cause", or "deeper rooted issues", were tackled. This demonstrates some understanding of ontological depth and structure. For example, an interview from the link worker below stated,

> *"It was 2017, when I first started working with social prescribing. This is before its more recent relaunch. I don't want to blow my own trumpet but I was quite successful. I had the highest referral, and some really good outcomes. And the reason for this, we were finding the root cause and it was deep-rooted socio-economic issues that were the driving problems."* (Ben)

Ben proceeded to note how, through his role as a link worker, he heard accounts that patients claimed to not have shared with anyone else. On some occasions these accounts contained histories of developmental trauma or abuse:

> *"Speaking to patients and getting to know their story you end up hearing things that they have never told to anyone else, you know like childhood abuse and trauma. I mean how can you have someone telling you to reduce your sugar intake and reduce your cholesterol when you've got these deeper-rooted issues."* (Ben)

The identification of the deeper-rooted issues, in this instance childhood trauma, connect with a life course understanding of the social determinants of health.

Similarly, another link worker reported that they elicited narratives from their clients previously not shared with others through a deeper form of enquiry that moves beyond the surface level diagnosis of the GP:

> *The doctor would refer them on to me and just put in their file that they need their bloods doing, but when they came to see me, I would ask them if they had stress in their lives and so many people would open up and tell me that they had historical abuse when they were children. So, there is a lot of people that go to the GPs and they are not clinically poorly, they are more emotionally and socially poorly*." (Jasmine)

Similarly, others described a way of working that moved beyond pharmaceutical or cognitive ways of treating depression in favour of a more contextual understanding.

> "*It's really about moving towards a more holistic way of understanding people's illnesses and so forth. I mean I read a paper by the BPS [British Psychological Society] recently on depression and it was saying, okay, someone is presenting to you as depressed, well you can go down the chemical route or C.B.T* [Cognitive Behavioural Therapy] *or you can see the person, not as something that needs to be corrected for some chemical imbalance but that is part of wider community, and why they might be depressed because of where they live*." (Connor)

Link workers interviewed described health and wellbeing as connected with access to supportive and enabling institutions:

> *"Well, I always look at health as a triangle, where you live, education, lack of stress. As a social prescriber, I advocate on it all, mostly for ethnic communities. You know a lot of them are entitled to benefits but they won't take them, you know, because it's not the done thing in their culture, for example the Somalis."* (Deepi)

In addition, to the reportage of a pathway of social prescribing delivered in primary care, some of the link workers interviewed reported offering social prescribing as part of a local council and were contracted in by the clinical commissioning group. Ellie described how as a council

delivering social prescribing, they aim to reduce demand on primary care by meeting needs on the social determinants of health.

> *"There was funding available through social prescribing, Because of our position as a council and the work we were doing at the partnership. We're very forward thinking at the council. So, we offered to run the social prescribing for the GPs and we have tried a different model."* (Ellie)

Other members of the sample from the model of social prescribing offered by the council, claimed that the aims of their care are "public service reform", that will effectively reduce demand on primary care by meeting needs on the social determinants of health.

> *"As a council were working to create more integrated care across the partnership as part of public service reform, we picked up work around population health which was quite a forerunner for social prescribing. Our aim is to reduce demand. Most of the time people are attending GP'S with concerns about a broader determinant like health houses or finances or so on, it's not necessarily clinical."* (Freya)

Despite their claims to be working on the social determinants of health, on some occasions, the link workers reported that clients in deprived Northern areas are referred to stress management, or encouraged to develop their resilience. Both are examples of cognitive psychological interventions, that, whilst not without their place, are not always consistent with a needs-based understanding of the social determinants of health. For example, whilst Freya claimed to be working "upstream" at the level of the system, before mentioning the cultivation of resilience and emotional support; these are cognitive forms of emotional regulation delivered interpersonally through the coaching and practice of a link worker:

> *"We have cases that come to us that we class them as non-clinical. But we work with them as social prescribers so hopefully we're creating some capacity in the health system. It's upstream stuff, if we can catch people at a much earlier point and help them be resilient and do emotional support before they hit crises it's much better for that person's recovery."* (Freya)

Thus, whilst the link workers often make detailed understanding of the social determinants of health, and how this understanding integrates into practice, often these understandings are inconsistent and make greater reference to solutions that point to interventions aimed at the level of cognition.

5.1.2 "Empowering" communities? The funding and launching services through social prescribing

A smaller number of link worker responses described their role within social prescribing as helping to launch and develop local community activities and resources through small investments and funding streams. Those describing social prescribing as providing pockets of start-up funding for small businesses, with this described this as "innovative".

> *"I mean, we are quite innovative, because we do something called microlending to groups that we think are viable, and it helps them start up, and we've been celebrated for that."* (Andy)

Others claimed how this initiative of launching classes with early forms of funding and support, with a view to creating a self-running and revenue-generating project, was connected to an understanding of 'empowering'.

> "*I empower communities. So, for instance, if we put on yoga in the community. So, I'll put on a session for 6 weeks, where we fund it and will pay for the 6 weeks as the NHS.*

> *Then after 6 weeks if the class say has ten participants, each person attending will pay like two pounds and then class can run on its own then. I think it's more empowering that way."* (Deepti)

This was combined with a description of encouraging the social prescribing user to pay which it was argued developed commitment and repeated attendance.

> *"Yes, it's been very successful because, what I'll say is, that, it's free for so many weeks. See if you like it and then you will be paying for it then. You'd be surprised that this is more successful than when we put them on for free. I've put stuff on for free and had no one turn up."* (Deepti)

In this theme, link workers have described, in a variety of ways, how social prescribing is framed with some form of connection to the social determinants of health. Sometimes, however, this connection seemed tied to inconsistent understandings of the social determinants of health, with some evidence of more emphasis of individual level change through mindset or cognitions. These accounts are vital forerunners to understanding how the link workers engage with men. The next theme will continue with this focus, describing how broader economic constraints of lack of income, time, and power, often impinge upon the daily operational realities of the link workers. It will then describe how these, again, like the above theme, can generate tensions and inconsistencies between what they hope to do, and what indeed they can do with limited resources.

5.2 Social prescribing as "dumping ground" and link worker as gatekeeper to basic resources

The link worker narratives contain frequent references to a perceived stretch of their role. On this, some note that they feel their role has shifted from connecting patients to activities they

find purposeful and enjoyable, to servicing the needs of those feeling extreme emotional distress and deprivation. Often, this was combined with a sense that it is important for the link worker to feel like they are doing a good job and competent in their role. Nevertheless, as will be demonstrated, the desire to feel competent in their role when located within less than adequately resourced contexts sometimes led link workers to report feeling overworked. This was combined with comment on how they experience low pay and are under resourced. The mismatch between resources and scale of need was highlighted in the following statement on the scale of clients the link worker in question is responsible for servicing:

> *"I mean for a good while it was me on my own across the PCN [Primary Care Network}, which is ten physical sites. Over 1000 patients."* (Ben)

Others commented more specifically on the gap between how social prescribing was initially marketed to them as at the beginning of their employment, and how this contrasts with the operational realties of delivering social prescribing in a deprived area:

> *"I think people are missing the point of what it means to be a social prescriber, like thinking they are just nice people who meet lonely people for coffee and tell them about arts and crafts and things. Don't get me wrong that probably is socially prescribing in some areas where the population is elderly and affluent, but I know in urban areas like this, I'm more of a social worker."* (Gillian)

In an extension of the above, worth quoting in length, the interviewee described a feeling of conflict. They want to help people, and find it hard to turn them down, but are ill prepared to treat the cases they are receiving, with many of these taking the form of more severe mental health problems likely to require higher level interventions.

> **Male participant**: *" These people are still in the community and then the only option then is access northern C.B.T* [Cognitive Behavioural Therapy] (anonymised) *and that's not gunna work for someone whose got schizophrenia or a personality disorder. So, a lot of these are getting referred into social prescribing […], so then you question if is this social prescribing?"* (Gillian)

In addition, however, Gillian comments on how her emotional ties to feeling competent in caring, and to the wellbeing of her patients, often leads her to pick up the phone to distressing calls from patients out of her working hours.

> *"I shouldn't do it really, but I do give my number out. Sometimes I'll be sat there of an evening and get calls off someone saying they're gunna do something stupid. And it does get a bit much, but if I don't pick it up, then who knows what's going to happen to them?"* (Gillian)

The complaint that, in some areas, social prescribing has drifted from its initial remit, was repeated by others:

"I mean we get referrals from Fire Services and from social and stuff and I think why are we getting this? There just passing them on. Yes, sometimes you do feel more like a social worker. Sometimes it feels like a dumping ground." (Ellie)

Ellie here seems to express regret that her role as a link worker seems to be servicing deprived areas. In these instances, social prescribing, as substantiated by the link worker narratives, seemed to be less about connecting patients to meaningful activities that can promote wellbeing and more about plugging gaps in other services scarred from previous rounds of funding cuts.

In addition to giving out phone numbers, on some occasions the link workers are clearly managing the scarcity of their time by offering more care to some patients than others. Some of the link workers offered very specific examples of where they have managed their limited time by ending their involvement with patients who they feel they can no longer help, or are perhaps deemed as too dependent.

> *"I mean, I'm going to have to take a phone call in a minute to close someone because they are ringing us all the time, and it's just getting out of hand."* (Ellie)

The termination of some clients deemed unsuitable for social prescribing is contrasted to the seeming unending broader scope of support offered to other patients:

> *"But I said to him, this isn't the end for your time with us, you can ring us whenever you want."* (Ellie)

Whilst not concerned with managing scarcity, others again comment on the seeming inability of social prescribing to meet needs associated with mental health:

> *"I mean the main thing at the minute is people needing support for mental health. Our ability to meet their needs isn't great to be honest at times. I mean we have a directory with loads of counsellors, but often if they' re not interested in that it sort of hits the rocks. We do have an app that offers like a C.B.T support but if people don't have access to these things, then that's not going to do much either."* (Harry)

As we will see later in the men's accounts of their experiences, it is often reported that social prescribing is tasked with meeting their basic needs, like offering food and basic goods. It often seems these goods are secured through the charity or beneficence of the link worker.

These inconsistencies and tensions are evident in the following account connected to the COVID-19 context, with Izabelle combining a "wellbeing chat", with wellbeing an emotional

state that is only likely to be reached when a background of certain conditions has been secured, with the action of signposting individuals to a "food bank".

> *"Well we had to adapt pretty quickly really, so we starting phoning people up and having what we call wellbeing chats and then signposting people to foodbanks. The pandemic has really hit home to us the socio-economic challenges that people are facing really."* (Izabelle)

Whilst Izabelle remarks on the importance of the "socio - economic challenges" there is a tension between the offering of a wellbeing chat and the signposting to foodbanks that is underexamined.

As we have seen, social prescribing is often reported to be under – resourced. This is often combined with link worker reports of being under paid, whilst heavily emotionally invested in describing competence and providing good care, evidenced for example by giving their mobile phone number out for contact after work hours. The next theme will discuss link worker narratives more specifically focused on the men's engagement with social prescribing.

5.3 Mental health, meaning and mothering: men and social prescribing

The following section documents the way the link workers describe dealing with male users of social prescribing and the solutions they offered. In continuation with earlier themes, the solutions offered to meet men's problems are often framed within an account of the link worker who is heavily emotionally invested in the wellbeing of the men they are dealing with, combined with a need to feel like they are providing effective care. In addition to this, the other sections of the theme will examine how the link workers specifically discuss what matters to men.

5.3.1 Mothering and emotional labour

In earlier themes, some of the link workers reported receiving calls out of hours by patients in distress, whilst also complaining about their lack of resources and low pay. In contrast, some of the link workers when dealing with men offer an insight into how their own need to feel valued as an employee and deliverer of care may indeed become problematic. For example, the following interviewee discusses becoming like a "mother" to her patient:

> *"A lot of the men. The men can be a lot less self-sufficient than the women. A lot of the time we are almost like a mother, well not like a mother, but you know what I mean, you know encouraging them, relating to them with unconditional positive regard, and nurturing what they are good at. But we do, sometimes, we laugh and say like, it should be called the mothering service."* (Ellie)

This may be tied to the following remark, where the link worker over extends herself to feel of value:

> **Researcher**: *"What do you find rewarding about your job?"*
>
> **Link worker participant**: *"What's important to me is feeling useful. It does feel good when you see how far some of the patients have come. I've got one chap here who has said "Ellie gave me the kick up the backside I needed"* [paraphrasing patient feedback].
>
> *So, a lot of them do say we should be like the kick up the bum service. Like gentle encouragement that helps them overcome the barriers that people put in the way of themselves."* (Ellie)

Ellie reported taking pride in being one of the first recipients of stories or secrets that men have kept to themselves for years, with Ellie conveying a clear sense of pride when describing her ability to draw out stories of trauma and pain from patients:

> *"This one gentleman has told me stuff about his past relationships that he has never disclosed to anyone. And my colleagues will say, how are you getting these stories out of them."* (Ellie)

Here we can see the tangible pride felt when the link worker described being able to elicit stories and secrets from patients that have previously been denied expression, with the next subtheme describing how the link worker engaged men with what mattered to them, but not without difficulties.

5.4 Link workers and connecting clients to "what matters" to them

A smaller number of the link workers claimed that one of the central aims of their practice is to open a conversation with their client on "what matters" to them. This is usually described as a preliminary move before connecting the patient to an activity that will hopefully resonate with the patients stated response to the question:

> *"We lead with the mantra, what matters to them and we were honing in on what hobbies people enjoyed, and most of the men had forgotten what they used to do if that's drawing or painting or something what hobbies they enjoyed. But hone in on what was fun. That really worked well. But have a dance or whatever, cooking, yoga."* (Ellie)

In continuation of this,

> *"For us, our whole service is about connecting patients to "what matters" to them. So we do a lot of coaching conversations with them. A lot of the older male patients have sort of lost sense of what it is they enjoy doing, not because they have to do, but because they like it."* (Harry)

Moreover, several of the link workers describe the barriers they have faced when trying to conduct coaching conversations with men to understand "what matters to them". Many have never considered the question before:

> *"Some men are like, "what, I've never been asked that before, so I wouldn't even know where to start". So, it's trying to find what resonates with men, and what matters to them, but that can be really difficult to do sometimes, they don't really know. Sometimes there like, what do you mean what do I want to do? They can't even make sense of the question."* (Ellie)

Similarly, the following link worker described an example where they helped a man navigate an earlier presentation of need based on deprivation, which later built into an understanding of what mattered to him, and what meaningful projects he wished to pursue:

> *"He was struggling on the breadline, really struggling. So we said, we will get you what you want. And I was thinking this isn't really social prescribing, he just seemed to want money. But when we went and met him, we'd been told that he wouldn't open up in a clinical setting, but we found out that all he wanted to do was get some money so that he could go on like a short holiday away on a coach to Blackpool. Since then it's just snowballed and he's been involved in a few things."* (Ellie)

And, in addition, Jasmine described the need to deal with deprivation and debt:

> *"I mean there is one guy I'm working with now; he's ringing all these energy companies and getting prices and stuff and I did sort out his debt with him. But I didn't force him. When I ring him up now, he's out of bed by ten, he's doctor used to ring him every week, now he rings him every six weeks."* (Jasmine)

In contrast, others commented similar problems associated with loss of motivation in elderly men:

> *"One of my biggest barriers with men is personal motivation. Once life roles change as we get older our circle of social support decreases. Once you lose the why, and the process of getting out of bed. That motivation is really a catalyst."* (Katrina)

As will be documented in later chapters, the metaphor of "opening up" is used with frequency by some of the men interviewed who discuss sharing emotions previously denied attention, usually drawn out in their relationship with the link workers.

In contrast to the limiting factors of older age, other link workers pointed towards the limiting norms of male socialisation and how they delimit the options available to men in speaking up about suffering; this is a central focus of the next chapter which will explore male socialisation as erecting barriers to help - seeking behaviour, and how this interacts with some of the processes involved in social prescribing.

> *"I would say mental health is the biggest problem I see with men. When they are younger, they got told, don't be a wimp, don't cry. I mean if they go to their mates and they say, you know, I miss me mam and I'm a bit down their mates will usually go, what!...I've worked with a lot of men who don't think they are worthy to get help. You know they'll say like Jasmine, no one has done this for me before."* (Jasmine)

Another link worker continued this theme by drawing attention to male stoicism and emotional restraint:

> *"Men, as a generalised statement, just think, well I'll have to get on with it, this is just how it is, or they're not aware and not mindful of it."* (Katrina)

Others discussed how men in situations of deprivation report feeling shame and are often reluctant to discuss emotions. The link workers also described how through their own practice they have used innovative and empathic ways of helping the men gradually communicate their problems so they can begin a conversation at least on how to assist them:

> *"We did the GAD 7* (*Generalised anxiety disorder screening*) *with him and he had severe anxiety. And when we got to the bottom of it, he was a taxi driver who was unfortunately facing a court claim for speeding. So obviously he was worried about losing his income, losing his job, and then when we spent a little bit more time with him it also transpired that he was actually living in his car….So, we got him help with stress management, got him help with emergency housing. And he didn't come to us with that if that makes sense, he would have just lived on the street. So, whether it's a lack of awareness of the support, or embarrassment, or motivation or whatever, I don't suppose we will ever really know will we"* (Katrina)

With Izabelle further describing ways in which some men's reluctance to speak can be broken down.

> *"I think with men, there is a reluctance to not be seen to be unwell. So, with social prescribing I can say well, let's go for a chat, let's have a coffee. And we've set up a digital group called "Men who Make", which they really quite good because the talking sort of comes after, rather than the sole focus being mental health. And this is the way*

> *I support myself really as well; I don't like to talk about things with people directly head on, there's too much stigma."* (Izabelle)

Moreover, a link worker described how man opened about previous trauma:

> *"When lockdown ended, I went to see him, and we were listening to some of his music. This is where the music group came from. And then we had a dance and I fun time and stuff. And then on the phone call he told another male client and he was really supportive. And you could see the beauty of him talking about his emotions and I just facilitated it."* (Jasmine)

Here we see the lingering presence of deprivation in the background of most of the accounts; this is combined with points on the limiting effects of male norms of health seeking and how theses limits have been broken down with success in some settings. The next theme will offer an insight into a smaller number of responses that describe optimism about social prescribing place in helping the country move out of lockdown.

5.5 Hopes for social prescribing beyond Covid-19

A smaller number of link workers commented on their hopes for social prescribing beyond the lockdown, with the qualification that more support is needed for the policy, politically, and through public funding, if it is to reach the scale of need predicted to emerge from the scarring effects of Covid-19.

> **Researcher:** *Can social prescribing be successful under the current funding it receives?*
>
> **Link worker participant:** *"It needs more support mate. It does mate, it does. I mean I'm not party political at all; But I will say that social prescribing, if it is to be successful, needs to get the support it deserves. More awareness more funding*.

The participant then reflected on the strength of people coming together through social prescribing during recent times including the lockdowns:

> *I've seen things that have astonished me, you know people suffering with huge mental health problems that have turned into real warriors, and are now running food banks, working for food banks, they are running free cycle sites in the community."* (Andy)

.

Katrina discussed the need for reintegration, with the drive to connect patients to something that they experience as emotionally positive. This is combined with an understanding of the need not to duplicate pre-existing services within the community.

> *"Our job now once things are back in person, is to reintegrate people back into society. Once we are face to face, I think we will see an increase in people, once they have the confidence, there will be a massive increase. The therapeutic nature of the groups we put on, belonging, community, sense of being part of something nice and something that we'd choose to do. Our job now is to listen to the needs to the community, identify gaps that are already out there. There's no point duplicating if there is a good a drama group."* (Katrina)

Another link worker, Harry, placed a similar stress on their role in reintegrating communities post lockdown:

> *"We're going to run a program called "coming out of Covid" that will be funded by the PCN* [Primary Care Network]. *We're going to run a workshop that will help people back into their local community. I'm really excited by this."* (Harry)

As we have seen, the link workers show significant investment of hope in the ability of social prescribing to reintegrate people back into society, post - lockdown. This may connect to earlier themes that stress the emotional investment made by link workers in the need to deliver effective care, despite the stated limitations of pay and scale.

5.6 Conclusion

This chapter has explored the narratives and responses from link workers on how they use understandings of the social determinants of health in their work through social prescribing. It has also examined how sometimes the link worker narratives demonstrate both explicitly and implicitly, that social prescribing is often under - resourced and ill - equipped to meet clients' needs - both on the supply and demand side. On the demand side, this inability to meet need is especially stressed when pertaining to mental health needs but also in the form of a perceived stretch in role for the link worker. This was clearly identified by some interviewees who claimed they felt like underpaid social workers. Nevertheless, these limiting conditions were also combined with a need for the link worker to convey their competence and success in their role despite contextual constraints.

The chapter has also documented how the link workers outlined and looked to meet men's needs in several ways, all of which seem to be described within a background condition of poverty or deprivation, but not without some success in getting men to "open up", or talk about their needs. Lastly, the chapter documented link workers' hopes for the future of social prescribing, often qualified by the need for the policy to receive further support by politicians and public funding. The next chapter will describe male socialisation, with some of the limiting elements of this documented by link workers in this chapter. It will explore how male socialisation predisposes men towards problems when discussing health. In addition, the chapter will also document how men find things that matter to them through discussion of

role models and activities they enjoy or do not enjoy engaging in, arguing that this is a vital context to understand if we are to understand why social prescribing is needed, and if it can connect the men to activities, they had previously taken pleasure form and enjoyed or new ones.

Chapter 6: Exploring what matters to men who use social prescribing: an exploration into the cultural context of masculinity, meaning and activity engagement

In line with the central question driving social prescribing and personalised care, the chapter will trace what matters, or following PERMA, the presence or absence of meaning in the men's lives interviewed and how these are a part of their primary socialisation through Bourdieu's habitus. Further to this, the description and analysis of the data in the chapter will be driven by the Aristotelian virtue ethics component of PERMA discussed in the theory chapter, with the men reporting virtues and vices contained within the norms of their cultural context. In addition, Bourdieu's concept of habitus will help examine how culture, class and levels of capital become part of the men's cultural context. Both these theories will help us understand in later chapters how and if social prescribing can connect "men to what matters" through the negotiation of the men's cultural context covered here. The chapter presents data mainly on values, norms, activities, engaged with prior to their social prescribing engagement. As noted by (Sayer, 2011), this cultural context is important as to be successful, interventions and policies social prescribing often must tie into our previous interests, learning and competencies. In addition, as presented in the last chapter some of the link workers reported that the men, they engaged with often found it challenging to talk about their emotions and what matters to them as some had forgotten what activities and activities, they had found meaningful and enjoyable earlier in life. As a result, then, before proceeding to explore how the men experienced social prescribing, it is important that an effort is made to understand what matters in relation to the values and activities of the traditional working class and precariat men interviewed. This chapter will provide an answer to the first component of the first the research question stated at the beginning of the thesis, namely: "What cultural, social

and material contexts do working class and precariat men report and how do they relate to the need and referral to social prescribing". In addition, further to the description of the sample offered in the methods chapter, below is a table containing data on the men.

Table 3: Male Participants

Age	Economic capital	Social capital	Cultural capital	Reasons for referral to social prescribing
One man aged between 30-39 years Four men aged between 50-59 years Three men aged between 60-69 years Two men aged between 70-79 years Four men aged between 80-89 years	Two electrical engineers; three manufacturers; one gardener; one tree surgeon; one construction worker; one salesperson; one security guard; one taxi driver; one delivery drive; one cleaner; one unemployed. Six men refer to a history of benefits	Twelve of the men reported experiences of loneliness and isolation; eight of the men reported this in relation to the loss and death of friends and family members which left their connections and social capital depleted; all but one of the men reports mistrust of elites, politicians, and other forms of bridging social capital; whilst the social restrictions of Covid intensified the above, it was never the sole reason reported by the men for low levels of connection and social capital. Finally, only two of the men reported varied forms of social capital with one man coaching a football team and another now working as a link worker.	Education used as a proxy for cultural capital. Two of the men had described apprenticeships in electrical engineering. Twelve of the men reported a dislike of school, preferring the less credentialled forms of cultural capital participating in sports like boxing, wrestling, football and activities like comedy.	All the men described mental health and negative emotion as a key driver of their referral. The various perceived triggers for these mental health problems ranged across the following: the death of wife, friend or family or an affair leading to loneliness; the loss of employment and the loss of employment through furlough because of Covid. Two of the men reported indebtedness, isolation and mental health and drug addiction and mental health.

The chapter will proceed through the discussion of three main themes that report data from the men's adolescence to their later years. It was not the intended aim of the interviewing to reach back into adolescent years but in response to questions and lines of enquiry on practices they found meaningful many of the men reverted to school and adolescence. This is of considerable interest, with the next chapter on the context of the social determinants of health offering some insight into why this may be the case. The first theme concerns the values the men report being socialised into, and how these values contain goals and qualities the men were encouraged to cultivate with some of this data relating to the emotional restraint and denial observed by the link workers in the previous chapter. The other themes focus on reports of activity engagement, with some of this data tied to state promoted activities like the military and education. The final major theme discusses the presence or absence of activity engagement later in the life course, with some connection to how the activities engaged relate to the social prescribing referral. The chapter also documents the early presence of social capital in the men's lives and how this waxed and waned throughout the life course, with the decline of social capital and cultural participation in the men's lives later leading to their engagement in social prescribing.

6.1 Role models and the norms, values, and activities associated with masculinity

Through discussing their early engagement in practices and the values and qualities that motivated them, some of the men described the powerful presence of a male role model, or figure of influence and authority, that shaped their early socialisation in perceived positive and negative ways. Often the discussion of these role models connected to the perceived virtues and vices (Sayer, 2011) contained within masculine norms, and how they relate to the

concept of habitus, with the role models highlighting the that the men were encouraged to cultivate and those they were taught to avoid. The following subthemes will examine the number of ways the men described the power of the male role models they discussed, ranging from influencing them towards the virtues and values of aggression and independence to fears around certain qualities that were perceived to be threating to masculinity.

6.1.1 Virtues of aggression and independence

Most of the sample of men discussed moments of trying to gain praise or recognition from a male family member or parent. The following section will provide an insight into how episodes of bullying, were often mentioned as a key developmental challenge. This period of challenge was frequently negotiated through efforts to receive instruction, advice and support from a male parental or father figure. Within these key moments, the male interviewees reported feeling lacking in some ways and emerged from the experience with a sense of having failed to measure up to the instructions offered to them:

> *"I were born in a little mining village in the North of England … I was bullied at school, which at the time I didn't realise had an effect on me, but it clearly did. When I told my Dad I was getting bullied, he said you turn round and give em a crack. Well that just weren't me."* (Andy)

Andy's report of not measuring up is elaborated upon further when he described the qualities and virtues of his father and uncle, and his need for praise and encouragement in his early years.

> *"When I was growing up, I was always trying to get my dad's praise. He never really showed any emotion. I mean, I now know that he was feeling things but I think I was 35 when I first seen my dad cry. My dad was a master builder, no qualifications mind,*

> *but used to work long hard days in construction. My uncle, he was part of the GB lions touring party to Australia (national rugby league team), so you know they were both tough men."* (Andy)

Whilst still focused on the role of the father, some of the men gave accounts that offered some variation from most of the sample, who were predominantly white precariat or white working-class. Karl described the way that race, masculinity, inequality and perhaps, adoption, intersect to provide a lack of felt security within context of their development. His adopted father suggested an aggressive strategy to deter bullies and their racist remarks with the hope that this would prevent them from inflicting further acts of bullying. In addition, Karl seems to have felt undeserving of potentially having his needs met and in his own words, "settled for second best". In this instance it is both the perceived inadequacies of living up to the instructions of the adopted father, combined with lack of security felt under prejudice and racism, that caused him to feel significantly lacking in his early years:

> *"Growing up, I'm mixed race and I was adopted and I was like the only brown person in the school. I settled for second best sort of thing and got in with a bad crowd, and obviously it's difficult to, I find it difficult to speak about racism, because my dad's attitude was he'd go and knock them out. It's a difficult thing to have to deal with."* (Karl)

In response to episodes of bullying like those described above, Andy described how the effects of early bullying led to protective responses, both unconscious and conscious, that ensure further hurt does not occur.

Another participant described how he was instructed to become a sort of rugged individualist, perceiving little need for the support of others, or seeing the declaration of needing support

from others as some form of weakness; this is an ethic that often runs up against the grain of health seeking, including "social" minded intervention like social prescribing:

> *"I was always told growing up by my dad and grandad, look after yourself, deal with things yourself first. If you do this, you'll be half all right; I still do this now to a large extent. I don't like burdening and I don't like boasting."* (Cliff)

This theme has described how many of the men were encouraged towards an ethic of masculinist aggression and independence, where their explicit need for others support is at best de-prioritised or at worst prohibited. The next subtheme will discuss additional virtues that the men described in their accounts: namely, wisdom and respectability.

6.2 "Wisdom" and being "respectable": role models outside the immediate family

In their efforts to describe the formative influences on their early goals and socialisation into masculinity, many of the interviewees discussed males beyond their immediate family. Often, this was because the father was absent, and, because of necessity, they had to find guidance beyond their parents. At other times, the formative influence was mentioned in relation to early engagement with sport and activities associated with aggression and competitiveness. Most of the men offered examples of perceived virtues or idealised qualities in early male interactions. In the following interviewees account we get a description where the father was absent for reasons unstated:

> *"I didn't know my father, never met him. I don't really know how much of this affected me because I never knew any different."* (Eddie)

In the absence of his father, Eddie claimed to have looked towards the guidance of his uncles who he reports having a good relationship with. When asked about the norms and values that his uncles represented, and why he looked to them as role models, he stated:

> *"Well, they were basically self-made men. They weren't millionaires or anything, but they came from nothing and they had nothing when they were kids and worked their way up. They were respectable people who had worked from nothing and got their selves up to a reasonable position. They were down to earth and respectable to me as well even at times people might look down on you, thinking that I was, you know, beneath them."* (Eddie)

Here we can see the perceived virtues his uncles displayed was being self-made, which like the individualist ethic described above, may devalue or social dependence on others.

In addition to the key role of his uncles, Eddie described the guiding presence of a headteacher as role model. In doing so, he also described experiencing stigma and derision, before receiving advice from a male headteacher that encouraged him to move away and avoid certain outcomes, namely being "stupid", whilst moving towards the virtues of discipline:

> *"I remember getting up to all sorts at school; I used to sit at the back and get called a dunce which was totally wrong, but that's the way it was. I was probably dyslexic. But I remember the headmaster called me in the office and said, basically, get your act together and stop being stupid, and he sort of took me under his wing to be honest."* (Eddie)

Alongside the reported influence of his headteacher, we also see that the response is, again, peppered with an early recognition of institutionalised stigmas and perceived inferiority. The interviewee's description of the spatial layout of the classroom displays similarities between

his previous account. It seems Eddies world is a refracted through the lens of status and power and he is in both instances of his narrative placed at the bottom of the field; the description offers a profound window into the way that relational inequality, shaped by both the economy and education in the above, permeates the everyday life of some of the men at an early stage in their development.

In continuation of this, others discussed role models and virtues associated with more explicit engagement in activities. These responses are representative of more classical spaces of socialisation for working class men. In addition, through discussing their role models, the interviewees referred to positive apprenticeships in activities associated with traditional masculine images, with the following offering probably the most notable example of this with the interviewee participating in a boxing club.

> **Researcher:** *Is there a role model who had an impact on you in this period?*
>
> **Male participant:** *"The trainers at the boxing club Peter Normington and Charlie Heath [both given pseudonyms] between them they had so much wisdom. It wasn't that they were just physically training you, they were planting seeds as well of respect. You might be able to fight but you don't have to; you treat people with the respect they deserve and I've always lived by that."* (Arthur)

Furthermore, Arthur demonstrated the power to reflect and examine the teachings from his boxing years, discerning the parts of his learning that now seems outdated, whilst carrying with him the parts that remain of value:

> *"They were old school, do you know what I mean. They had their brutal side and they had their cynicisms, but they had values. I think that's what has gone missing in society today. It's personal values that have gone. So, once they go and you don't care about*

yourself, how you gunna care about anyone else? They're only little things [transmission and integration of values] *but they make you who you are."* (Arthur)

For many respondents, it was the subtle pedagogical transmission of perceived virtues and in the above extract "wisdom", which are framed as responsible for guiding the direction of the men's values and goals. After enquiring further why these values are important, he stated:

"Well it's self-worth it means to me. That my values mean something." (Arthur)

Although not explicitly developed in the interviewee's answer, for his values to "mean something" they must be socially recognised as bearing worth; this is a quality of interaction seemingly absent in many of the men's lives and this will be discussed in length within later chapters. In contrast to the above subthemes which focus on the virtues men identified as qualities, the following subtheme will examine things men were encouraged to avoid if they were to gain the support and esteem of others. These are described as vices of masculinity.

6.3 Role models and the perceived vices of masculinity

The men also discuss key relational components of their socialisation, whereupon their expression and articulation of masculinity is framed in opposition to other qualities that are deemed as threatening and treated with fear, here referenced as perceived vices.

The data presented in this section presents evidence of where several the men interviewed engaged in a process of othering, where things external to them are either implicitly or explicitly identified as threatening to their esteem and status as a man. Examples are given from data extracts that range from discussions of homosexuality, the division of labour between men and women, and an uneasy discussion of mental health engagement with a professional. Again, in common with many of these themes is a fear of being seen as

vulnerable and soft, as opposed to "hard". This fear of vulnerability, as we will see in later thesis, is often carried by the men into the social prescribing engagement.

Some of the men detailed how they became influenced by historical and stereotypical ideas of gender roles, with one notable example describing how these gendered ideas on role "rubbed off on him":

> *"It was a sort of expectation of the family, or the men in the family at least. It was the old thing that the men went to work and women stayed at home and looked after the kids, which isn't unusual for this part of the world. I think that expectation rubbed off on me and I were gunna work hard but I were gunna play hard."* (Andy)

The discussion of a women's perceived role here is tied to a regional understanding of the domestic division of labour in "this part of the world" and the specific subcultures of masculinity in the North of the UK. Further to this, it is through the persuasive power of "expectation" that the norms seem to become activated. When combined with earlier reflections on the need to gain care and love from the parent, a picture begins to take shape of how men negotiate these norms and understandings at key points in the socialisation process. Moreover, through further elaborating on the ends that he then aspired to, and their "hard" quality, we can see how ideas of the work ethic, combined with the pressure release of hedonism, that is short-term and immediate emotional pleasures, are also part of the implicit pedagogy of masculinity in the North of England for some of the men.

Furthermore, other men offered an examination of how socialisation into masculinity, and subsequent negotiation of it, can cause heavy resistance and defences against engaging with any conversation concerning mental health, with this important to understand for later

referral to social prescribing. Discussion of this is seen as compromising the norms transmitted through the pedagogy of masculinity earlier in the life course. When discussing a consultation with his GP, Cliff elaborated on the strictures and restraints he experienced when trying to understand his mental health problems. By using the term "nuts", he suggests that any effort to discuss feelings, emotions would be deemed at odds with the rules learned through socialisation. In fearing that he would be labelled in this way, Cliff worried that his standing and worth in the community may be at risk and compromised. Why the data refers to a contemporary consultation, it is the retrospective reference here that is key to the present theme:

> *"He (GP) asked me if everything was alright and suggested I go and see a counsellor, well the way I was brought up you just don't do that. That was the general consensus on the street and the workplace. When he said to me like, I am going to refer you to the mental health, I said wooow, Brickdale Mental authority (anonymised)! I don't want that going on my record for you to think that I'm nuts – I know it's wrong now but that was the way I associated it."* (Cliff)

As shown, this section has described the way in which the men's early socialisation points them towards certain goals, shaping the parameters of, in the rhetoric of social prescribing, "what matters" to them. In addition, elements of this socialisation do seem to rub against the grain of health seeking behaviour making it harder for men to discuss their needs and emotions. The following section will examine the power of global role models in a more systematic way, connecting this explicitly with activity engagement. Whilst the last section described some aspects the emerging power of role models, like Hollywood actors, to shape the men's early negotiation of masculinity, the following will examine this in more detail; rather than focusing on the way in which these role models shaped things to be avoided,

through perceived vices, it will look at how they often sparked inspiration for activity engagement and thus help a picture take shape of what activities the men enjoyed and why. As argued throughout, this is a vital context to understanding the men's later experiences of social prescribing, later exploring if these practices become a part of the men's later social prescribing engagement.

6.4 Global role models and celebrities as drivers of activity engagement: football, boxing, weightlifting and comedy

In the following, the men described the power of new technologies and commodities like the Television in shaping their exposure to role models. This section will present a discussion of the formative influence of the role model, which coincides with a description of the early emotional motivation towards forms of activity engagement. Some of the men were born in countries outside of the UK, only later moving to the North of England, with the following interviewee born in North Africa. Batosh described the power of international football stars and how they motivated him to play football:

> *"We had the first T.V in our house in 1974. My Dad bought us the first TV; it was the World Cup final. It might have been Brazil and Germany in the final. Rivalino, he was like a Brazilian player, when had a free kick, it was like a penalty. He was a beautiful, majestic player.* (Batosh)

In the above, the interviewee used rich language to describe the almost enchanting power of visual sporting images. These are images that are received and interpreted as captivating, offering inspiration and motivation. Indeed, the affective qualities of the description are also embodied, with the interviewee reflecting on his subsequent habitual commitment to replicate the prowess and skills of the named footballer with peers after school:

> *"I used to watch his things over and over again and then try to copy it on the sand everyday after school."* (Batosh)

In addition to footballers', others described more hypermasculine images of power and strength:

> *"I started when I was 15 (bodybuilding). I joined the International Federation of Bodybuilders, that was when Arnold Schwarzenegger and Lou Ferrigno were about, you know the Incredible Hulk, and I used to copy myself on them."* (James)

The image of the bodybuilder, as someone engaged in a practice devoted to growing their muscle density, and, in the case of Schwarzenegger, swelling in huge size and proportion connects to an archetypal masculine aesthetic of power and size. Whilst weightlifting offers physiological benefits that may release tension, rebalance then nervous system, and improve fitness, the description of role model here seems suggestive of something else: an aesthetic of power and strength, and in the incredible Hulk, aggression. In continuation of this the interviewee listed several psychical indicators of his progress in bodybuilding that are clearly a source of pride and competence:

> *"It was about ten years of bodybuilding. I could bench over 200lbs, twice a day, every day! My legs were quite musclebound. I used to have 19-inch arms and a 54-inch chest."* (James)

Other men interviewed offered a reflection on role models, consistent with some of the data above, again referencing masculine traits and perceived virtues of physical potency.

> *"I liked George Foreman, he could have stopped a train with that punch; and I liked Tyson because of his raw savagery."* (Arthur)

The imagery and descriptions used here contain parallels with the images that the interviewee used to describe his own boxing participation:

> *"If I hit you with a left hook, you were going down, there was no two ways about it."* (Arthur)

Nevertheless, in offering some variation to the extracts displayed above, Howard cited the expressive emotional traits and qualities that they admired:

> **Researcher***: How about role models when you were growing up?*
>
> **Male participant:** *"I used to love Ken Dodd, you know Doddy, he was funny. And Slade, I was a big Slade fan. I've always said if you can make someone laugh and entertain them then that's the most impressive thing; that's a different talent that if you can make someone happy."* (Howard)

As evidenced above, there are some variations in the responses of the men: it was not just powerful, hypermasculine traits of masculinity that were selected but the ability to make others laugh and smile, stressing a more pro-social worldview perhaps than some of the other data points, and one that perhaps runs less against the grain of health seeking and interventions like social prescribing.

Some of the men, for whatever reasons, chose not to describe a public role model in the influence of their development, but instead discussed the formative presence of contemporary figures from the current time. The following interviewee for example, expressed praise for the public intellectual, Jordan Peterson. In doing so, he referred to the power of Peterson's socially conservative teachings, renowned for their attempts to repair masculinity from the perceived onslaught of postmodernist critics who claim that gender is a social construct. For Peterson, this can be achieved through the reappraisal of the rugged

virtues of self-help and discipline. One of Peterson's most renowned teachings is to "make your bed", as a way of fostering order and routine at the expense of chaos (Peterson, 2019). Whilst this focus on the individual making small behavioural changes is often demonstrative of positive change, if this focus is not combined with a broader connection to surrounding context the individual finds themself in this may be problematic, with the individual perhaps blaming himself too heavily for his troubles. As discussed in the introduction and review chapters, this type of individual behaviour change may connect to the idea of a lifestyle drift (Williams and Fullagar, 2018). This drift under-theorises the way in which individual behaviour perceived as problematic towards health and wellbeing is connected to broader social structures that shape the distribution of power and resources in society. But also, how the often-positive small changes at the level of the individual may need to beconnected to broader social relationships and resources that can alter some of the negative social structures impacting society. For example, the interviewee discussed the way in which responsibility and small behaviour change shapes "what matters" to the participant:

> **Male participant:** *"Do you listen to Jordan Peterson? He was one of the people who get me out of my rut as well".*
>
> **Researcher:** *Ah yes okay, and what lessons have you drawn from his teachings?*
>
> **Male participant**: *"Clean your room* (*Laughing*)*. Watching some of his interviews, I got a lot out of it. It wasn't just about what he was saying; it was about what the people were saying under the videos in the Youtube comments. When they were writing, all I did was tidy my room, and it led to this, this and this, and it's kind of snowballed. So, I just started and I just carried on and could see the progress."* (Karl)

And, in further developing the effect Peterson has had on Karl's views on masculinity (what matters:

> **Researcher:** *Peterson has views on men and masculinity, doesn't he? Have these had any influence on you?*
>
> **Male participant:** *"Yeah, because men have got a bad rep haven't, they over the past ten years. Toxic masculinity and all that. I hate that phrase."* (Karl)

The interviewee, Karl, also referred to sources that also stress mastery of the self and self-discipline:

> "I've also been listening to stoic quotes. I was at the stage where I was listening to them like five to ten minutes a day. I'll just put them on why I'm doing chores and they're sort of taking root in my subconscious." (Karl)

Here we have seen the men describe the power of global role models and celebrities in inspiring them to engage in certain activities.

The theme has discussed the presence of male role models in relation to norms, values, and activities. In doing so, the chapter has charted some of the concerns of the men, describing, in the words of social prescribing and personalised care, what matters to them, and how this is negotiated within the context of masculine socialisation. Through some of the role models and activities described, we can see how men are socialised into stoic norms, with some evidence of this transferring to activity participation like boxing, weightlifting but also the self-discipline of tidying the room. The following section will discuss how the male interviewees described interacting with the state, and how this shaped their early engagement in hobbies

and activities. We will later see if this early context of hobbies and activities described by the men form a part of their social prescribing experience.

6.5 State promoted activities: education and national service

In addition to their own private activity engagement, some of the male interviewees described ways in which their early exposure and participation in activities was shaped by services associated with and often delivered by the state. The following data examples range from activities involved with education and the military. These experiences range from positive to negative experiences. Some of the men describe how early exposure to the school and its formal curriculum intersected with inequality. This is often in an unconscious way where the men discuss the realisation of how social structure and inequality tacitly constrained their opportunities; in contrast, however, some of the men consciously recall awareness of inequality and class, before elaborating on how this shaped their thinking and interests. Moreover, often these extracts are compelling when viewed through the participants' later engagement in social prescribing, with many of the later activities engaged in through social prescribing described as initially alienating when encountered at school:

for example, despite a later fruitful engagement in poetry and drama at social prescribing, Cliff reported:

> *"I hate English, I hate writing. I can't pick up a book and read a book because I don't have the attention for it. I think it's probably down to my own education If I'm being truthful to you."* (Cliff)

Cliff continued this by claiming,

> *"I mean, if I could get out of lessons, I'd play anything, I wasn't bothered: football, rugby, rounders, table tennis, swimming, you name it, anything to get me out of*

> *school."* (Cliff)

Moreover, other participants continued this theme of opposition to the pedagogy of school, privileging the skills of the body, and sporting prowess, instead of the mind. Some described an experience of feeling that school was a forced imposition that obscured interests rather than developing them. In the following, the formal pedagogy of school is deemed lacking in value and utility, failing to prepare them for the demands of the surrounding labour market and the perceived functional requirements of tasks at work:

> *"School was something we had to go to. Not that I paid that much attention when I was at school, especially English. If I could write my own name and that and get my address that then was all that I needed. I mean, in terms of English, the most I ever did was write up delivery forms at work."* (Arthur)

In developing this, Arthur discussed the pressure of the peer-group and the need to adhere to certain norms, often at the expense of interests that were identified as potentially fruitful, but obscured through adolescent peer pressure:

> *"Growing up, I always had nice handwriting. I did a little bit of calligraphy but nottin serious, only like what you'd pick up yourself. Like the Christmas cards, I used to sit at a table and do them. I was quite artsy when I was at school, but I had other things to do like go out fighting and kicking off with me brother and things you know what I mean.* [Laughs]." (Arthur)

Arthur further developed this by proposing a counterfactual scenario, arguing that if he would have openly professed to liking poetry, which is the activity he later engages in through social prescribing, his peer group would have responded with stigma and perhaps even violence. In contrast, the skills acquired and cultivated in boxing were met with praise and esteem.

> *"The thing is, if I'd have come out and said to me mates when I was at school, I like poetry, I'd have been walking home with black eyes; I'd have been jumped* (*laughing*) *classed as gay, it's just the way the 70s were then. If I went to school and said I'm boxing now, ahh great; if I said poetry, I think I'd have been shunned."* (Arthur)

In continuation, other interviewees described a more pleasurable engagement with literature, whilst still offering an interesting description of awareness of inequality in his adolescent years.

Another participant claimed that his favourite novel growing up was Billy Liar. In the book, to escape, or disassociate, from the reality of the British class structure, the main protagonist opts for the world of fantasy and illusion. This allows his desires to be lived out in his own mind without the impediments to opportunity that may exist in society. This example seems compelling as many of the men unfortunately later describe experiences of loneliness and isolation, often demonstrating a retreat from a world too often experienced as threatening. In addition, whilst the extract seems less oppositional directly to the school curriculum, Fred describes and early awareness of his social position and power of and his family relative to others:

> **Researcher**: *You said you enjoyed reading when you were younger and you enjoyed English at school, did you have any favourite novels?*
>
> **Male participan**t: *"Yes, the only subject I remember being particularly fond of us was English. One that I like anyway that we did at school is Billy Liar. It's a kind of study of the class system. It uses a lot of humour, lots of visuals come up in the screen of this imaginary world that Tom Courtney invented for himself as an escape.* (Fred)

In contrast to experiences of education, several participants commented on the way in which national service and military training helped shape their hobbies and activities. For example, Micky discussed in detail how his time in the national service represented one of the most pleasurable times of his life, with much of this down to his role as a fitness instructor:

> *"Got called up into the army at 18 for national service, did 2 years national service. Kicked off at stonewall barracks (anonymised), PTI in the army because I used to do lots of fitness stuff when I was a kid, rugby, lifting, and weightlifting. I absolutely loved it to be honest, and my seniors begged me to stay on."* (Micky)

As shown, several of the men report alienating experiences of school, with this intersecting with income and relational inequality. As we will see later, in some cases it is topics that are reported as alienating in school that are picked up in social prescribing. We have also seen how some of the men report positive experiences of national service where they gain competency and pride through participating in certain tasks. Moving forward now to more contemporary data that sheds light on the cultural context, the following theme will discuss present day and their presence and absence in the men's lives.

6.6 Men's narratives of present-day activity engagement: pleasure, mastery or absence

As demonstrated, most of the earlier themes and subthemes are drawn around discussions from earlier in the life course. The following data now moves on to a cultural context experienced later in the life course to contemporary narratives of practice engagement. The narratives focus on reports of present-day activity engagement. The subthemes will explore data where men report pleasure and mastery, before progressing to the next subtheme where men report leaving activities behind, and having no hobbies that they can report. Often this data overlaps with some of the men reporting recent pride in certain practices that have also

recently been threatened through ill health. In doing so, it adds some contemporary detail in the chapters efforts to describe the cultural context of social prescribing and chart "what matters" to the working-class and precariat men interviewed, before examining how this context interacts with social prescribing pathways sampled in later chapters.

6.6.1 Mastery and pleasure through present day activity engagement: rugby, reading, gambling and carpentry

As stated earlier, whilst some of the men chose to describe earlier activity engagement, others chose contemporary ones or both. In moving further up the life course than most of the other data presented, this section will present extracts on the men's descriptions of mastery and pleasure in more recent activity engagement. This is again another vital surrounding context that mattered to them, or if it helps introduce the men to activities and activities, they previously perceived to be off limits. In the following, the men reflect on some of the activities they have gained significant forms of pleasure and positive emotion from in the present day, again selecting activities that are associated with the North of England, masculinity, and, with rugby league, the working class (Scambler, 2023):

> *"I like rugby league. I still enjoy weight training and I've started doing it again recently. I think my hobbies are now just being right with folk to use an old northern terminology...* [*laughter*]*. Oooh and I love reading, I must mention that. Any historical fiction, Con Diggleton. I'm reading one on Genghis Kahn at the minute, and anything that can transport me back so you can always imagine yourself being on the planes in Mongolia."* (Andy)

Following similar themes on participation in sport, other described a strong history of football coaching, and how this engagement offered him positive emotion, meaning and connection to "what matters".

"I'm still managing football now. I had to give it up for a bit after my wife died…I love my football, love my rugby, love my boxing and I love horse racing; it's Crinchester (*anonymised*) *later on today, so I'm going to have a look at it shortly and probably get one of my sons to put a bet on for me, you know why all the betting shops are closed."* (Cliff)

In contrast to sport, George reported taking pride and pleasure in producing carpentry within the spatial context of his own home:

> **Researcher:** *Ah, right, have you made anything of late or in the last couple of years that you could discuss?*
>
> **Male participant:** *"Well I made myself a granny clock, with all the mechanisms in as well. It was all new materials. It took me three years to make."* (George)

This subtheme has demonstrated the men report positive experiences of present-day activities, that adds a contemporary focus to some of the data presented earlier in the chapter that focuses on narrative of adolescence or earlier.

The following subtheme will describe examples of when the men report practices that have been left behind. This absence of activities is a vital context of social prescribing referral; it is indicated with a general sense of social isolation, combined with a lack of connection to relationships and resources that can sustain health and wellbeing. This context of isolation is often an important part of why the men required the referral to social prescribing, as will be discussed in more detail later in the thesis.

6.7 Activities left behind: men and the loss of what matters

Rather than continuing or picking activities from youth back up, many of the older men interviewed reported the highly emotional topic of leaving certain commitments behind. Often these hobbies were undertaken with a close friend or partner who had now passed away and as a result it was felt they could no longer be engaged in. This will be discussed in more detail in chapter 8 on the context of loss. In addition, some of the men discussed how through the presence of low mood or physical incapacity, they could no longer engage in activities that previously mattered to them. It was not always due to age and loss that the men described leaving cultural activities that mattered to them behind. Often, some discussed leaving behind activities that had sustained them because of the perceived norms and obligations of family life and "the real world":

> **Researcher:** *Why did you stop Boxing?*
>
> **Male participant: "***Well, the real world hit and I had to get a job."* (Andy)

The impingements of the economy, combined with the obligations of adulthood, at this point, seemingly precluded any further continuation within the social practices that the interviewee had taken part in.

> *"There was a time when I thought about going back to it* [boxing] *and then family and girlfriends and kids come along and it all gets blown out the window – I did always have a skipping rope in the back garden though."* (Arthur)

It seems the obligation to family, intersecting with the conditions of class inequality crowded out the interviewee's engagement in boxing. As we will see in chapter 8 often the family unit takes on huge importance in the men's lives with this sometimes seeming to prevent them from engaging in leisure and activities that may support their health and wellbeing.

In addition, others discussed a commitment to activities that seemingly defy any understanding an all encompassing stereotypical masculinity, were all men are socialised into a culture of emotional denial and macho activities, presenting nuance and complexity to experiences of the men interviewed. In doing so, however, we can see that the initial interest manifested in a space associated with more traditional working class and masculine spaces such as the pub and karaoke circuit. Indeed, this variation is supported by the fact that the interviewee would later attend university to pursue a fine arts degree, which he did not finish, with the reasons for this seemingly evaded within the interview and so not probed further:

> *"I lost my confidence a long time ago before the lockdown. I don't go in pubs anymore. I used to go with my friend. He had his own karaoke business. We'd go to the pubs that had karaoke and we use to sing. It was through him that I got started singing and I started practicing at home. Since he passed away, I've not been able to do that."* (Eddie)

With other interviewees describing the loss of his space to craft his skills and create in his spare time:

> **Male participant**: *"Since the Covid, I've not felt like doing much. I mean since I've moved into my bungalow I've lost my workshop. but you know, I used to say, give me a piece of wood, and I'll make something out of it."* (George)
>
> **Researcher**: *Ah, right, have you made anything of late or in the last couple of years that you could discuss?*
>
> **Male participant:** *I used to have a shed that I used as a workshop type of thing. But moving up here, I've had to let all that go. I'm just persevering really, day to day."* (George)

Similarly, others claim that with the passing of age, they are now no longer able to engage in activities that mattered to them.

> *"I've always been involved in cars and motorcycles all my life. Either driving them or fixing them yano. The kiddies (the interviewee's children) have stopped me driving now so, they said you're too old dad. Fair enough I suppose."* (Henry)

Going further to discuss the adaptations made considering the intervention of his children:

> *"I'm still tinkering round with my Morris Miner in the garage, and when I'm gone, I'll probably leave that to my son; it's worth 27 grand I think."* (Henry)

Andy discussed how addiction had led him to abandon participation that provided him with meaning and pleasure, but that had to be left behind if they were to move towards improved health and wellbeing:

> *"I love horse racing, but obviously, I can't have a bet because of my previous problems with gambling that I've had. So, I do my best stay away from it now."* (Andy)

A smaller number of the men reported having no hobbies, leisure, or other engagement, reporting largely solitary, lonely lives seemingly devoid of any connection, power, meaning or purpose. Often this was a result of reported mental or physical illness. In relation to the question of "what matters" associated with social prescribing engagements, these men seemed that disconnected from social life that an answer to this question may be unavailable:

> **Researcher***: What do you enjoy doing James, do you have any hobbies?*
>
> **Male Participant:** *"Erm not really now, no. I used to have my bike. I used to love my bike. I did a bit of fishing for a while but that never really caught on. Somedays at the*

minute I'm that ill with it all (multi morbidities) I just can't think of doing anything at all." (James)

In addition, Lenny stated:

Researcher: *Do you have any hobbies,?*

Male participant: *"I haven't got any! I don't watch sports to tell you the truth. I used to play football like and go out walking. I don't live a riveting life. Putting on weight that's about it. I don't know why like [that is why he hasn't got any outlets for meaningful activity] I don't really watch sport, neybody knocks, neybody rings."* (Lenny).

For reasons associated with mental health, co-morbidities or other factors, perhaps associated with their location being out of the labour market or otherwise, a smaller number of men expressed no activity engagement that they could name.

As we have seen in the above subtheme, often the men report leaving practices behind or simply not having any meaningful activity participation they can draw upon.

In progressing from presenting data from earlier in the life course, this theme on present day activity engagement has moved to later in the life course that previous data. As we have seen several the men report pleasure and mastery in certain activities, with later chapters focusing on how this pleasure and mastery is negotiated in the social prescribing pathways sampled and if these activities as what matters to the men, are part of the offering. In addition, in the second subtheme, the men often had to leave certain practices behind or reported an absence of any activity engagement at all. Again, this cultural context feeds into the later social prescribing offering with the men often having to find new hobbies or activities through social prescribing or using their experience as key topics to discuss in their groups and create trust

with the other male clients involved. The following section will provide a conclusion to the chapter that has traced what matters to the men and offered some insight into the cultural context of the men's lives.

6.8 Conclusion

The chapter has documented in detail the antecedent cultural context of the men's social prescribing engagement. In doing so, it has offered example of the norms, values and activities the men report engaging with, and how these might interact with their social prescribing journey. This focus connects to some of the data in the previous chapter from link workers who claimed that they often had challenges with men on their emotions or in getting them to respond to questions on what matters through social prescribing. This chapter has traced why this may be the case. The data presented in the chapter has ranged from describing meaningful values and activities through the influence of role models, to exploring why the values and activities that matter to men may run up against the grain of health interventions like social prescribing, with men often reporting hypermasculine and stoic norms of independence and strength. With have also seen how some of these masculine norms intersect with race and ethnicity alongside contexts of relational and material inequality. Lastly, we have seen contemporary data on activities the men report pleasure and mastery in, alongside other examples where activity participation has been left behind or there is a lack of reported activities. Moving on form the cultural context, the following chapter will discuss reports from the men on how they have been supported or not supported by the resources and relationships associated with the social determinants of health.

Chapter 7: Men and the social determinants of health: the context of employment, community and politics

7.1 Introduction

Building from the last chapter which documented the cultural context of the men's lives, the following chapter will continue to unpack the antecedent context of the men's social prescribing engagement. In doing so, it will focus on first research question "what cultural, social and material contexts do working class and precariat men report and how do they relate to the need and referral to social prescribing?". As the last chapter discussed the cultural context of the men's lives, this chapter will focus on the social and material context the men report. It will do so by focusing on the contexts of employment, community, and politics.

This context is key to understanding the distribution of the social determinants of health in the men's lives with these determinants always grounded in the contexts which people live and work (Marmot and Wilkinson, 2005). Moreover, these contexts are often overlooked in the social prescribing literature and the chapter will present data where the men report experiencing relatively little power or control across the three areas mentioned. In addition, their accounts describe a context where elements of resources, relationships and goods associated with the social determinants of health are lacking. If the discourse surrounding social prescribing makes discursive claims to tackle health inequalities and enable access to the social determinants of health (Calderon-Larranga et al, 2022), then this context is a vital pre-requisite for us to understand. That is, to explore if social prescribing can meet its aims and objectives stated above, we must first understand why some of these goods, relationships and resources are missing, and how this impacts some of the needs the men perceive as

important. This will enable and exploration into where the need for social prescribing arises from.

Moreover, through the ontological depth provided through critical realism and Pierre Bourdieu's habitus and capitals, it is here deemed that when these resources are missing, this absence is stored in an embodied way and in memory. It is only through a detailed description of the men's experiences of the social determinants of health, that we can ascertain how social prescribing can be of use to the men, and if it can help remedy any possible needs in the men's lives. The chapter is organised around three main themes. The first theme focuses on the men's context of employment as a major social determinant of health, documenting evidence that supports key explanatory accounts of health inequalities, that the men's lives are consistent with a lack of economic capital (Savage et al, 2015) participation in decision making and control (Marmot, 2015). The second theme describes the men's accounts of fining support in contexts low in in social trust and in other areas of the public sector like the Job Centre where some describe experiencing stigma and a lack of reciprocity. The third theme charts the presence of power and trust in the men's experiences and attitude towards democratic processes and politics, to again flesh out the presence and absence of power, control, and trust in the men's lives.

7.2 Men's narratives of employment and power

The first theme, containing three subthemes, will examine how some of the men report experiencing relatively little task control or power in their employment. This is sometimes coupled with descriptions of how these conditions prevented them feeling wellbeing and pleasure in their employment, alongside being employed in potentially health damaging employment. Lastly, however, some of the older men in the sample report higher levels of

choice when entering the labour market, likely to be associated with economic growth of the 1950s and 1960s.

7.2.1 Meeting the demands of the "higher ups": power denied in employment

Several of the men described situations at work where they felt stress or demands of an employer without the power available to them to check or curtail this. Often traces of these experiences remain with the men, prohibiting their ability to relax or rebalance some of the demands made on them by their employers. The following interviewee described a work history where he felt unentitled to take time off, even when ill, because of the perceived threat that this would weaken his reputation with his employers. This is described in detail in a specific example where upon being seriously injured at work, the interviewee felt reluctant to use a Doctor's note:

> **Researcher:** *So, your work history was quite stressful?*
>
> **Male participant:** *"Yes. I remember one year, I went to see the doctor about cutting myself. My hand got stuck in the press at work. I went to A and E and the week after I went to see my doctor and he gave me time off. I said, no one at my work gets time off so he wrote me a note."* (Batosh)

Batosh then described,

> *"He gave me the time off, but I didn't take it, I just wanted to get straight back to work."* (Batosh)

In this instance, even when permission was given to take absence from work, supported in writing by a doctor's note, the interviewee seems to have felt uninclined, or even unentitled, to do so. In addition to the lack of power or control felt by those located in lower position in

the labour market, the respondent's trajectory as a migrant from Libya is likely to have added to the feelings of insecurity he described, intensifying the fear that one misstep could lead to him being denied employment or citizenship status.

Moreover, the following interviewee, who represents one of the somewhat upwardly mobile members of the sample, discussed the stress he experienced in his role as a salesman at the gas board:

> **Male participant:** *"Every meeting we had with the higher ups they was always after more and more doing . Every holiday time something always seemed to go wrong, which really interferes with your relaxation... So, it's like pressure, pressure, pressure all the time."* (Micky)

Here the description of pressure and stress, carried with the interviewee into his leisure time, signals being overburdened by the demands of his management at work. In addition, Andy described the strain of working their way up the organisational chain, and how the cumulative effects of overwork, at least partially, led to a breakdown:

> *"I left school in in 1990 and did a YTS (Youth Training Scheme) apprenticeship. I ended up being taken on by a multinational engineering firm and begun climbing the ladder and got to a very senior position, almost director level position.*

With Andy describing how his overwork led to subsequent ill health,

> "*I used to work hard, probably 60 hours a week. And at one time, and I must admit, I'm not proud of it, my life was 12 hours work, 6 hours in the pub, wake up drunk, and back to work. Anyway, one day my brain just said you've had enough. You can't do this anymore and I had a breakdown".* (Andy)

In this extract, it appears that some of the earlier learned adaptations, of cutting off from his emotions and the needs of his body, discussed in the last chapter, and working relentlessly, were valued, and rewarded in his employment. This offers an insight into the emotional costs of mobility for some of the men, but also how the stoic elements of masculinity discussed earlier, though valued, and productive at work, proved ultimately detrimental to their health and wellbeing.

Others would implicitly describe employment conditions where they felt little control. Cliff described an episode where he was sacked as a pivotal moment in his occupational history, when, in deciding to act against the alleged illegal activity of a union representative, he subsequently found his employment choices limited. After reporting this incident, the participant claims he was blacklisted. This denied him the opportunity to pursue meaningful employment in the manufacturing sectors of the North, compelling him to find employment in different countries. Interesting to note is the way in which the interviewee framed this experience as a choice, although his choice was forced upon him:

> *"I have been a shop steward in my time. I have been blacked in my time, and the reason I got blacked was that I caught the union convenor taking a backhander, and I reported him, but no one believed me. Ended up I couldn't get a job anywhere for love nor money, so I went working abroad."* (Cliff)

With the interviewee elaborating on the adaptations made to deal with this:

> *"So, I decided to work for myself for about 20 odd years. I worked in the construction industry abroad. I always had a taxi when I was working me taxi was always there for a fallback and it supplemented my income. I mean we then went onto a 3-day week then in the 70s, so that stopped people getting taxis then an all."* (Cliff)

Similarly, the following participant continued the theme of his employment experiences lacking in choice, control and indeed power. Some of the men discussed the constraints of location with one interviewee in particular equivocating on assigning a stigmatising term to the place he was brought up.

> *"As you know, Broadside* (*anonymised*)*, it's always been known as a bit of erm, how can I put it, not a dump but, it's always been last in the hand outs for anything. It was 1979 when I left school. There was never much here, there was the Broadside Industrial Estate and that was it, so if you didn't get a job on here, you didn't get a job. So I ended up doing some schemes, but you were only 6 months at a time."* (Arthur)

The participant then described his subsequent employment trajectory:

> *"And then I was lucky enough to get a delivery drivers job, did that for a couple of years, and then moved to a haulage firm; got a job with a haulage firm, and worked there for the next 20 odd years."* (Arthur)

In commenting on his relative fortitude in gaining steady employment as a delivery driver, the response demonstrates an implicit insight into the comparative evaluation being made. This evaluation can only be fully understood in reference to the fate of others in his community who possessed no job or security of occupation. In the above the men described experiencing a lack of power, or choice, in their employment which is a vital context to understand as drivers of health inequalities, given social prescribing's claim to reduce them.

7.2.2 Hazardous and monotonous employment

In addition to descriptions of lacking control and power, a small number of the men described working in jobs that contained health damaging work. Often the men connect this employment to later periods of illness, describing repetitive or hazardous tasks in the

workplace. For example, one interviewee wrongly attributed a later diagnosis with a chronic illness to the repetitive strain contained in his daily tasks at work in haulage:

> *"You know I woke up in agony, but I just thought I'd done my back in like, you know, lifting loads of pallets and deliveries all day at work."* (Arthur)

In addition, Gary mentioned the chemicals or substances he handled repeatedly at work as a possible risk factor, with one participant who worked at "the crisp factory", reporting again:

> *"Well, I was only a cleaner, you know cleaning the aisles. But I had a heart attack at work, just dropped to the floor one day. I don't know if it was something to do with work to be honest, we used to use a lot of chemicals. But anyway, I had a pacemaker fitted after that."* (Gary)

Whilst we can see the clear exposure to the risk factors in his employment, we also see again a lack of tacit perceived value in one's role relative to others through use of the phrase "only a cleaner".

As shown, a small number of the men report employment associated with hazardous and monotonous employment. The following theme will discuss contrasting examples where some of the older men in the sample described experiencing relative choice and power in their employment.

7.2.3 Post-war economic growth, relative security and choice

In contrast to the above, a small amount of the older members of the sample often reflected on the positive experiences they found in areas of the post war labour market. One of the most notable patterns to emerge from this data was the experience of choice (albeit one previously constrained by early endowments and exposure to capital) within a labour market

regulated by high union density, corporatism/institutionalised bargaining and a macroeconomic policy which aspired towards maintaining full employment (Todd, 2015). This was combined with a highly productive industrial sector/blue collar jobs, especially in many areas of the North of England. Indeed, some of the men who were born outside the North of England, reported on the relatively strong employment conditions in the area that motivated them to move:

> *"So, I came down to New Town* [anonymised] *because I recognised that the ship yards in Scotland were dying, and you know I was a young man with two children. At that time, round here, you could literally go from one job to another."* (David)

Some of the older men would offer examples of how the power to refuse certain forms of employment allowed for more freedom in selection, with David's ability to exit from his employment contract releasing him from the compulsion to persist with a job that was disliked for fear of finding no alternative.

> *"When you got the New Town Gazette* (*anonymised*)*, and after the third page you could go and get a job at twenty places. I remember some days, I'd turn up and start a new job and by 12pm I'd be walking out the gate, turning round to the boss saying no thanks, I'm not working here pal".* (Henry)

In contrast to some of the earlier accounts, here we can see how a smaller number of the older men described more positive experiences of employment where full employment seemed to allow them greater choice with the ability to exit employment deemed unsatisfactory. Nevertheless, across all the narratives of employment, most of them claim to derive no meaning or pleasure from their work. This lack of meaning at work seems to be channelled into other directions to give their lives a sense of ethical anchoring. However, as

we have seen in the earlier chapters, many of the men report very little meaningful activity engagement in middle age and later life. Often social prescribing helps to bridge this gap, as we will see in later chapters. Moreover, it seems that many of the men reported a primary orientation towards serving the family, with this possibly crowding out their engagement in hobbies and activities. Most of the men reported employment conditions where they either explicitly or latently report feeling little control, power, or choice. Moreover, often these reports coincided with an experience described as lacking in any discretion over the nature of their work life. In the background often latent in these descriptions is a more powerful and demanding presence of ownership, management, or a boss. The demands of these seem to impinge upon the lives of the men, with very little reciprocity or balance described in their narratives of employment. In addition, many of the men report feeling of little value in their role relative to others in the division of labour. Moreover, some of the men report repetitive or hazardous tasks, again suggesting an awareness that their employment context did not provide an adequate context for sustaining health and wellbeing. Nonetheless the men had little perceived or actual alternatives to exit this. As a result, we can see that many of the men report deficits in wellbeing and capital in their employment, with social prescribing needing to understanding these deficits if it is to meet the aims of connecting people to what matters and the social determinants of health.

7.3 Adaptations to power - denying employment: what matters compromised

The following sub theme describes how the mean found forms of meaning, and purpose to sustain them when their employment is reported as lacking in power. The meaning the men describe offer some ethical anchoring to the men's life, providing them a sense of pride and coherence in the face of a background condition of relatively little control. The men describe their role in the workplace as a form of sacrifice for others, even when power and control are somewhat lacking in the labour market.

For many of the men, especially those with children and families, these accounts came through descriptions of acts of self-denial. Here, many of the men described foregoing opportunities or pleasure to direct resources towards their children or to allow them the opportunity to enjoy everyday goods whilst denying themselves. In addition to employment, this again may erect a barrier to the men partaking in meaningful health sustaining activity participation and leisure, with some of the men unable to provide an adequate account of activities that matter to them, as documented in the previous chapter. Moreover, as described in the earlier chapter documenting the link worker accounts, some men have problems answering the question "what matters" to them. Part of this may be a result of a life where most of the resources they have, both time and money, are channelled towards others, most notably their children.

For example, the following interviewee legitimated having little control or choice on the direction of occupation through the need to provide for his family:

> **Researcher:** *Did you have any sort of preference for the jobs you did?*
>
> **Male participant***: "Whatever put the bread on the table; it didn't make no difference to me. I enjoyed work, I sometimes even loved me work, but it was just about getting the bread on the table to support my family more than anything".* (Cliff)

With Batosh adding,

> *"I don't buy myself £30 or £60 trainers. I used to get my trainers from Sports Direct for £15. And I bought my kids nice things. For myself I'd go a year without buying anything. Honestly, because I didn't have much money, when I'd take them to McDonald's or Burger King, sometimes they would say why don't you have something, but I couldn't afford for me. But I don't tell them that".* (Batosh)

Some described their sacrifices in a more blunt, emotionally flat tone, as if describing a shopping list of requirements indicative of the good life:

> *"I've had a very nice life. We've never wanted for anything. I've always been in work. I used to drive a stage coach for 50 years. I've always had a motor car and a motor bike. The kiddies were always well dressed and never gone without and the wife was good to them. So, we were a family".* (Henry)

This relative affluence contrasts with Henry's youth; born during the years of World War Two, the interviewee recalled receiving school shoes previously owned by his many siblings:

> *"I've been to school when I was young and my mum used to put cardboard in the holes in our shoes called linoleum so the water wouldn't leak in because they had holes in them".* (Henry)

In the above, we get an implicit sense of the interviewees perceived role within the domestic division of labour as a man. When asked about the experiences that he has found most meaningful, it seems the respondent's priority is to reflect on his relatively steady history of employment in the labour market. We can also see how his living standards have improved and the relative deprivations of his youth have somewhat been overcome. This serves as a source of pride and achievement in providing for his family. Although reported in a rather matter of fact way, this is clearly a source of meaning and purpose. As we will see in later chapters, this form of meaning and purpose fractures and must be renegotiated when the wife passes away, and then processed through the help of social prescribing.

> **Researcher:** What experiences gives you the most positive emotions currently?

> **Male participant:** *"Ermm, I think it's my kids to be honest. I mean some days they will do well in school or bring their friends home and I just think, yer they're turning into the people that I want them to be and that makes me smile. I mean were not wealthy like, but they've never gone without, they've got all the consoles and that."* (Arthur)

Whilst not directly associated with a narrative of sacrifice, one participant would offer a response which points towards the importance, perhaps disproportionately, of his family in his day-to-day life.

> "The only joy I have now is when I wind up my son to be honest. That's it". (Lenny)

With Arthur reporting that,

> *"I still have aims and ambitions, but you tend to transfer a lot of them on to your kids. What matters the most to me now is seeing my kids settled, I don't want a big extravagant life.*" (Arthur)

As can be seen from the above, the idea of sacrificing clearly for many becomes the centralising role that orients their life, and is clearly a source of pride, meaning and value even when power and control are somewhat lacking in the labour market. In connecting with the concerns of the other chapters, these narratives of sacrifice anchor men towards roles that provide them meaning. As we have seen, often link workers report that men do not understand questions on what matters to them, as we can see here part of the reason for this might be that the men report depriving themselves of asking these questions through orientating their lives to providing others in their family.

7.4 Searching for power in contexts where the men live and work

The following theme will move beyond a focus on the context of employment to other areas of society where the men look to gain support and power. The following theme will show that men report little success in searching for power in areas like the Job Centre and community, reporting relational stigma mistrust and intense experiences of negative emotion. Only a small number report positive experiences of this context. Again, the context of mistrust that emerged from the men's accounts is vital to understand if social prescribing is to be experienced positively.

7.4.1 "It's set up for you to fail innit": Negotiating the Job Centre, suicidal thoughts and being made to feel lacking

Some of the men discuss negotiations with the Job Centre when unemployed. Their accounts address the nature of welfare conditionality, that is the contractual obligations that are a part of receiving benefits, including attending regular appointments at the Job Centre and adhering to the requirements of applying for a certain number of jobs a week. To fulfil these demands, the participants describe being made to feel "inadequate" and needing to "justify their existence". The experiences reported seem to run contrary to the aim of such institutions that purport to offer support for those experiencing unemployment. It is likely that these experiences are both a blend of objective strain and stigma driven by negative experiences of the Job Centre, and subjective feelings and perceptions that they are being judged as inferior and lacking in their situation as unemployed. These experiences continue to support the central focus of the chapter that the men report a context lacking in power. The lack of power reported in this context to ground the later experiences of men using social prescribing, with the men often contrasting their experiences of social prescribing with these other areas of the community and the public sector. On several occasions these experiences of the broader public sector are described as the tipping point that led to some suicidal ideation, intentions, or stated attempts of committing suicide.

Researcher: *It sounds like your experience with the Job Centre or the DWP has not been great?*

Male participant: *"That's the reason I was suicidal! I was asking the dole for help but they just kept making me feel inadequate. I went in one day and the lady who worked there said that if I didn't change my attitude, she was just gunna press a button and stop my claim. She got two security guards to come behind her. I got put on the sick because of my mental health, and they made me feel like a criminal or something."* (Lenny)

In the above, Lenny describes a situation that is lacking in actual and perceived control where one minor misstep could lead to the loss of support from staff and benefits. The negative aspects seem starker when considered that the interviewee is out of work because of mental health problems.

Eddie described his trajectory through the benefits system through a description of key junctures in his occupational career. This contained a period at university where he studied art and graphic design at the age of 48. After not completing the course, he then spent ten years caring for his mum unpaid where he described his experience as the following:

"*Nothing was good enough for her, no number of things that I did was enough".* (Eddie)

Eddie then developed his response to describe working for British Rail and Virgin Trains.

Male participant: *"The last job I had, I worked at Virgin trains as a sort of trolly dolly. It changed to a new agency, it went to quite a lot less money".*

In addition, after a breakdown that was discussed in earlier themes, Andy described in more detail his perceived breakdown:

> *"Anyway, my job went. So I went down the route of benefits and the Job Centre, basically, saying you can't claim this and you can't claim that. The benefits assessor used to say to me that "it's all in your head". And I remember saying, "well, I don't want it there". And at that point, I would only leave the house for a litre and half of Jack Daniels and neck it in the hope that it would knock me to sleep."* (Andy)

Andy then described a particular phone call with the Job Centre that tipped him into suicidal ideation:

> *I think they expected me to have savings, but I was gambling heavily. When they told me that I'd failed, I just turned round and said to the advisor, well I may aswell end it then. I slammed the phone down and got in the car with the intention of driving straight into the back of a lorry truck trailer on the motorway. I'd had suicidal ideation before but this was with more intent."* (Andy)

In the above, the men discussed feeling unsupported and stigmatised by institutions that purport to enable. Like the experiences of employment described above what seems to be lacking is a sense of being understood and a level of reciprocity and trust in their interactions. Nevertheless, as stated earlier, this poor experience of the Job Centre was not reported by all who had experienced use of it, with a small number claiming that their experiences had been positive and that they felt well supported.

> *"Oh yer, they've been good with me. I mean, they've extended my claim over the pandemic no problems whatsoever. I got a letter the other day saying basically don't worry we'll review your claim in six months or something like that. I mean, I'm hardly spending anything at the minute so, it's quite good."* (Karl)

Despite the small number of positive experiences, many of the men reported negative and often highly stigmatising experiences of the Job Centre where they felt treated with suspicion and even contempt. This offers a vital contextual understanding of the experiences of men where they lack power, stored in the body, and carried with them, but also, a needful comparative frame with which to discuss their experiences of social prescribing. In further developing this theme, the following subtheme will discuss the context of community.

7.5 Community and social trust: "something missing", stigma and isolation

In addition to the workplace and the public sector, another context where control and power is found is in community life and the social support we give and receive from others.

Nevertheless, many of the men interviewed described a pessimism about community life, often coupled with a romantic nostalgic vision based upon a prior point in time when community felt stronger and better connected. This can be seen in the following response where the interviewee described feeling unsupported after the death of his parent. Here we will see how inequality, community engagement and social trust intersect, with many of the men now reporting feeling lonely, especially those with no significant ties to employment:

> *"This house that I'm in now, which I still consider my mum's house, the immediate neighbours, not one of them has knocked on the door to see how I'm doing. I mean, it's been 30 plus years I've lived here. But not one of them has knocked on the door to say, we know you are on your own, we just wanted to see if you were okay.* (Fred)

Developing his response further, Fred described his account of why community life has perhaps weakened and become increasingly isolated.

> *"When these houses were built, like most of council properties, no one could afford a motor car. That meant that most of these people worked for the same employer,*

walked together, cycled to work together, whereas now you see someone going past in a vehicle you don't know who they are." (Fred)

This pattern continued with some of the other men described heavily stigmatising experiences in their interactions with neighbours:

"I think community has got a hell of a lot weaker. I live in a terraced house and 2 years ago a couple moved in and I tried to talk to them and they just didn't want to know. They say hello but it was like they stepped in some dogshit and I found it bizarre; there's a guy who's just moved into one side of me and we stopped to have a chat and I find it refreshing that somebody is actually willing to talk to me." (Karl)

Coupled with his attitudes and reported experiences of a weakening of community, the interviewee referenced moments and personal experiences where he has felt mistreated and shunned by those who live near him. It is also reported that he feels these are looking down on him, evoked through the idea of the dirty and polluted "dog shit", connected to the idea of stigma and status.

In addition to more overt experiences of loneliness and isolation, some of the older men in the sample report a similar nostalgia for stronger community ties:

"Young people today, are a lot better educated, a lot better than I am, but they are paying the price because they have not got family. I mean, I lived in a tenement where there were 42 kids, and you could go to other people's houses and get fed. Nowadays, and I've been in this street now here 45 years, people don't do that anymore" (David)

Developing his response further to tie this specifically to decline of industry:

> *"In the street that I lived in most of the people worked for the same employer, so we all knew each other, whereas now the industrial side of thing, that community is all gone."* (David)

Moreover, other men offered some slight variation on the decline of community, citing not technological change and loneliness, but the illegal market of narcotics and drugs as partly responsible for the weakening of the community:

> *"See Broadside (anonymised) has always been a place where there has always been a strong community. I think that's because we were working class and we know that the only way to get out is to do it together, like herd mentality. We are stronger together than we are apart. But in recent years the drugs problem up here was bad. There wasn't a person I knew who wasn't affected by drugs in that time. It's starting to go back like that now there's no work."* (Arthur)

Whilst the strengths and solidarity of "working class" communities are here acknowledged; the interviewee also referenced some negative aspects of the community: here again the solidarity of the community is perhaps ranked at the expense of individuality and privacy:

> *"I mean the home itself, it was cramped, it was noisy, there was no way of getting any privacy, but it felt safe."* (Arthur)

Eddie would discuss this in context of the coronavirus, claiming, that it was during this period that he felt a renewed sense of community belonging:

> *"I said to a few people, this coronavirus has been a positive for me. I don't mean any disrespect to those that have died, and I don't wanna glorify it. But my life situation before the virus was isolated anyway. When you live on your own and you don't have*

> *any friends and you don't go out often people start thinking you're weird. But with the coronavirus, I ended up in a situation where everybody was like me. I felt like I was part of the community again."* (Eddie)

As evident from the above, despite some positive experiences many of the men reflect on a period of community decline, experiencing stigma or loneliness in a community context devoid meaning and connection. These experiences of community indicate that the men experience a lack of positive health sustaining relationships, with it naturally following that social prescribing must understand this absence if it aims to meet unmet needs. The following theme will present data on the men's discussions of politics power and democratic engagement.

7.6 Politics, democratic engagement and power

Previous themes have documented how many of the men reported feeling a lack of control and power in the workplace, accompanied often by, though not always, a lack of support and trust in their current community. This theme will discuss another context within which some of the men reported feeling differential levels of power: namely, in their discussions and reported experiences of politics, discussed in connection to the aims of the personalised care agenda, which aims to empower users, democratise health service relationships and given people more say over the direction of their care. This context of democratic engagement is a vital pre -requisite context to understand the men's experiences and attitudes towards democratic processes. Here we will see that even when men report civic involvement through politics, it is scenarios and spaces traditionally associated with the male traditional working class, namely union activity. Like the previous theme, many of the men describe feeling no trust in democratic processes. Like the claims made throughout, this must be understood and foregrounded before examining the pathway through social prescribing.

7.6.1 Men and trade union engagement

As stated, some of the older men in the sample described greater political involvement, either in formal party settings or in union politics. In doing so, the older men described moments where they felt a potent form of agency in securing greater power over their work. *"When were teenagers, the shipyard community we had what we called the UCS… where we actually took over the shipyards in Glasgow and Scotland… and they built the ships without any foreman as a group of men we would look to Liverpool, we would lock to Liverpool dockers like Hugh Scanlon, Jack Jones, Mike Feather".* (David)

Moreover, Henry discussed being involved in local Labour party meetings:

> **Researcher:** *"What about politics, Henry do you have any interest in it?"*
>
> **Male participant:** ***"****When I was in the Labour Party, I used to sit on a school committee you know and one day, (a notable Labour MP) was giving us a speech and she was waffling on and I said, I don't know about these other people sitting by me nodding their head, but you're abbreviating everything and we don't know as laymen what you're talking about. And then, she never used big language after that".* (Henry)

Nevertheless, in raising his concerns, a remedy was achieved, signifying in a small symbolical manner, elements of the ideal of the democratic process and having control over one's life through modifying communication so that he was unable to understand. Moreover, the following participant claimed that,

> "politics don't interest me; i'm more interested in moral issues". (Cliff)

Cliff offered a response demonstrative of how the values he holds have seemingly been shaped by his experiences:

"Zero-hour contracts now, they are a joke. I grew up with the stance fight for your right!

if you've got a cause and you think it's motivated, you've got to go and show it.

I think things that my generation fought for have been given up without a fight". (Cliff)

As we have seen, although most of the older members of the sample expressed stronger experiences and attitudes towards politics in representation associated with power like trade union activity, this was not always the case:

Researcher*: Do you have any political beliefs or experiences, Gary?*

Male Participant*: "No I don't have any of them, no".* (Gary)

Whilst some of the older members of the sample described greater political involvement, with examples given where the men report experiences of providing a countervailing force to employers, others express a sort of fatalism and mistrust. Elements of this mistrust and fatalism are discussed in the following subtheme, with any efforts that social prescribing makes to empower users needing to understand the presence of this.

7.6.2 "No hope": Mistrust, fatalism and politics

These more triumphant narratives of the older members of the sample in gaining some form of control and power through political participation sit in contrast with accounts that display an imposed helplessness and alienation when discussing politics. On many occasions this would take the form of accounts that described a complete distrust of politicians and the democratic process; this was combined with expressions that an unjust system that fails to meet their needs will likely never change; or, that human nature is naturally directed towards some attempting to gain power over others. And, similarly, the oldest member of the sample claimed:

> *"Well I'll be quite frank with you. I've never really liked politicians to start with and it's just sad when you hear of the likes of that Liverpool mayor whose been up to no good and you think well how many more is like that. So my own view is that they are all out to feather their own nest."* (Micky)

In some occasions, these reports of distrust intersected with the Covid-19 pandemic and with some of the interviewees describing a complete mistrust on how the pandemic is managed, indicating a sense of alienation from decisions that impact his life and a lack of control,

> **Researcher***: Do you have any views or experiences on politics, Fred?*
>
> **Male Participant:** *"Not really apart form I don't trust a single one of them. I mean I'm sure there are some of them that want to do good things, but it's if they ever get an opportunity to put them ideas in action*". (Fred)

Often these discussions give an insight into the broader issues of trust and experience of public engagement, with social prescribing needing to repair some of this mistrust if it is to successfully achieve the aims of personalised care alongside reducing health inequalities. This is also tied to an understanding of north - south regional economic inequalities and a perception of a Westminster bias. Often this is discussed alongside attitudes towards the management of the Covid pandemic, and how many felt unheard during the process, with some accounts conveying beliefs of a national conspiracy and corruption. Again, for some of the older sample, this was specifically tied to a form of class awareness, where the men are aware that they are lacking in economic and political power, and locked out of the processes and institutions ostensibly designed to support them in gaining some control over their lives. It is not then the objective validity of the statements that are in question, but the implicit and explicit indications they offer on power that are of interest:

Researcher: *are you optimistic about life after lockdown?*

Male Participant: *"No not really. Sometimes I wonder if this government is doing it on purpose. When it started off it was mainly just up here, now this is just like a theory type thing, but it first started in all your working-class cities, your labour cities, Liverpool, Manchester, Newcastle, Birmingham. Then when it went down south, they had to do something about it then."* (Howard).

Moreover, another interviewee would state similar concerns:

Male participant: *"At times it feels like it's being managed".*

Researcher*: You mean like planned?* To what end?

Male participant: "*Well, I don't know. There's lots of theories out there, they are all based on control. I mean, I've seen people out in the open landscape with masks on, when really there's no need; that's a tremendous amount of power and fear that has been instilled in people".* (Fred)

At other times, this type of pessimism would be accompanied by an explicit reference to the reproduction of political and economic power and privilege, and the inability of any political action to redress this:

"I always think this country is going to be a three-tiered class system. It's all about servicing their little nest of vipers, they don't really care about us." (Arthur)

Furthermore, many of the men expressed the idea that their concerns were being ignored by tying these to specific regional concerns of the local economic context in a de-industrialised town in the North of England.

> *"I don't want to make this political, but until the decimation is acknowledged in the area. People don't know any other way and people think I'm being melodramatic, but there is a lot of people in this area with no hope. Well I'm sorry but if you leave school and your job is to put boxes in boxes for the rest of your life, what do you expect?"* (Andy)

Another participant Lenny would offer a response that whilst not directly connected to macro political processes, still convey a sort of private despair and lack of orientation to the future, describing a state with no control over his future time:

> *"At the minute I'm just tryna take every day as it comes. I used to be thinking too far ahead and I would just depress myself even more. If I think too far ahead, my head hurts."* (Lenny)

Here we can see some of the men described feeling a lack of hope or optimism about the ability to change things. There is an awareness that things should change, alongside an implicit acknowledgement that they cannot. This is likely to be borne out by outer conditions and processes that deny control and power.

As stated, social prescribing as a part of the drive to democratise public services must interact with contexts like the men describe, which seem to contain a lack of power, control, and trust. As we have seen in earlier chapters, one link worker described this context as a "table cloth of pessimism", and the men's accounts of this context presented here has gone some way to describing a context that seems lacking in supporting and enabling structures. In following the men into their social prescribing engagement in later chapters, it is this context that social prescribing will have to repair, buffer against or moderate if the men are to report positive experiences.

7.7 Conclusion

This chapter documents how the men often describe experiences that reflect a lack of control and power across employment, community, and politics. To explore if social prescribing can support access to the social determinants of health, this chapter has contextualised the overwhelming absence of the supportive structures in the places where the men live and work (Marmot and Wilkinson, 2005; Marmot, 2015). Overall, the men offer narratives that describe a lack of capital and power across the contexts of employment, community, and politics. Moreover, this lack of power in the men's lives is often represented in their often-fatalistic attitudes to improved social change. We have also seen how some of the men, perhaps in response to power being denied to them, cleave towards a lay normativity where family is of overriding importance as a way of emotionally anchoring their lives. We will see in the next chapter that this attachment to family life is broken and frayed when loss of a family member occurs, or when a loss of job or illness occurs. With this episode of loss often acting as the trigger that leads to the social prescribing referral.

Chapter 8: Loss and the trigger for the referral to social prescribing

The following chapter will focus on the men's experiences of various types of multidimensional loss. This experience of loss often served as the key driver in the men seeking out support and help through social prescribing. Like some of the data discussed in other chapters, this focus was not part of the initial interview questions, but rather emerged in the process of interviewing as a common trigger to the men's referral and engagement with social prescribing. The chapter is the final response to the first research question driving the thesis, namely: "What cultural, social and material contexts do working class and precariat men report and how do they relate to the need and referral to social prescribing?". The men's various accounts of loss are a key driver to the context of the need and referral for social prescribing.

The chapter is focused around two central themes. The first central theme focuses on how the men reported experiencing loss of various forms. The first form of loss discussed is the loss of a parent or partner. In addition to this, some of the other men described losses that did not concern the loss of a loved one or family member, but the loss of a stable attachment to work, employment or a particular role. On some occasions, the rupture of Covid-19 is referred to as the trigger of disruption and loss that removed the presence of relationships or roles that partially supported the men. In addition, these losses sometimes put the masculine norms discussed in earlier chapters under strain. As a result, previous understandings seem to have broken down resulting in the negotiation of new forms of meaning after the losses. It is the response to the loss that is the second theme of the chapter. This theme will also describe how the men reached out to engage in health seeking behaviour, leading to a social prescribing referral. In summary, this episode of loss is a vital context, then, to understand

the key tipping points in the men's lives that often led them towards engaging with social prescribing in the hope of finding support and new forms of engagement, meaning and wellbeing.

8.1 Men and narratives of loss

The following theme will document the multidimensional losses that the men experienced in the run up to their social prescribing engagement. These range from examples of when the men reported the loss of another loved one, or when the men either through the loss of a loved one, illness or divorce, reported a seismic disruption in their lives. This disruption was often combined with a loss of meaning and direction. As we have seen in the last chapter, because of the relative lack of supportive structures in the contexts of employment and community, it often seems as if the relationships and connections that could help buffer the men against the loss are absent. This absence then leads to later social prescribing referral and engagement. The first subtheme will discuss how the men described the loss of another, before proceeding to discuss other forms of loss in the following subthemes.

8.1.1 Masculinity and the negotiation of the loss of loved ones

Some of the men described the traumatic experience of losing a family member. These connections were often some of the only strong relationships reported by the men, with the other areas of their lives seeming lonely. This is likely to be connected to the previous chapters, where the men reported contexts lacking in power and trust within community. The following section will present data where the men described the loss and the impact it had on them emotionally. As stated, it was often this emotional pain that led to the social prescribing referral.

Fred described the episode of his loss through the description of finding his mother passed away with no staff to care for her in attendance. This experience is now carried with him, interrupting his thoughts in the form of a recurring traumatic memory that now haunts his days:

> *"I went spot on visiting times. And it was me that found her in her bed, unresponsive. That image plays over in my mind every day, several times a day, I see myself walking down the corridor and not being able to get a response."* (Fred)

David described the moment of loss as a collapse of the self. This was often discussed with highly emotional images and descriptions of pain. Indeed, the participants often describe this pain as the worst experience of their life.

> *"And I just said come on doctor, cut to the chase, what's wrong with my wife and he says she's dying. Well, I just fell on the floor and I started to sob, but you must remember this is my world. All my family was with me and I'd lost it. I have never felt pain like it."* (David)

David then elaborated on his response to emphasise the helplessness and break down of control felt at the time:

> *"And do you know what the worst thing was, for the first time in my life I wasn't able to do anything about it or help. I mean, she was my world. And it was anything under 4ft she had it, anything above 4ft that was my job. I mean life before I lost Margaret was a breeze, a total breeze."* (David)

Not only does David draw upon a discussion of the domestic division of labour and his sustaining role within it, he also referred to the way her loss marked a stark rupture, where prior to the loss his life was one of perceived ease.

For some of the other men, the loss of control within the experience would take on a more latent and subtle form. In some instances, the men feel personally responsible for not being as vigilant as they felt they should have been in attending to their wife when fatally ill. This expression of guilt also connects to norms around masculinity and the breadwinner, provider and protector. Moreover, their efforts to control and care for their wife often come through the tacit reference that the outcome could have been avoided.

In the following example we can see evidence of this, whilst also a continuation of the visceral description of a collapse or shattering of the self:

> *"I was in the bedroom. I was holding her hand and she went to sleep and I went to sleep. That was my first mistake. I wish I hadn't. Anyway, in the morning I thought, I'll pat her and she'll wake up. Well, I couldn't wake her so my daughter came in who's a nurse and she said she's dead, Dad. Well I went to pieces."* (Henry)

On occasions, the experiences and perceptions of loss described seemed devoid of emotion. For example, the following interviewee says words that suggest emotion, whilst also moving through his account quickly as if to indicate he would rather not discuss in too much depth, bringing his emotions back under control. Following this, he quickly gestures to the need to sort things out in almost bureaucratic fashion:

> *"I lost my wife. I'm preserving. I'm getting there. She'd go out in the garden and do anything. I loved my wife I did. 1999… 1999! Nooo, 2019, I lost her to cancer, so i'm trying to get everything sorted out."* (Gary)

As we have seen, often the men seem not only scarred by the loss, but adding to the pain of self-blame in keeping with male norms that valorise emotional control and distance. The

following subtheme continues with the theme of loss but with greater emphasis on how the loss led to the absence of connection to others.

8.1.2 Loss of connection: depression, isolation and inequality

Some of the men interviewed reflected on how the experience of loss had resulted in a period of depression and isolation. In the previous chapter, we saw how many of the sample lacking in power and control also suffered from a perceived and actual decline of community with many reporting a state of isolation. In reflecting on the losses of loved others, the men often lost their only connection to social ties. On some occasions, the current loss was compared with earlier moments in the life course that resulted in a loss of belonging and direction. In the following example, Micky described being de-mobbed from the army, and how this experience of loss and self-reported depression led to a similar outcome, though likely incomparable, to the loss of his wife.

> *"I came out of the army, was depressed when I came out of the army, missed my mates, and then met a young lady called Carol who died a few years ago and left me on my own."* (Micky).

Micky developed his response further on how, since his wife passed, his days had become monotonous, lacking in meaning and lonely.

> *"About two or three years ago, being on my own, I was depressed. I still am a bit depressed. I just went to the doctors one time for a blood pressure check-up and he was asking me how I was doing. He said, "what do you do all day?" I said, nothing. Then he asked me, "don't you go out?" I said, no, I just don't move out. The only time I went out was when I did a shop."* (Micky)

In this example, the medical encounter with the GP demonstrates the severity of the participant's isolation after losing his wife. Through this we can see that he reported loss of purpose and social connection, only leaving the house to ensure he had some food to eat and secure the bare necessities to sustain life, with his later referral to social prescribing helping him find some connection.

For a smaller number of the other men interviewed, it was not the loss of partners but of family members that was described in detail. Some of these men associated the loss of loved ones with other forms of deprivation, documenting how the loss had intensified the lack of power and control, that, when combined with the grief and pain of bereavement, led to a life devoid of social connection, positive emotion and meaning.

> *"I have ended up being on my own in this pokey little flat and having no friends locally. I had no outlet to go and visit people. I lost two good friends. My family members in particular who had passed away well it upset me you know! And then my mother and two uncles."* (Eddie)

Going further to add,

> *"I had all this social aspect at one time, and then whushhh it's gone; totally on your own and isolated and you think god what I have done to deserve this."* (Eddie).

In addition to the loss of his social connection and loved ones, here the interviewee seemed engaged in a form of self-punishing interrogation, aimed at either consciously or flippantly a metaphysical being called "god", searching for causal answers as to why his life has ended in the state described. Moreover, the participant described the council flat he lived in as "the hell". This bleak metaphor was used to describe a host of unsatisfactory living conditions. In particular, the flat was based on the second floor, and, for reasons unstated, there was no lift,

or the lift was not used. As a result of his chronic pulmonary disease (COPD) the participant often physically struggled to reach the second floor; this was compounded by a gang of younger tenants smoking marijuana.

> *"The place was full of idiots smoking funny smelling things. It used to frighten me; it really did. Someday I'd hear their voices around the corridors and just sit huddled there panicking that the smoke would come in."* (Eddie)

Some of the other men described how the lack of social connection, which intersects with the various forms of health inequalities, economic and relational inequality described in the previous chapter, caused the parental bond to become more important and sustaining.

> *"It was that constant that she was there in my life. I don't feel the motivation to do anything because my mother was such a huge part of my life."* (Fred)

Fred also stated that, in addition to his lack of connection to the labour market, amongst other forms of social connection, the presence of an abusive, cold and impulsive father strengthened his bond with his mother. In falling reliant upon this source of stability and security, one of his other family members would make a comment seemingly pathologizing aspects of this relationship with his mother, claiming it to be detrimental towards his health.

> *"One of the cousins said, well, it's not healthy to become so dependent, and I agree; but we couldn't help it, it just happened like that. That was for both of us, me and me mum."* (Fred)

Moreover, because of a lack of resources and income, the interviewee remained living in the parental council house; a living situation which he described as triggering intrusive memories, associated with the routines and rituals he used to go through in the house with his mother.

> *"I sit here around six o'clock every night* [the time when he habitually had conversations with his mother], *and it all just comes flooding back. It's just so lonely and dark. If it wasn't for my two friends that I speak to every night on the phone, I don't think I'd have held on."* (Fred)

In continuation of this, after a fall out and subsequent estrangement from parts of his close family an interviewee reflected upon the anger and painful emotion he felt after being denied the ability to spend time with ill family members:

> *"Tragically, I lost my younger sister and my mother, close together. This came two years after losing my own wife, so it was like two sucker punches. At the time I didn't realise it had that much effect apart from being disappointed and upset. I knew they were ill but I didn't know to the extent that they were on deaths door. Unfortunately, my family didn't see fit to let me know about this* [the death of family members]." (Cliff)

In this instance, the interviewee uses a visceral and combative metaphor of his losses feeling like "two sucker punches". This response was combined with a description of his anger being held at bay and avoided (likely to be connected to earlier rounds of masculine socialisation which has been discussed in previous chapters), causing it to emerge, seemingly unexpectantly, in his other social engagements. This led him to avoid and lose some social connections:

> *"People started noticing a change in me; I was finding it hard to be around people, and I was biting people's heads off which is not like me at all."* (Cliff)

As shown, often when the men described loss, it is not just the loss of another that is at stake. In many of the men's accounts their losses were coupled and combined with social isolation. In addition, their loss was intensified when the living conditions of some of the men erected

further barriers to them moving forward in life and reaching out. As we will later see, some of the successful impacts social prescribing has achieved is by providing men with some social connection within the background of this loss. The following subtheme will document examples where the men reported loss associated with their identity, either through loss of employment or status as a husband. As we have seen, both are especially important to men in relation to norms of being the breadwinner alongside some of the earlier discussion of narratives of sacrifice.

8.2 Loss of meaning: illness, injury and the breakup of marriage

A recurring theme in the dataset is the loss or mourning of a former identity. Often this comes in relation to the loss of other family members, but also through illness and physical limitation on the execution of tasks that were previously achieved with relative ease, or, in one instance, through a sense of betrayal from a partner having an affair. Some of the men discussed how an illness led to a profound disruption in their perceived value, often framed in relation to how others view them after illness, and how the vulnerability of being ill often threatened internalised ideas of what it means to be a man. Arthur discussed being diagnosed with a chronic condition and how this led to a negative spiral, leading to problems with his mental health:

> *"I woke up I was covered in head to toe in a rash; anyway, I went to hospital and did a biopsy. It came back and it's called IGA nephropathy. It can kick off anytime; it just lies there dormant. People laugh at you, but there's days where you feel like your paralysed in bed. I've been crawling the walls at night with it."* (Arthur)

Alongside the physical experiences of his condition, the interviewee emphasised the lack of understanding received from others. Moreover, Arthur offered an insightful account of an experience claimed to altered his state of mental health, which touches upon a masculine

understanding of what it means to be a son with responsibilities to the father, evidence of which we have seen in chapter 6.

> *"Because I was going through so much medical stuff myself, I was tryna look after my dad. He needed lifting from chair to commode, to chair to bed. One day I picked him up and I just couldn't do it. I had to put him down on the floor and call one of my brothers in to help me lift him. And from that time on I think the depression just kicked in; I just felt like I'd let him (his dad) down. I just wanted to curl up in a corner. I know that my dad wouldn't have judged me really, but it's what you think about yourself."* (Arthur)

It was after this event that Arthur claimed his mental health started to dip. It seems that when he failed to achieve what he expected of himself, (which always contains an internalised expectation of other people), Arthur began to suffer psychologically. This is further substantiated by the following remark:

> *"It just robs you of any self-worth. I just felt like I was robbing oxygen."* (Arthur)

Others discussed a severe loss of meaning and purpose through discussion of a recent divorce, which was also tied to a loss of employment and cancer diagnosis.

> *"I was having a bad shoulder at work. I never go to the doctors. I'm always good on my health so I don't go really. But I had a really bad shoulder and I went to the doctor and he give me a couple of tablets and whatever. On the Thursday he rang me and I got diagnosed. I got told I have cancer on my spine and my lung."* (Batosh)

It was through being laid off from work (unrelated to his cancer diagnosis) that the interviewee observed patterns of behaviour in his partner that seemed unusual. From this initial hunch, it

followed that his wife was having an affair. This caused huge sadness and disruption to his valued emotional investment with in family, with this evidenced in earlier data presented through his". Indeed, the interviewee did not talk in length about his treatment, or cancer, with the weight of his discussion pointed toward the perceived betrayal of his wife

Moreover, the interviewee described examples of existential questioning, where he seems to enquire if the commitments in his life and the compromises that followed were worth it or if he should have made alternative choices.

> *"My life wasn't my own really...I wouldn't do it again; I mean what was it all for?"* (Batosh)

With the interviewee quickly interrupting himself,

> *"But I shouldn't complain too much, I'm doing okay."* (Batosh)

Here we can see a momentary reflection on a life that seems heavily compromised, before deciding to foreclose on his enquiry. For others, it was a severe injury at work that interrupted the forms of meaning and purpose sustained by employment.

> *"Yeah, it was like doing a workout every day and getting paid for it... I like being in the countryside and it was just, it weren't a perfect job by any means; I didn't earn a fortune, but I just enjoyed it. I was fit and healthy and then my accident happened and I kinda spiralled out of control again."* (Karl)

The injury marks a period of disruption, and a loss of the employed and engaged self in an environment experienced as pleasurable. After the injury, the buffering effects of employment are removed and engagements lost. As a result of this, Karl returned to using marijuana and ecstasy, perhaps to blunt the pain of his loss, hijacking the pleasurable reward systems of the

brain and proving a source of escape. Karl's relapse with drugs led to him being heavily indebted to local drug dealers. Unable to service the debt, the drug dealers broke into his house where he suffered physical abuse perhaps leading to psychological trauma. This unfortunately represents some of the exploitative outer conditions, in this example, predatory lending institutions, in areas of economic deprivation. This is later dealt with in his social prescribing engagement whereby his link worker helps him throw out certain items that reminded him of the break in and violence inflicted upon him. In another instance, offering some variation, a smaller number of interviewees described how the choice or decision to give up something caused a devastating cascade of events for them. For example, an interviewee described how upon giving up alcohol, their life spiralled out of control. It was giving up alcohol that, according to the interviewee, set off a chain of reactions, including an estrangement from his children:

> *"I've got a thirteen-year-old son and an 8-year-old daughter and I don't see them"* (Lenny).

In reflecting back on the reasons for this he suggested the following,

> *"I think I were tryna prove my dad wrong. He said, I could never stop drinking. I mean my dad's old school, and I just think I got to a point where I thought if you're gunna be thinking the old school thought all the time, you're gunna have ney life. I used to go work, go home, and drink 8 cans and then be stuck in the house, I had no life."* (Lenny)

In addition to the loss, here we see the clear motivating and powerful presence of the interviewee's father, with some of this substantiated for other men in the sample in earlier chapter on what matters to the men within context. It seems that the numbing effects and masking elements of alcohol helped to offset some of Kenny's negative emotions. Nevertheless, what is clear is that in contrast to a previous time of social engagement,

employment as a concreter and fatherhood, these forms of social engagement are no longer available to Lenny. As these connections are lost, so are the capital, recognition and emotion deriving from them that can improve wellbeing. As a result, Lenny described an almost hypervigilant state of threat which is often associated with a lack of comforting social connection.

> *"It was probably the worst thing I could have done (stopping drinking alcohol). I lost my job, I wasn't the person I was. A knock on the door and I'd just start panicking, which I never used to do. Looking over your shoulder all the time, and I don't understand why… neeebody is after us like."* (Lenny)

Nevertheless, ceasing to drink alcohol is cited as allowing Lenny to reflect more clearly on the now perceived limiting conditions of earlier masculine socialisation.

> *"What it is, and I only realised this when the alcohol must have left my bloodstream, it's the old school mentality that you have to bottle things up. I only really felt this when I stopped with the booze."* (Lenny)

Whilst most of the losses and disruptions reported occurred prior to Covid, for a small number of the interviewees, it was the interruption to employment of the Covid-19 context that was reported as a major contributing factor to his current emotional pain. This was particularly intense when the isolation of lockdown caused rumination on an existing health condition.

> *"I had a few health problems at the time and my boss said to me, do you wanna be furloughed, so I said okay. But I didn't know had bad it was gunna be because I live by myself in a flat (council owned) and I was staring at the four walls. I've got some anxiety with it all at the minute."* (Howard)

In this period, the interviewee described the constraints often faced by men asking for help:

"Furlough was the worst thing that ever happened to me, I think. I went through a bad stage and my cooker went and I lost loads of weight. I never had nothing to cook food with. Before the pandemic, I was nipping out and eating in restaurants or going to the shops for my sandwiches. But obviously, I never told anyone about my situation and I lost a shedful of weight." (Howard)

Researcher: *"What stopped you from telling anyone Howard?"*

"I think it was a bit of pride to be honest. The way I was brought up. I just didn't wanna bother anyone at the time. Everyone was going off their heads saying why didn't you say anything." (Howard)

Howard continued the theme of the disruption being negotiated through the socialised norms and expectations of masculinity, with the participant reluctant to tell others of his situation, and of any discussion or assertion of his need for support stated as being perceived as bothersome for others, and denting his "pride" in his own perceived autonomy and independence. In the above, we see that by giving up a substance or work, some of the men effectively lost some of the sustaining roles or habits that helped buffer their levels of wellbeing, and offset the negative experiences they described.

As demonstrated, most of the men described experiencing some form of loss or disruption to their life. Much of this must be negotiated through the limitations of masculine norms discussed in previous chapters, with men often feeling out of control or exposed to emotions previously distanced from. In the next section we will look at how the men responded to this loss, and how this search for meaning after loss, eventually led to social prescribing engagement. Whilst the first theme of the chapter has documented and described the process of loss and the emotional pain it caused, the second theme will describe the response to loss,

before concluding that the loss for many led to them seeking help, sometimes inadvertently, through social prescribing.

8.3 Responses to loss

As stated previously, the experience of loss often leads to the men reporting the need for new forms of understanding and meaning to make sense of their lives. In doing so the men draw upon diverse cultural forms ranging from spiritual questioning to notable philosophers. This search for new forms of meaning developed further in their later social prescribing engagement, with the men often drawing on these cultural forms to create renewed forms of trust within the social prescribing group.

8.3.1 The search for meaning, understanding and purpose after loss

An important pattern of recurrence in the data, was the way many of the men who had experienced loss continued to feel connections to their wife or family member on a spiritual level, with some claiming to see them still or receive guidance from them beyond the grave. For some this could be interpreted as a sort of rumination or wishful illusion. This may be intensified because of their lack of power, control, meaning and social connection. For other men interviewed, however, the discussion of these experiences later spark and sustains group cohesion and identity in the social prescribing participation; this was especially the case in the bereavement group, but can be seen far beyond this in the sample of men:

> **Male participant:** *"I've seen the wife twice. I've seen sitting in her in the armchair and I've seen her sitting in the parlour. You know people say you're going soft, you making stuff up, but I can't explain it."*

Researcher: *"No, who's to say, I suppose. And is this part of a broader religious belief or a private thing?"*

Male Participant: *"No, completely private. It's a very nice feeling. It's very nice to see her, and I think that by seeing her, it's okay, I haven't forgotten her, and she hasn't forgotten me."* (Henry)

Henry progressed to discuss a particular instance of when he felt supported by his wife through his description of his felt spiritual intervention in helping him find a lost item in his house.

"I lost the keys to the safe, and I was telling the wife you know that I'd lost them, can't find them, and I had to get the passport out, anyway, I went to bed that night and the wife said to me, the keys are in the bottom draw. Anyway, I went downstairs and there they were. In the bottom draw where she said." (Henry)

In addition to the above, David claimed that in the aftermath of his wife's death, he now longed to be with her again.

Male participant: *"I wanted to die. I mean, I didn't want to die, but I wanted to be with her so much that I wanted to die."* (David)

Researcher: *And is this part of a religious belief, David?*

"Not really, I'm a lapsed Catholic. I'm a coward. But Maggie believed in God. Before Maggie passed away, I was petrified of my own mortality, but the moment Maggie died, that went." (David)

With David progressing further to add that although the longing for a return to his wife is experienced as comforting, it may cause problems for others:

> *"It gives me comfort to know that I'm going to be with her sooner rather than later. It doesn't do my children any good, or my grandchildren any good".* (David)

In continuation of this pattern, others described more philosophical forms of questioning, seeking reference in academic resources. Since the loss of his mother, a participant claimed he had started to reflect more intensely on existential, metaphysical, and spiritual questions. The participant seemed to consciously appreciate that his search may be driven by unhelpful motivations, but this cannot offset or dampen down the emotional pull to search for answers to questions on the loss of his mother.

Male Participant: *"Well, since I lost a lot of my family, I've been thinking more and more about the possibility of there being an afterlife. I think there's an element of desperation there. I can't concentrate with my mind enough to read But I am keying things in online. I keyed in the other day is there a consciousness? Something came up about were all made up of atoms, and atoms can't be destroyed."* (Fred) Despite this exploration, the interviewee remarked that the sources had failed to provide him with the answers he was searching for with the argument of the book claiming that consciousness may go on but in a different form. This would mean Fred would not be reconnected with lost loved ones:

> **"***I mean the author of the article flags up that for most people it's the loss of the self that they dread but for me it's not my self, it's the hope that I'd be with certain others again and not just my mum but my dad, my uncle and my grandparents."* (Fred)

In continuation of this search for answers through questioning, others would refer to notable thinkers from the western tradition of philosophical thought, whilst also combining this with conspiracy theories about UFOS:

Male Participant: *"I mean, sometimes when I'm not sleeping well, I find myself like listening to podcasts, and scratching around trying to find answers to things. But the other day I was listening to one on someone called spppp Spinozey or something.*

Researcher: *Spinoza?*

Male Participant: *Yer that's it and Einstein, and they didn't believe in god, but they sort of referred to nature as god. You know like God for them is like acceptance and that really hit home to me".*

Researcher*: And is tied to a broader religious belief?*

Male participant *"Erm, I just hope this isn't all you get. I would hate to think that we have spent all this earth just to turn to dust. Sometimes I wonder if there is such a thing as reincarnation, you know life coming back as someone else. I just think there has got to be more meaning to why we've been put here in the first place"*

Researcher*: And do you ever talk about these sorts of spiritual and existential concerns at the social prescribing group?*

Male participant: *"Oh yer, yer. Some of the girls that turn up. They are very, what's the word, ethereal. They believe in spirits and stones, etc."* (Arthur)

Moreover, to ease his pain of being diagnosed with cancer, along with his wife's affair and loss of employment, Batosh described how prayer as a practicing Muslim has helped him through. Moreover, some of his practices and beliefs may tie into his later participation in chair yoga and meditation through social prescribing.

> *"At the moment, I'm doing a quiet prayer every hour. I used to pray and it makes me feel better anyway. I used to have a prayer mat and go upstairs and pray and they didn't even know.".* (Batosh)

The use of prayer as a way of navigating loss and rupture is mentioned by another participant, with again an interesting qualification that this has nothing to do with the institutionalised forms of religion like attending church, taking a more private form:

> *"Well, I don't really go to Church. I try to steer away from the organised side of things but I do say prayers and I do believe in god. So, when I say prayers, it's usually not a structured thing. Say I'm washing the dishes, I just think about my mum and my family. I just say a little prayer."* (Karl)

Here we can see that some of the men reported engaging in quasi spiritual and religious forms of meaning and questioning after the loss; We will later see that some of this is carried with the men into the social prescribing pathway. The following subtheme will discuss how men began to reach out social prescribing in response to their loss.

8.4 Connecting to social prescribing after loss

In many of the interviewee's accounts, the episode of loss caused them to finally reach out to a health professional. Often the men provided poetic and insightful metaphoric descriptions of their experiences:

> *"It was just a build-up of everything. My dad, my health, I'd lost my job. Anyway, I went to my G.P. you know for just a routine check-up and she just said, I can see you're struggling, and it just all came out. It was like there was a crack in the wall, and you think you're getting away with hiding it with some plaster or something, and then when she pointed to it, the whole structure came tumbling down."* (Arthur)

In this instance, the cracks in the interviewee's structure, and his need to present to others that he is doing okay, are finally seen through. As a result, emotions, long held at bay, now seemingly rise to the surface. Here it is important to note that the interviewee mentioned the way that adhering to male norms was identified as an important factor in causing him to hide his emotions.

> *"You know we are taught men don't cry, and basically, you feel like you have to be a lot stronger than you are capable of being. I was tryna be stoic with it, but it comes to a point where even the strongest you're not gunna hold them doors them shut. Once they go, they go with a vengeance."* (Arthur)

In addition, in other hugely significant metaphorical language, Arthur drawn comparisons to a time in the past when he felt more clarity and power, to one now where he feels the weight of indecision and hesitancy.

> *"I felt like I was walking in treacle. I couldn't get anywhere fast. I used to be quite decisive, and I couldn't think fast. It just ripped me soul out. I thought I was just staying out the way being quiet and I was just festering inside myself. And it took the doctor to see it."* (Arthur)

Others described an experience of therapeutic interventions that led to their subsequent social prescribing referral:

> *"Anyway, I went to this bereavement psychiatrist for 5 weeks, and then she told me about the club. I mean, I struggled really speaking to the women psychiatrist about it, all's I could do was cry. After that she then referred me on to the group."* (Henry)

Moreover, Cliff described a social prescribing referral that resulted from seeing their G.P, after discussing the loss of his wife and his mother. Following this the interviewee was referred on to a "counsellor", or therapist to assist the processing of loss.

> *"Only through talking to that girl. I was shocked by what I said because I knew it was in there. But I was shocked that I shared it with someone. If I didn't get it out, I felt I was going to physically hurt someone."* (Cliff)

Similarly, others described how they got referred to social prescribing as a result of loss.

> *"I got referred through the CVS* (*Community voluntary services*) *because I used to be involved in the resident's association in Newtown* (*Anonymised*)*, and I knew the girls down at the CVS. I've always been community orientated and my wife really was. I lost her in 2019 and I think the girls heard, and that's why I'm going to the meetings now."* (George)

Karl reported that it was the drug use that re-emerged after their loss that led to them being engaged in social prescribing.

> *"When I started using quite heavily again, they put me on to social prescribing through the drugs team. And then I jumped at the chance."* (Karl)

Offering some variation, a small number of the men reported dissatisfactory experiences of care after reaching out after their loss. This perhaps highlights the tension sometimes between finding new forms of emotional forms of meaning, in contrast to rational forms of mental health interventions that get one to think differently about their emotions. In one interviewee's account he was first referred to C.B.T [Cognitive Behavioural Therapy] before being referred to the bereavement social prescribing group. It seems to be the process-based

components of the C.B.T intervention that are reported as cold, remote, and ultimately ineffective. As we will see dissatisfaction with the perceived remoteness of other interactions is often compared with the more favourable closeness of interaction experienced through social prescribing:

> **Researcher***: What was it about C.B.T that you found lacking?*
>
> **Male participant**: *"Well I got sent to this so-called bereavement therapist. She said that I could do with some C.B.T. Well, you see I had two courses of C.B.T. I think it said up to 12 sessions. The first time I had one, the person who took it after four sessions, said well this is the last one today. And it was almost like take one of these away a printed form, and it gave me activities to do. Then she said, see if you can start going the gym once a week, and she wrote gym in the activities box, and that was it."* (Fred)

As following chapters will document, the men's reported dissatisfaction with the perceived remoteness of other interactions, some of which have been described in the earlier chapters, is often compared with the more favourable closeness of interaction experienced through social prescribing. As discussed, many of the men report reaching out for new forms of understanding meaning and advice after their loss, as we will see in subsequent chapters, this search for new understanding becomes a large part of their social prescribing experience. This combined both the search for new forms of understanding alongside reaching out for support through health seeking.

8.5 Conclusion

As we have seen, most of the men described an episode of loss that places considerable strain on their mental health and ruptures their long-held beliefs about their role and purpose in life. In response to this, the men described looking for new ways to bridge the gap of this loss

by making sense of it with various examples of spiritual and intellectual resources. Some of this content is later used to develop group cohesion and identity in their social prescribing engagement. Lastly, the men described efforts of reaching out to health professionals after loss, breaking down some of the earlier norms associated with masculinity. This concludes the chapters on the context that surrounds the social prescribing engagement, with the next chapters now focusing on the men's experiences and perceptions of the social prescribing pathways sampled.

Chapter 9: The Two Poles of Social Prescribing

The chapter will proceed by presenting narratives of the men's perceptions and experiences of social prescribing. In doing so this chapter provides a response to the second research question stated earlier at various points in the thesis: **How do these (working class and precariat) men perceive and experience social prescribing, and why?** The chapter will therefore examine if social prescribing can intervene in a context of relatively deprived power, trust, and control. Moreover, it will assess if social prescribing connects the men to resources and relationships that help move them towards sustained engagement in activities that support health and wellbeing, meeting its aims of connecting the men to what matters and tackling health inequalities (Fox and Mason, 2022).

The central analytical claim being made in the chapter is that the men's social prescribing experience operates along two poles. The use of pole here refers to two opposite ends of an item, for example, a magnet has a north and south pole. As a result of this, in connection to the negative pole, social prescribing may buffer against the weight of health inequalities in some examples, but overall seems lacking in scale and resource to meet some of the challenges associated with the men and discussed in the contextual chapters. This is connected to macro-economic policies like austerity as well as models of growth that are dependent on high levels of income inequality, and a rewarding of a culture of materialism and individualism. Nevertheless, in relation to the positive pole there are certainly examples as we will see, where social prescribing offers relational connection that is otherwise lacking in the men's lives. In these cases, this is part of the positive pole. This will be discussed further in the discussion. To summarise, the use of the two poles dichotomy, whilst unavoidably heavily stylised, offers some theoretical insight into the ways in which the components of social prescribing interact with the contexts presented in earlier chapters. Where possible the

themes follow the temporal sequence of a social prescribing journey, moving from the initial link worker engagement to the activities referred to later in the journey.

The chapter is organised around four main themes. The first theme presents data on the early conversation with social prescribing link workers. It will explore how the link worker interaction has both strengths and weaknesses. The second theme continues the two poles analysis by juxtaposing examples of when the men report scarcity and the meeting of basic need through social prescribing, with more developmental experiences where they report experiencing safety and meaningful participation in activities. The third theme explores the way in which forms of interpersonal trust really become established through the social prescribing pathways sampled, with the subthemes focusing on the different forms this took. The final subtheme explores the way the earlier forms of interpersonal trust become increasingly leveraged into networks and social capital through social prescribing. This theme again demonstrates both positive and negative components, with the men often reporting positive horizontal bonds, but also volunteering in contexts of high deprivation which may be problematic.

Figure 1: The men's cultural context and the two poles of social prescribing

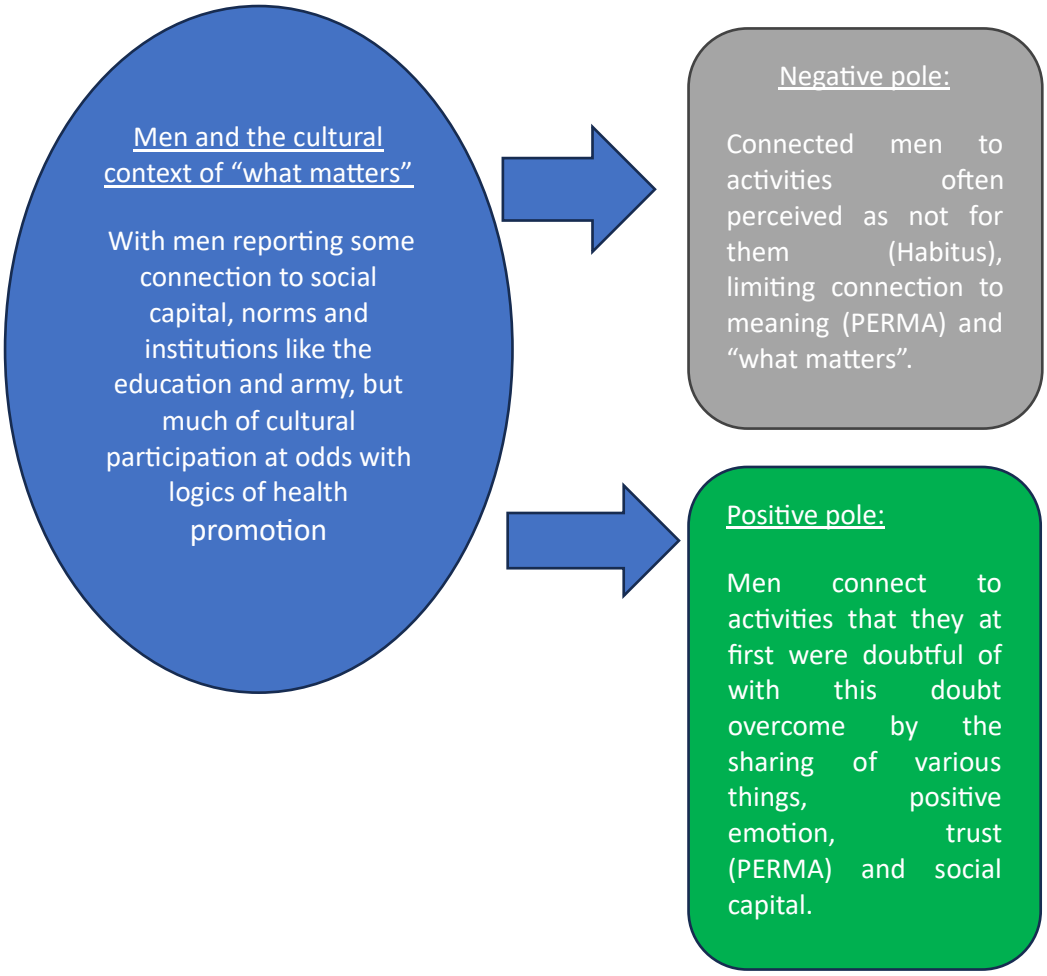


Figure 2: The social and economic context and the two poles of social prescribing

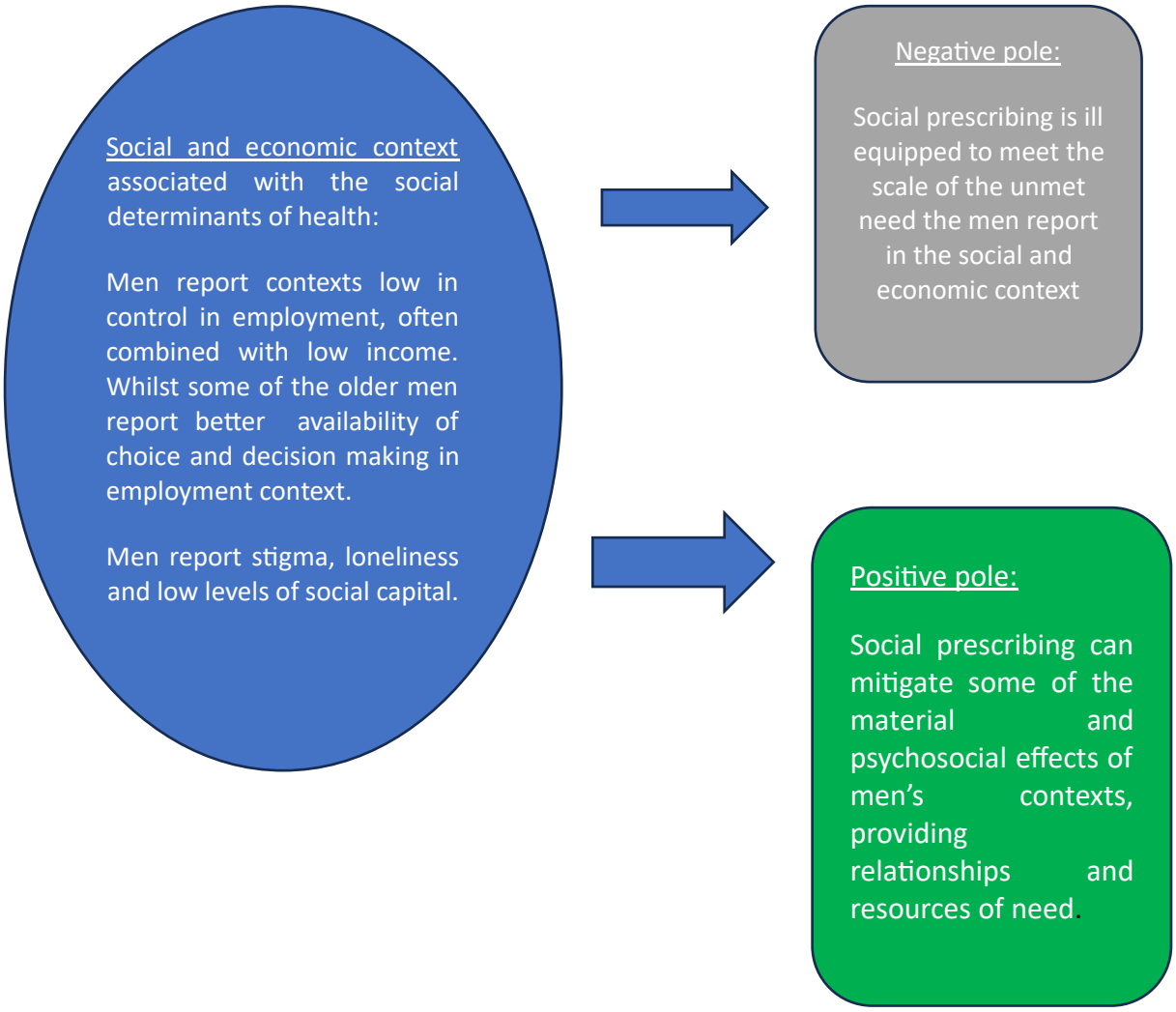
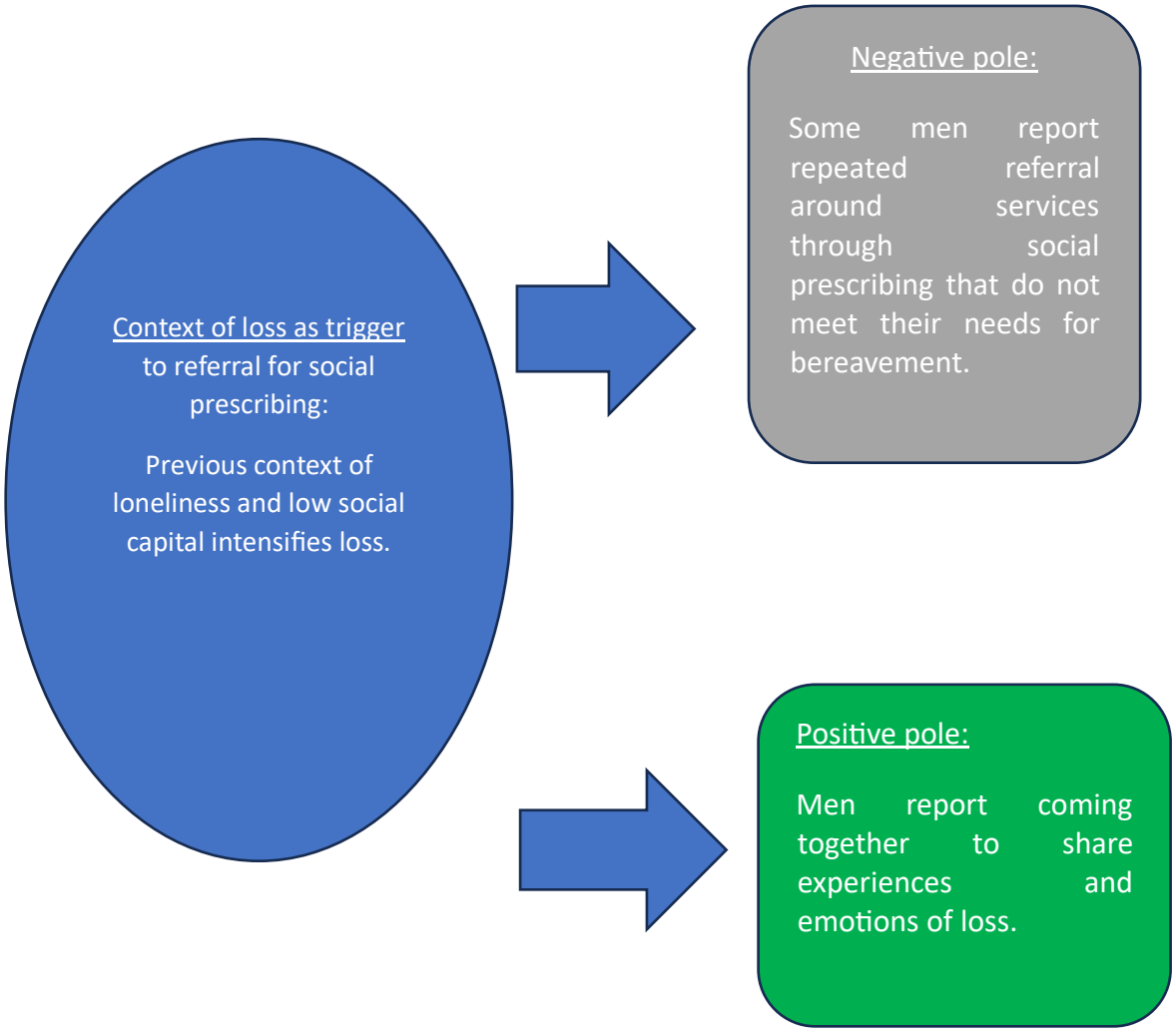


Figure 3: The context of loss and the two poles of social prescribing



9.1 Early conversations with social prescribing link workers

The first theme discusses early forms of link worker engagement reported by the men. Following referral, this takes the form of initial phone call conversations between the link worker or in person. As we will see, in line with the central analytical claims of the two poles of social prescribing, whilst the men often report favourably on the informality of the relationship with the link worker, with this contrasting with some of the negative experiences discussed in others areas of the public sector, in other occasions the link worker relationship seems ill equipped to meet the men's needs. The first sub-theme will present data from examples when the men report positively on the informal relationship with the link worker, but that this positive informality occurs often in ways that seem to breach some of the assumptions contained in the Personalised Care agenda and connecting men to what matters to them (Sanderson, Kay and Watts, 2019). The second subtheme examines how the link workers often get the men to discuss their emotions, often in positive ways that help the men move away from the strictures of masculine norms discussed earlier. Nevertheless, on some occasions, it seems the link worker seemed to rush the process, before leaving the men feeling exposed and lacking in support.

9.1.1 "She doesn't really take no for an answer": persistence, pushy or personalised care?

The initial link worker engagement was described in several different ways by the men. Despite this, a common feature of the accounts was the way in which the men discussed the development of an informal relationship with the link worker. Whilst all the men commented on this informal relationship in a positive way, it often seems that this informality breached some of the assumptions of the personalised care agenda, with the link worker using more

directive forms of persuasion. On other occasions, it is not the persuasion used by the link worker, but the inability of the link worker, or social prescribing, to offer participation in an activity that connected with the men's previous interests, skills and competencies. Often however, the men interviewed reported surprise at liking something they had not previously tried or perceived to be for them. Some of the men described how they were offered social prescribing after seeing their GP or "psychiatrist". In the following extract, Arthur describes how he received a phone call from a link worker which leaned towards a stronger style of persuasion, evidenced through the term "harassing", even when used light-heartedly, rather than a non-directive form of interaction:

> *"After seeing the psychiatrist, my GP said why don't you get involved in something called social prescribing here and you could get vouchers for exercise or do a class or some other stuff."* (Arthur)

After this he received the initial phone call from his link worker:

> *"Jasmine* [anonymised], *she rang me up, and if you know Jacky, you will know that she's quite a strong character, and she doesn't really take no for an answer. Anyway, she said, we've got these classes on at social prescribing North Wetherwell* [anonymised]. *She kept going on about the creative writing and I was saying, ermm, I don't really fancy it. Anyway, in the end she was harassing me that much just to shut her up, I think I said yer* (*with a slight laugh*). *And I've been going 3 and a half years now."* (Arthur)

Likewise, another participant reported that after a first engagement with social prescribing for anger and mental health issues, he saw the link worker he had interacted with out in his local community. This led to a second engagement. The interviewee noted that he perceived the offer of potential social prescribing activities to be female-orientated. Like the above extract,

it seems that some participants initially viewed activities as unsuitable for them because of perceived gender constraints and norms, discussed in the previous chapter. Similarly, it can also be noted that, given the history of interests, hobbies and activity engagement discussed in chapter 6, the offers of poetry, singing and drama, for example may not have been engaged with since school days, and seem lacking in congruence with their previous practice engagement. And, as we have seen earlier in the chapters on context, many of the men reported largely alienating experiences of the formal curriculum at school with the most notable example being the reference one interviewee made on English literature.

Nevertheless, like the above, we see how the initial offer was not really driven by the men's previous interests or by choice in any obvious way, but rather by quite strong efforts of persuasion by the link worker. This is likely to be connected to the constraints of activities and partnerships within some communities, or the need for link workers and those who commission activities to secure numbers on courses:

> *"I seen her out, and she recognised me* [link worker] *because I'd done a genealogy course with them earlier on in the year. Anyway, they said, why haven't you been in touch. I said, well, you said you would get in touch with me. She said, come and do another course, but to be honest the only things they had on were all women-orientated."* (Cliff)

In contrast, Eddie discussed the closeness of the relationship with their link worker as more explicitly favourable, referring to the fact that they perceived them as friends. In contrast to the above, the interviewee described a more positive form of persuasion, perceived as "persistence". This is often contrasted to other more impersonal and remote forms of interaction experienced elsewhere in the public sector:

> *"I mean I didn't really have much faith in the council to be honest. When I've had problems with my rent or whatever they just don't seem to care at all. You're just another number Whereas with Jessica, she introduced herself as a social prescriber. I didn't know what this meant at the time, but she really encouraged me. I don't feel like she works for the council, she is more like my friend. I'm happy she persisted with me."* (Eddie)

Within this section, we see a level of involvement that whilst often reported as effective, seems to bridge the non-directive gap associated with personalised care. The extracts suggest both a quality of relating and an offering of an activity that lack patient choice and control. Nevertheless, alongside this, there is a level of closeness and male participant put it "persistence", that seems to be received as positive and sits in contrast with more remote bureaucratic encounters. The next subtheme will discuss how this level of informality assisted men in expressing emotions previously distanced from.

9.2 Supporting men through emotional expression with partial success

Some of the men described their early engagement with social prescribing through the expression of emotions previously described as troublesome, with this documented in earlier chapters. Some of the interviewees also remark on their inability to "open up" to their GP, but note that through the more informal relationship which they developed with the link worker, they are now able to speak more freely. Reasons for this seem like those discussed in the previous theme. Instead of the remoteness of the council, however, the men in this theme described having a closer relationship to their link worker than G.P and even members of their own family. Moreover, in contrast to expressing emotions, others report how the link worker motivated them by encouraging them with some form of persuasion that helped them move towards tasks they had been avoiding.

> **Male participant:** *"I could not speak to my local GP, I dunno why, but I could not open up. Maybe they weren't pushing the right buttons or asking the right questions. But with* Ellie [his link worker], *the first phone call, I was on the phone for about an hour with her, and everything come out. But I don't understand the reason."* (Lenny)

Progressing his account to add,

> **Male participant:** *"Erm, I think she just asked me the right questions… It was stuff like, what happened in the past, what are you like this for.* (Lenny)

Lenny also described an experience where the link worker used empathic questioning to enquire into his past with more depth than other interventions. This offers interesting comparative data drawn from a failed experience of talking therapies for some of the men:

> *"At the talking therapies, it was just like they wanted to go with the flow. They weren't interested in me, they just wanted me to get off the phone as quick as possible I think."* (Lenny)

The similarities in this therapeutic experience are also compared to his bids for help from his mother:

> *"It's the same with me mam. if I'm on the phone to my mam and I get upset, she puts the phone down."* (Lenny)

By reflecting on the positive emotions experienced, the interviewee directly relates his previous inability to orient himself to his emotional life. In doing so, he refers to the perceived and felt constrictions of masculine norms, demonstrating how some of the issues discussed in the earlier contextual chapters make their way directly into the relationships contained in social prescribing:

> *"You know men, we're not supposed to show emotions. If it wasn't for Jasmine, you wouldn't get ney emotion out of me."* (Lenny)

This was combined with an almost cathartic and pleasurable description of releasing his emotions to his link worker:

> "It's a lovely feeling getting it all out; she will say, go on, cry, let it out." (Lenny)

Despite seemingly helping the interviewee to discuss his emotions, it seems his progression on this front was curtailed, with him reporting anger, aggression, and a return to his previous habits of using drugs in a later interview that took place at a different point in time a, month later:

> *"All's I can think of doing is going out and fighting. I'm angry, I'm sooooo angry; I've missed me calls with Jasmine* [anonymised]*, I'm just done with people – I'm done."* (Lenny)

With Lenny going further to add*,*

> *"I'm not even gunna lie to you matey, yesterday, I was that pissed off I went and smoked a dope."* (Lenny)

Other interviewees continued this theme of the link worker helping them to feel more positive emotions through tough times. A further interviewee described how this pain of his multiple losses, discussed in the last chapter, including the affair of his wife, cancer, and unemployment, were negotiated in the initial stages of his social prescribing engagement:

> *"They were encouraging me and giving me hope and really that's what I want. I'd lost hope and without hope you've got nothing really."* (Batosh)

And, in further developing this,

> *They were encouraging me. I was in lockdown; I was home on my own. I was watching T.V and I don't even know what I was watching or what was on. Your brain is miles away."* (Batosh)

Moreover, other men claimed that the link worker used physical gestures and embodied forms of communication that are described as enabling the release and expression of emotions. Also notable is the referencing of the gender of the link worker, which in this instance is male, and how his size, combined with his ability to express care, may have further encouraged emotional expression. Moreover, through describing the emotion (anger) and its release through screaming, we get an insight into the negative emotions that can be denied if the link worker moves towards encouraging positive emotion and optimism too prematurely:

> *"He's a big man Martin [anonymised] and yet he will put your arm around you. There's been a few times where I've cried. We all call him the big man, and he holds everything together. You could cry, you could get angry, you could scream."* (David)

In addition to the physical presence of a link worker to contain and support emotion, others claimed that the link worker helped stimulate him emotionally and motivate him. It seems this was only partially successful:

> *"She did her best to jeer me up and say I should do this or that. She was trying to encourage me to fill out these forms. I knew I should and I wanted to, but I just couldn't get round to doing it."* (Eddie)

This subtheme has explored how the initial link worker engagement helped them to express emotions, with some efforts clearly more successful than others. Using the two poles dichotomy, there are both positive and negative components of this. Some of the positive

components of this derive from the men's cultivation of a better way of relating to their emotions though the initial social prescribing interactions. When this fails, however, the link worker may encourage the expression of emotion too quickly, with this representing the negative component of the subtheme.

As we have seen in the above theme, often the early link worker interactions are reported favourably by the men. Nevertheless, there are often some elements of this that seem to be problematic in relation to the aims of social prescribing and personalised care. Moreover, whilst the link worker often helps the men express emotions, an impact that should not be overlooked, this often seems to be only partially successful. Here we see the two poles of social prescribing in action, with both positive and negative elements in play in the previous theme. The following theme continues the central analytical claim of the two poles of social prescribing by presenting data where social prescribing seems lacking in resources to meet the needs described in previous chapters. But that this negative pole of social prescribing sits in tension with more positive experiences where the men report experiences of a felt sense of safety in the early phases of involvement.

9.3 Meeting the needs of scarcity and safety through social prescribing

Many of the men described how their social prescribing link worker engagement was orientated towards them securing basic needs. This is sometimes, though not always, reflective of the way in which social prescribing had to adapt to the Covid-19 context. Social Prescribing was often remobilised to more urgent forms of care associated with the pandemic where rather moving people towards activities that could sustain people's wellbeing, link workers ensured that clients had basic food and goods necessary to survive. This sometimes seems representative, however, of forcing social prescribing to tackle problems it seemingly does not possess the scale to resolve. As we have seen in earlier chapters, some of this is

consistent with the link worker accounts presented earlier. Many of these seem like symptoms of a poorly functioning economy, cuts to services and widening income and wealth inequality. It follows from this that symptom of these macro - social forces which often drive social dislocation are then pushed onto services like social prescribing. Despite these problems, many of the men describe a more positive early engagement with social prescribing where they felt trust and positive emotions, often claiming that they had not experienced this for some time. These small moments of connection do often represent triumphs for social prescribing, demonstrating some examples of rapidity in reacting to the Covid-19 pandemic.

The following subtheme describes how social prescribing often seemed to be meeting basic needs and perhaps plugging gaps in other services.

9.3.1 "Practical stuff" and fish and chips: social prescribing as a gateway to basic needs

Several of the men interviewed describe experiences of social prescribing where the primary orientation of their engagement is the securing of basic needs vital to their everyday functioning. In the following the interviewee described how his main concerns discussed with his link worker focused on how he can claim additional funds to offset his time out of work:

> **Male participant** *She has been very good. Yer, when I get my hernias done, I'll need to take time off work to recover so I was just asking her is there anywhere I could go where I can claim money for my council tax and stuff."* (Howard)
>
> **Researcher:** *And do you ever discuss your hobbies with your link worker?*
>
> **Male participant:** "*Erm, not really. It's more like practical stuff."* (Howard)

Some described how their lack of income often impaired their efforts to connect to others. An interviewee would report how his lack of finances, evidenced in his inability to put credit on

his phone, often prevented him from returning phone calls to his link worker. It is the link workers persistence within this context of scarcity and deprivation that helps lead to the cultivation of trust:

> *"I mean with Jasmine, I don't have ney credit on my phone and she will keep ringing me until she gets through."* (Lenny)

Another interviewee in a context of multimorbidity and deprivation claimed that he was unable to really discern what the difference was between other areas of support he received:

> **Researcher**: *What is it that your link worker offers you that's different from the other areas of support that you're receiving?*
>
> **Male participant:** *"Erm, I'm not sure. She's a social prescriber that's what she calls herself and she knows Dr Blumenthal* [anonymised] *aswell."*
>
> **Researcher**: *Has she ever asked you about hobbies, or certain activities to engage in?*
>
> **Male participant**: *"Well, she did mention them, but to be honest, at the time I wasn't interested."* (James)

Some also described their lack of interest in engaging in activity through the doubt and caution caused by Covid:

> **Researcher:** *Has the link worker mentioned engaging in any activities?*
>
> **Male Participant** *"At the moment I don't wanna mix with anyone so, I'm still wary about that. She has asked me to a few things, but with the virus, it's just too soon for me."* (Eddie)

Similarly, several the men described how the progress they made with social prescribing had been halted by the pandemic and the Covid restrictions. Nonetheless, whilst the progress described is reported favourably by an interviewee, helping move beyond the repeated triggering of seemingly traumatic memories, the interviewee may need additional support from other expertise to ensure progress:

> **Researcher:** *So, what progress had you made with social prescribing?*
>
> **Male participant:** *"They sort of supported me through tidying my house really. It was all the bad memories from when I'd been broken into and assaulted, so I just threw everything out. I had like towels, and even pots and pans, and all kinds that were just reminding me of getting assaulted and they have helped completely throw it all out."* (Karl)

Karl further elaborated on how the arrival of Covid led to suicidal thoughts and frustration:

> *"When lockdown first happened, I was suicidal. I was like, I can't believe this I was finally getting better* (pause and laughs)*. I couldn't fucking believe it."* (Karl)

On other occasions, it seemed that it is simply the constraints of Covid that preclude further involvement and that once the Covid restriction had lifted, he may start to participate in a club or activity.

> *"At the minute, I can only do that phone therapy you know because of the Covid, but, yer, I think I would get involved like. But like I say the unfortunate thing with this Covid really is that you don't see anybody, it's all on the phone."* (Howard)

In addition, some of the men claim that it was basic forms of food that were procured by the link worker that were one of the most notable forms of their engagement; it is likely that this

was the result of the contingent charity of the link worker and their emotional investment in the interviewee, where the link worker goes above and beyond her role for some patients they have emotionally connected with:

> *"I've known Ellie for a good few years now. She's smashing. She has helped me a lot. I remember the first time I met her, I didn't have much food in and she took me to get some food. I haven't seen her for a long time with this lockdown but she has helped me a lot."* (James)

Similarly, it is not simply the food that is commented upon but much like earlier themes, it is the care and the feeling of being cared for that is valued:

> *"I remember I wasn't eating well and she got someone to do fish and chips delivered to my door and it made me feel like somebody was looking after me, you know."* (Batosh).

Often the men reported struggling to keep abreast of innovations that shape the delivery of services, and the skills required to navigate them. It is sometimes through either developing the men's skill or tacitly doing forms for them, that the men reported as beneficial:

> *"It was through the link worker's help, because she knew my circumstances. She told me to go on Secure Move* [anonymised] *which is a database of all the housing associations in the local area. They used to be council but they are private now, so you have to bid for them. She helped me bid, which I don't think she should have done to be honest, so I'm very fortunate really."* (Eddie)

Likewise, Batosh described how his flat had been adapted to assist his mobility, which had become compromised by cancer.

> *"The link worker is the most important person really. With my condition she got someone to modify a lot of things for me in the flat. Because If I got in the bath, I couldn't get out."* (Batosh)

In the above subtheme the men stated how they were supported through social prescribing to meet some of their basic needs; often this meeting of basic needs reflected a repurposing of social prescribing because of the Covid-19 pandemic, but this was not always the case. In contrast to this focus on basic needs, some of the other men report a highly supportive engagement, alongside participation in a meaningful activity, with the following sub theme documenting this.

9.3.2 "There's no judgement being made on you": experiencing safety, engagement and enjoyment

In contrast to the meeting of basic need, associated with cuts to services, widening income and wealth inequality and increased forms of social disconnection, some of the men report developmental experiences through social prescribing. These often seem more indicative of promoting wellbeing as discussed in the theory chapter. As stated earlier, some of the men described the emergence of trust in the early phases of their participation in the social prescribing activity they were referred to. Importantly, the men often comment on vital moments in early stages of the activity that were fundamental for the establishment of a feeling of safety:

> *"I walked in the room and it's hard to say, but I didn't feel a stranger, if that make's sense. It was such a small and intimate group at the time that I didn't feel uncomfortable. If I'd have felt uncomfortable, I mightn't of gone back."* (Arthur)

With the participant going on to describe the following,

> *"What it was, no pressure on you. If you wanna go away Cliff and write about whatever you want or anything that's happened here, and then come back and share it to the group next week or just to the girls that run it, and it worked out brilliant."* (Cliff)

The use of phrases like "not feeling like a stranger", and "no pressure", indicate an emerging feeling of trust and safety. As we have seen, these qualities, are often lacking in other relationships the men have experienced, supporting the positive pole interpretation of social prescribing.

In addition to reported feelings of safety, some comment on the quality of experience relaxing, or were time elapsed quickly. For example, one interviewee described a relaxing experience in the early phases of "group walks", and how this enabled him to bracket off worries and concerns in other areas of his life. In addition, though the interviewee also draws attention again seemingly to where the link worker "put" him down for an activity. While no certain conclusions can be drawn from this, it does seem that, similar earlier data, the client may have been steered by the link worker into engaging without full deliberation:

> *"I was put down for group walks and then an activity the link worker put me down for was Burgess Hall* (*anonymised*)*. It's gardening. Just outdoorsy kinds of things. That was brilliant, I absolutely loved that. When I got to the place it was like a weight had been lifted from me. It was such a peaceful atmosphere and you're looking over and you see the fields and the trees and it just relaxed me straight away."* (Karl)

Also, the interviewee described how the social prescribing engagement helped to divert his attention away from negative memories. Despite this diversion only lasting for a brief time, by engaging in new activities, the interviewee described how he was able to temporarily suspend his thoughts from his everyday concerns:

> *"Well, I think it was all the bad memories. It was kind of like someone had put me in a box for a couple of hours if that makes sense."* (Karl)

Moreover, in the poetry, some of the men report how quickly time passed when writing. This suggests immersion in the task and deep engagement. This can be contrasted with earlier experiences of negative states of wellbeing previously documented. For some men the engagement in the activity provided a release from some of the excessive worries and negative thoughts about the self, cultivating a partial release from rumination.

> *"That first hour just and we talked about a varying amount of stuff. It wasn't structured, it was more like chit chat. Like we were given a theme at the beginning to talk or write a bit of poetry about, but it was more like I just found myself doing it there and then, in the room and read it out before we left."* (Arthur)

Through developing his response, Arthur expressed his surprise in liking the poetry, perhaps demonstrating the lack of continuity between his involvement in previous practices like boxing, as contrasted with poetry. Whilst again this seems to run against the grain of a person-centred form of working through personalised care, it seems that the pleasure of the experience may have enabled the interviewee to override his unease:

> *"It was a bit of a shock that I found myself liking it."* (Arthur)

In addition, Cliff claimed that although they possess no ability in the actual activity they were participating in (namely singing) the ability to laugh and take pleasure in one another's performances provide the enjoyment required for the maintenance of the practice. This ability to laugh at one another was seemingly built upon the ongoing establishment of trust, suggesting a sense of ease in the company of the group:

> *"I've been dealing with the link worker now since October. She started up a virtual choir. We used to go to the choir in person, but now with the Covid and that it's all gone on line. I mean I sing like a cat in a back alley, but I enjoy singing. We don't just sing. We have a good conflab with the others, and laugh at one another's expense."*
>
> (Cliff)

As documented in the above theme, social prescribing seems to operate according to two poles: the positive pole seems to be endeavouring to connect people to basic needs; nevertheless, in line with the negative pole, the policy often seems to be extended into areas where it seems that the scale of the need may extend beyond social prescribing's capacity, with this perhaps symptomatic of budget cuts in other areas of the public sector. Despite this tension, some of other examples are more developmental in the experiences they offer the men through the pathway offering clear examples of where social prescribing has successfully connected men to activities likely to sustain wellbeing. Though even in the latter it seems the men's engagement is not fully driven by their decision making or deliberation. Building on this section, the next theme will discuss specific examples of where men described ongoing efforts to establish trust in the groups taken part in.

9.4 Sharing to create trust in the social prescribing activity and referral

The following theme presents data on how the men move through the social prescribing pathway into the activity, practice or group referred to. Most of the men described examples of where the cultivation of trust was facilitated by them sharing something personal within the social prescribing setting. These seem to range across three examples: namely, sharing images and tales of loss; the sharing of positive feedback through creative or physical activities; and, lastly, in a small number, the development of a safe word. The following

subthemes draw upon data from these three specific examples and describe how this took shape.

9.4.1 Getting past the "awkward" part: sharing images and tales of loss

Some of the interviewees commented on the lack of fluidity in their beginning interactions when partaking in activities and groups through social prescribing. The following man for example described feeling uneasy in the initial stages of the group.

> *"Well, I remember wanting to be around people who understood me, and who understood what loss was like, and why it sometimes makes you feel like you want to join your wife. The first meeting was a bit awkward; you know we told one another a story about ourselves, but the point that through sharing this we felt like we belonged to a group."* (David)

Another participant expressed similar sentiments about the early attendance and experience of the bereavement group:

> *"The first time we went it wasn't too good, but after a while it got better. When we talk about stories and things, not just about our wives, it takes your mind off you see."* (Henry)

In contrast to the need to take one's mind off the pain associated with loss, others claimed that the most effective moments within the group came from actively discussing, sharing, and approaching the most painful and vivid images associated with losing their wives or loved ones.

> *"One of the lads said that the worst part was when they put his wife in a black bag, so we share the experiences we've had losing our wives."* (David).

This is combined with a sense of sharing and communal witnessing of the others experience. This connects to data from the previous chapter where the men discuss searching for new patterns of meaning after losing a loved one:

> *"Although I've not met any of the others wives; I can tell you loads of things about them, and I've seen pictures of them, so I can even tell you what they look like."*
>
> (George)

This familiarity with each other's wives and the group discussion of associated memories led to some interviewees referring to members of the bereavement group as 'family'. The metaphor of the "family", seems particularly noteworthy as it is precisely elements of their family which many of the men have lost, with the void of this loss leading them to reach out and search for new engagements.

> *"We all have a story to tell one another, you know, because of the lot of the lads take interest in what you used to do. But when we're sharing stories, the club feels like a family."* (Henry)

As we have seen, it is often the sharing of emotional experiences that develops trust within the group. The following subtheme will continue the orientation of the main theme on sharing by discussing data on sharing doubt around participation in certain activities. Like the sharing of loss, this sharing of doubt is also related to the contexts discussed in earlier chapters. The men have very little experiences in the practices offered to them through social prescribing and as a result, it may be that communicating this with others allows the men to feel a space of trust and possibility often lacking elsewhere in employment or community.

9.4.2 "I didn't think what I was doing was poetry". Sharing and receiving positive feedback to relinquish doubt

A smaller number of men discussed how their doubt in early engagement in the activities on offer through social prescribing was overcome though the sharing and receiving of positive feedback from others. Several of the men described perceived doubts about the legitimacy of their creative expression or their engagement in the activity like Yoga or poetry. Often this remark was made in connection with how their output was perhaps at odds with more conventional and established forms of practice or engagement associated with the activity This doubt is likely to connect to the sample's social class or position in social space and their possession of economic, social, and cultural capital, as many of the men had not previously engaged with the practices offered to them. This has been documented in previous chapters, where many of the men describe a history of cultural engagement that runs counter to the activities likely to be contracted in by the public sector. For example, many of the men described boxing, football, rugby league and gambling; others reported carpentry, reading of historical fiction and comedy. None of these activities were drawn upon in the social prescribing pathways sampled. This suggests that there may be a cultural bias in the activities that offered, contracted, and partnered with through social prescribing. Despite that as stated earlier in the chapter, some of the men interviewed report positive experiences where they were able to overcome their doubt:

> *"I didn't think what I was doing was poetry. There was no grammar, no punctuation, or whatever, it was just my thoughts coming out of the end of the pen on to the page."* (Arthur)

Despite this self-doubt, another interviewee implicitly notes the positive emotion felt by moving others through the performance of his poetry through the expression of emotions and

experiences that again involved the loss of a family member, a common theme across the men interviewed:

> *"Anyway, the first proper thing I wrote was called the Distant Lady* [renamed] *and it was about my wife,* [recently deceased], *and Maureen* [anonymised] *started crying and Carol* [anonymised] *started crying, and I was gobsmacked. It wasn't a sad thing you know; it was about my grandkids and that as well."* (Cliff)

Likewise, Arthur described something similar:

> *"Anyway, I wrote this piece and Maureen* [*anonymised*] *turned round and said, "you've got a real talent there", anyway, I said, don't start (laughing)! The last thing you want is false praise."* (Arthur)

Again, the interviewee developed his response to suggest that by evoking an emotional response in others, he felt a sense of power. As we have seen in earlier chapters, the ability to influence others is a quality lacking in many of the men's lives:

> *"When I read it out, it touched people so, I mean, to know you've made someone laugh or made someone cry, that's a powerful thing that mate."* (Arthur)

In addition to the above, the interviewee developed his response to combine the power of moving others, with a feeling of positive emotion:

> *"It really gave me the lift I was looking for; it really cheered me up."* (Arthur)

In addition to poetry, two of the other interviewees discussed engagement with chair assisted Yoga as part of their social prescribing referral. As seen in the previous chapter, in the theme titled "searching for new meaning after loss," many of the men describe spiritual and quasi - religious experiences after their loss. The seeming underlying need for these experiences

somewhat connects to the broader appeal and growth of eastern spiritual traditions into western professional medical knowledge (Kabat Zinn, 2021; Fox & Mason, 2022), with several link workers and interviewee's describing the inclusion of yoga as part of the social prescribing referral.

Batosh reported positive experiences of a chair assisted Yoga class. More specifically, he described the skills learned in regulating his breathing through the class. Alongside his skill development, the interviewee expressed similar forms of doubt after falling asleep in a Yoga class. This is combined with the interviewees reflection that he had no knowledge of Yoga and had never "seen" it before. If this is the case, then it seems the link worker again may have taken the lead in referring the interviewee onto an activity he has no previous awareness of. Also, as discussed in the earlier link worker chapter, some forms of social prescribing pathway involve the use of payment to gain admission to classes

> *"You pay three pounds. The first time I did it I was a bit sceptical. But then once I knew what it was about, I was fine. There is nothing wrong with doing it at all."* (Batosh)

With Batish going further to add,

> *"You get your breathing control right and bring your heart rate right down. She starts putting very low music on. I actually fell asleep a few times. And I told her, because I was a bit embarrassed. She said it is not unusual a lot of people do it.* (Batosh)

As with other interviewees earlier in the theme, the doubt was assuaged by the course deliverer, who reassured the interviewee that this was a frequent response to the relaxation techniques in the practice. Also, as discussed in the earlier link worker chapter, some forms of social prescribing pathway involved the use of payment to gain admission to classes. It was reported in the link worker account that this was often more successful than putting on classes

for free, but no evidence can be confidently drawn upon this here. Nevertheless, social prescribing seemed to be used to partner with and help scale local health classes and assets; as we have seen however, when those who engage with social prescribing cannot put credit on their phone, to give an example from an earlier interview, the charging for classes may be problematic and erect further barriers to participation for those who need it most.

9.5 Social prescribing as space of enquiry: creating and sharing a safe word to manage discussion and build trust

A small number of interviewee's described how the group they were involved in created its own norms and processes designed to develop trust. These were successful according to the interviewees. Moreover, this data described how the social prescribing activity sometimes function as a space where political discussions take place, and are, in a small number of cases, allowed to flourish. If, however the discussion gets too heated, the brake is applied by using a safe word – a device used to generate trust and respect one another's limits:

> *"Valarie* [anonymised] *who runs it, she's from Belfast and she's proper, proper, how can I put this, well she's very political. I mean I think she's had to calm down a bit. Her moral outlook is like welfare rights, whereas one of the other girls is a Tory. There was one day where it was on the brink of getting a bit out of hand and it did sort of leave an atmosphere. I think someone was called like, what's that word, a snowdrop. So now we have a safeword, and if it gets too heated then we just say that and move on to something else."* (Arthur)

With Cliff making a similar reference to the same device:

> *"The level of trust in the group is incredibly strong, and we've got to the point where I think whatever is said in that group doesn't leave the room. Like I say we have a*

safeword because it can get a bit heavy at times and we don't all share the same opinion, but as soon as someone says that we just move on." (Cliff)

This theme has documented three examples of how the men described how trust developed in the activities they engaged with. This trust was developed even though the men often report hesitancy and doubt in their initial partaking in the activities connected to social prescribing. This development of trust through the early stages of social prescribing is a part of the positive pole of social prescribing. The doubt report is likely to be intensified because of the lack of congruence of the activities offered with the men's previous history of activity engagement. Whilst it is impressive how this was doubt was overcome by the men, some of the other men in the sample who reported more hesitancy in engaging in groups through social prescribing may have found this doubt too much to overcome. This will be discussed in more detail in the discussion chapter. Furthermore, in the final subtheme, we have seen that the group developed and shared a safe word to facilitate discussion on political and contentious issues.

The following theme will discuss how the reciprocal relationship of giving and receiving help is described by the men. In following the major analytical claim of the two poles, the theme will discuss the way in which this exchange although sometimes supporting the men and enabling them also seems to be reproducing the very power differentials reported in earlier chapters.

9.6 Receiving, volunteering, and delivering help through social prescribing

The men described examples where they had received or given help through social prescribing. Often when receiving help by those perceived or more powerful, the men seem to express a highly hesitant response to the assistance they have received from others. On other occasions the men seem to feel somewhat exploited. In contrast, for others who are

receiving help and attention from those with greater power is a source of pride, again stressing the central analytical claim of the two poles of social prescribing. Whilst there is some overlap, the men also described examples of where they have volunteered to help others, often through donating money to charity. This is frequently in cases where the men are unemployed and receiving benefits. Whilst this is often stated as developing their confidence or allowing them to exercise behaviour that is consistent with their idea of duty and obligation, it is again, not without its problems in the context of unemployment and scarcity of income, wealth, and even social relationships.

The following sub theme will document examples of where the social exchanges that occur through the social prescribing pathway sometimes seem at first glance to be connecting the men up to powerful others, but that this sometimes is reported unfavourably by the men. Perhaps more importantly, there are times that even when the experiences are reported favourably by the men, that objectively, that is through the analytic lens offered here, they seem problematic and exploitative of power differentials.

9.7 The beginnings of bridging/linking social capital: the two poles of social prescribing and connection to others more powerful

Many of the interviewees described how social prescribing often acted as a bridge to other more financially, socially, or culturally powerful organisations. For example, organisations like the BBC, Channel 4 news, "buddy groups", and drama organisations, took an interest in the work of the social prescribing pathways sampled and looked to facilitate partnerships with them. Often, these experiences are described with great pride and pleasure, but sometimes the interviewees tended to implicitly describe feeling exploited or displeasure at the experience. If, as we will see, an interviewee feels like he must make good T.V. to receive help, then he may feel like his care is contingent upon his exhibiting certain forms of conduct and

behaviour. Rather than engaging in an activity, some of the men, often the older and more isolated, were signposted to friendship or "buddy" groups. The following interviewee describes how he connected to two professional people, almost conveying disbelief that they would want to take interest in his life and make friends with him.

> *"She would phone me every week for nine months, and she put me on to Friend Connection* [anonymised] *were I've met a nice lady who rings me every week. We've made really good friends. In fact, both her and her husband came and visited me recently at Christmas and brought me some food and things in a hamper, which was lovely. And, I mean she is quite high up in the NHS as a nurse, and her husband is a professional person aswell. But I just can't understand why they would want to help me."* (Eddie)

Whilst the account perhaps overstressed deference and gratitude, the interviewee does also describe times where exercised choice and dissatisfaction at the earlier connections provided by the link worker:

> *"I mean I should say that I was paired with another friend before this, but we never hit it off so Jess swapped them for me, no problem."* (Eddie)

Others claimed surprise and almost disbelief that their social prescribing experience may lead to a paid salary; again, like the above, this offers an insight into how power and status interact with the social prescribing experience.

> *"I mean, I really loved the experience of the nature walks. I keep meaning to go and see them again actually because they need some help with a few projects. I think he was after me helping them out a few hours a week and actually getting paid for it."*
>
> (Karl)

As stated, other efforts towards bridging the gap between those with more power and capital can be found in numerous examples where national television corporations whose primary aim is to shape and meet the cultural needs of the public like the BBC and Channel 4, visit the social prescribing groups. The visits mainly centred around publicising the creative output of groups and documenting their activities, but also interviewing those that were chronically ill and isolating during lockdown. Often these experiences were deemed a source of pride, with the ability to showcase published work:

> *"The week after the BBC joined us. I got pulled out and they wanted to interview me about all different topics related to social prescribing. They just wanted to document the work the group had done, and they said some of it was very powerful stuff, you know some of our poetry. Us as a group, we were pinching ourselves."* (Cliff)

Some, on the other hand, describe a more ambivalent experience of this type of bridging relationship, combined with an exploitative feeling seeming to be conveyed, with Batosh seeming to dislike the public viewing of the expression of his pain and illness.

> *"I had a phone call from Nathan (anonymised), he'd spoke to Ellie (anonymise). He was doing this program about people who were isolating who were ill. Apparently, it was for the news on how people were staying in and how they feel and whatever. So, he gave me a camera, and stuff to document what I was doing."* (Batosh)

Despite this effort of publicising the interviewee's experience, he reported feeling somewhat uneasy and perhaps exploited by the process:

> *"I didn't really like how it came out in the end. He was very helpful, but I'd rather keep things like this to myself."* (Batosh)

Here it is the connection with others in more power and capital, can, rather than supporting the men, as the aims of social prescribing state, rather make them feel displeasure and perhaps exploitation. In this extract the interviewee seems to feel like he has having something imposed on him, rather than making a committed choice to partake in the project with the television company. This seems like a form of paternalism and is like some of the link worker referrals to activities where the men do not fully discuss or decide in the activities they engage with. In contrast with the above, the following section examines how the men have also developed more horizontal bonds with others of a similar social class, or suffering from health problems, with this representing a more positive pole of connecting with others.

9.8 "It feels good helping people": The beginnings of new forms of community

In contrast with the last sub theme, but not without overlap, some of the men progress from being users of social prescribing to volunteers and delivers of social prescribing initiatives. Some of the men described how, through becoming link workers themselves, they have gained new forms of community involvement. Andy explained how his experience of social prescribing led him to meet two of his closest friends, before proceeding to describe how he has taken on more of a leadership role in his local community as a link worker:

> *"Anyway, I went on something called the expert patients programme which was the start of social prescribing in this area. On this course I met two of the best friends that I've ever had in my life. One of them looked like he was gunna hit me the first time I met him, but now I realise that it was because he couldn't speak out. I'm there talking about all my mental health issues, and he was looking at me like, can you read my mind, cus I were saying how he felt."* (Andy)

With Andy connecting the change he felt at personal level, in being the voice for others in his community, to the broader change he has experienced in his Northern community:

> *"Communities around here starting breaking down in the 90s. I reflect back on the old communities, before the mines shut where there was always someone on the street who knew about this, or who knew about that. I mean it wasn't perfect by any means, there was always bitching and gossiping, but there was always somewhere to turn."* (Andy)

Through connecting his narrative of personal change with a broader policy perspective, the interviewee provided a critique of the breakdown of working-class communities in the North. In doing so, he highlights elements of social change of perceived importance: namely, that the loss of industry also led to loss of community and social trust, leading to isolation and loss of identity. The interviewee then claimed that social prescribing is best suited to fit this void, by seemingly helping people to regain power over their condition, without creating dependency.

> *"So social prescribing for me was a revamp of the old communities. Okay, you've got a problem, were not gunna fix it for you, but were gunna enable you to sort it. We are gunna show you so you begin to feel empowered again, so you're not a passenger in your condition."* (Andy)

Others discussed how the experience of previously being an economic motivated them to volunteer with assisting "refugees". Connecting with the friendship scheme discussed earlier, with Batosh's volunteering arranged by his link worker. In the following, the interviewee described how he assisted refuges with the paperwork and cultural requirements of citizenship:

> **Researcher***: So what's your experiences at the buddies group been like?*
>
> **Male participant:** *"Yeah, I like it. I help look after some Syrian refugees. I go to help them and translate for them. I got some paperwork done you know for the families so*

their kids could go to school. So we all help one another because they are refugees and it's not their choice to be refugees; it's good".

Researcher: *So you've sort of become more active in the community I guess?*

Male participant: *"Yeah, it feels good. It feels good helping somebody. I haven't got much money but even a few quid, I'll give the kids a few quid here and there and it feels good. It made me feel better you know."* (Batosh)

Thus, feeling good from giving to others, often associated with a form of duty, can sometimes seem problematic when the interviewee is not in paid employment. For example, in the following the interviewee described an incident when his employers visited him after learning that he was unwell from cancer. Interestingly, they had found this out from his involvement in the T.V. production described above not through the interviewee communicating his problems with them. Moreover, the employers had also recently made the interviewee redundant from his job just prior to him receiving the news that he had cancer:

"They heard I was ill because I was on TV. They brought me some money that they raised in a whip round at work, but even though I could have done with it, I donated it to Buddies for You [Anonymised befriending group] *to help them."* (Batosh)

Cliff described how this new form of community engagement provided connections with other men's groups. The following interviewee described how he shared his poetry with a local group focused specifically on tackling men's health. This experience also seems to have been a source of pride for him and his son, who took the opportunity to secretly video and archive the reading of the poetry.

> *"I've been on to men in shed's this morning* [*anonymised*]*, you know to read my poetry. I read them walking the line, you know about men's health. It went down quite well. My son came down to set it up, you know because it's all online. They all seemed to like the poem and after I read it I didn't realise at the end he (son) was videoing me the little bastard."* (Cliff)

This relationship can be contrasted to the more vertical forms of bridging and connecting with larger corporations documented in the previous subtheme. Here all the men connect with and do work with others with similar power and experiences to them. Whilst this seems to be reported favourably and be an important component of restoring their confidence, when the men also report receiving benefits or are without paid employment, these experiences seem problematic and can be exploitative of the lack of power and esteem they currently hold without these basic goods and experiences.

This theme has presented data on the variety of ways in which the men report connecting with others through social prescribing. These range from friendship groups, to volunteering, and being involved with large media corporations. The theme has shown that whilst these experiences are often reported as positive, in some examples they seem to perpetuate and reproduce some of the negative relational dynamics discussed in earlier chapters on context. This is by no means on all occasions, with this theme again continuing to demonstrate the strength of the main analytical point being made in the chapter on the two poles of social prescribing.

9.9 Conclusion

As shown in the chapter, the men report a wide range of ways they have experienced social prescribing. Many of these experiences and perceptions seem reliant on the mechanism of

trust; nevertheless, given the previous discussions on context, it is argued here that the social prescribing experiences and perceptions seem organised around two poles, one that is servicing basic needs and picking up gaps in services, with another that is providing relationally responsive forms of care that are often compared favourably to other institutions and policies, with these relationships often leading to sustainable forms of wellbeing and practice engagement. The following chapter is the final findings chapter and will draw some conclusions to men's social prescribing experiences.

Chapter 10: Social Prescribing, inequality and wellbeing

The final findings chapter will build on the focus on the previous chapter, drawing some conclusions on the social prescribing experience for the men, before making more substantive theoretical connections in the discussion chapter. Towards this end, the chapter is orientated around discussing three primary experiences of social prescribing reported by the men, with these organised around three main themes: firstly, many of the men report finding connection with others, albeit largely within a context of social and sometimes material deprivation; Secondly, the second theme focuses on how some of the men report finding new forms of meaning, purpose, and wellbeing through social prescribing. This is reported through participation in new activities, practices or groups that have helped redirect the men towards new forms of engagement. Thirdly, the last theme focuses on when the men report an unsuccessful or failed social prescribing experience.

It is in this chapter that the methodological choices on critical realism offers a distinctive approach. The multiple levels of analysis which the method supports are drawn upon to make connections from the micro subjective reports the men offer to the broader meso and macro context of their lives (Fancourt, 2021). The chapter will also document what some critical realists refer to as the "silences" in the data (Fryer, 2022). Whilst very few of the men explicitly report an outright negative experience of their journey through social prescribing, as the title of the chapter suggests, even the reported positive experiences of social prescribing described by the men must be viewed within a broader social context of loneliness, loss, and a lack of capital and power. As we have seen, this context was documented in the previous chapters earlier in the thesis. In doing this, the chapter cross -references the men's subjective appraisal of social prescribing with other perhaps objective areas of their social context. That is to say

that whilst many of the men report positive perceptions or experiences of social prescribing, they continue to report loneliness, isolation, and intense negative emotion alongside this, with these reports running in the opposite direction to some of the components of wellbeing described through PERMA. As a result, this chapter ultimately argues that social prescribing lacks the scale or the reach to reverse some of the forces that have left the men isolated and adrift, much of which has been documented previously. When social prescribing does have success through its positive pole, this is through connection to meaningful activities and supportive relationships. It must be stated that the social connections and activity engagement that the men report must always be viewed against the background context described in other chapters, but also cross referenced with other data that the men offer on how they feel about their lives.

10.1 Negative pole of social prescribing: positive experiences within a broader context of social inequality

Many of the men describe a positive experience of connection through social prescribing; however, this sociability is reported within a context of relative loneliness, negative emotion and a lack of power associated with other areas of their life. For example, the following interviewee described a positive form of social connection made through the social prescribing process after being referred to a "friendship group" claiming that:

> "*They've become very good friends… she rings me up every week and I really look forward to her calls."* (Eddie)

Following this, Eddie described meeting people he never would have encountered in his everyday life, conveying perhaps the gap in perceived status:

> *"It's only through Ellie* (*anonymised*) *referring me that I would never have met in everyday life in the pub or something, that I've now got two very good friends. She's a nurse and he's also got a good job."* (Eddie)

Eddie further developed his narrative to offer a description of how his experience with the link worker has renewed his sense of trust in others; in the following extract he described feeling a renewed sense of faith reported as a renewed sense of trust and optimism in "human nature". This connects with some themes of earlier chapters, especially in the chapter on loss, where many of the men draw upon spiritual or religious forms of understanding and meaning to make sense of their loss, to gain some form of understanding and direction.

> *"Ellie and social prescribing, it's opened my eyes that there are nice people out there. I didn't realise how nice people could be. She has restored my faith in human nature and human beings."* (Eddie)

However, the expression of renewed optimism and trust at the cognitive and narrative level seems to sit in tension with an embodied feeling of malaise and low mood. The ties of social connection cultivated through social prescribing therefore must be viewed against the background context of the men's lives. Evidence of this is framed within the context of the link worker helping the interviewee to move from his "hell hole" flat, into a bungalow. This is also combined with a restructuring of his benefits. Whilst the interviewee noted the positive impact these changes have had in his life, he combined this with ambivalence. In the following he reported he remained lost and lacking in motivation. He noted that the positive emotion he expected to feel given these changes had not occurred:

> *"The only way I thought I was gunna get out of that hell hole was if I won the lottery, but I just feel sluggish and lethargic; I should be hysterically excited really. I mean I've*

> *got eighty pound a week extra but something just isn't right. And my tenant's amount, which* Jasmine [anomymised] *helped me fill the forms in for have gone into my account. It's a lot of money. I mean I'm even looking to get a cleaner in."* (Eddie)

Despite this increase in finances, as facilitated through the social prescribing link worker restructuring his benefits, when asked if he could remember when he last felt a pleasant emotion, the interviewee could not retrieve an example from recent memory:

> **Researcher:** *Can you remember the last time you felt significant forms of positive emotion?*
>
> **Male participant**: *"Wow, that would be a very long, long time ago. Probably when I was on the karaoke circuit - probably then with my old mate."* (Eddie)

Eddie then went further to add that his hopes of ever recreating the strength of his partnership with his deceased friend was unlikely. This is substantiated through his self-stigmatising remark that he is a "lonely old man". This was tied with other areas of regret:

> *"I don't think now I'll be able to meet anyone with that same feeling. You know it took years to get to know him. I'm just a lonely old man now* [laughs]*. My days of pulling the women, that's gone as well. I mean at one time I wouldn't have thought twice about going into a pub and chatting the bar maid up but not now!"* (Eddie)

Here we can see that although Eddie makes enthusiastic claims about the impact of social prescribing, when these claims are cross - referenced with other areas of life, they seem to lack the necessary force to alter his emotional state.

Similarly, other interviewees describe a positive impact of social prescribing, highlighting its merits in reintegrating people perceived to be like him, back into the community.

Nevertheless, this positive evaluation is once again combined with a private sense of malaise and self-reported depression that seems almost untouched by the social prescribing experience:

> *"Well, they've been absolutely very good. It's been a good few years I've been involved with them now and I thanked them again today for supporting me. I think social prescribing has been a good system to get people like me kind of back into the community."* (Micky)

This positive evaluation of the impact of social prescribing, however, again sits in tension with a more private form of despair and pain over the loss of his wife:

> *"They say times a healer. I have no idea where they get that from. I feel worse every day. I'm taking antidepressants at the minute. I think it's only a low dose like but to be honest they haven't made me feel better at all."* (Micky)

Moreover, others positively described the power of being a member of groups where they can use their lay experience of pain to help others. For example, some described volunteering to help addicts and those suffering with mental health problems. In doing so, Karl described how he was connected to a volunteer group through social prescribing where he felt pride in helping people face the associated problems with addiction. Karl claimed these experiences enabled him to regain his confidence by feeling valued and competent.

> *"You know, it was Jasmine (anonymised) who sorted out the volunteering and it was done in matter of hours. The volunteering is helping me tremendously. I've gotten my self-confidence back."* (Karl)

Going further Karl described:

> *"Through the volunteering and stuff, I think my wellbeing is better now, my relationships with my family are better than they were, and a lot of that is because of the progress I've made with the link workers."* (Karl)

Karl then claimed that his late father would have been proud of his volunteering. This connects to how the renewed form of meaning and purpose that social prescribing has given is tied to the losses discussed in the earlier chapters. The changes Karl reports are evidenced in the following extract, which demonstrate clearly his pride at his development through social prescribing, combined with a detailed vision of his future that ultimately derive from the support received through social prescribing:

> *"You know I'm going to be secretary of Friends for You Soon* [Anonymised]*, and I know that my dad (who passed away a year ago) would have been proud of me which is really nice because I know a lot of times this wasn't the case. I'm now doing quite a bit of community work with both Newtown (anonymised) Buddies, and Saint Vincent De Paul* [Catholic voluntary organisation]*."* (Karl)

Like the other data presented, Karl's positive appraisal of his volunteering is combined with a broader context of loneliness in his personal life. This is also combined with the fact that he is currently on benefits: whilst unpaid volunteering may have its benefits in helping people gain their self - esteem and competence in a flexible way, it may be exploitative. Moreover, whilst some of this he perceived as necessary to break away from the corrosive influence of drug dealers, it still indicates how social prescribing is offering only a slender thread of connection in an otherwise isolated life, with much of this isolation driven by negative structural changes that have worked against the interviewee, ranging from stigma, racism and unemployment:

> *"Outside my family, I don't really have any friends. It does sometimes bother me but also there's positives because I've had to cut a lot of people out of my life that were no good for me. Hopefully soon I can start hanging round with some good people again."* (Karl)

Continuing this theme, the subjective positive appraisal of social prescribing is often combined with a broader reportage of disconnection. This is the case with the Batosh reported feeling that he had "been given his life back", before he proceeded to describe the continued pain felt in his private emotional life alongside his reluctance to discuss his emotions with others:

The participant also reported that his relationship with the link worker repetitiously reinforced an optimistic vision of the future; this was especially the case during the Covid-19 lockdown.

> *"I've been through it all with Ellie. The cancer, the radiotherapy, the affair, Covid: they've just about kept me going. They've been on the phone to me all the time and have given me hope that I would get through it, you know saying like "it's only matter of time before you see your family again."* (Batosh)

Alongside recognising the need to communicate better, Batosh described how it is only through being interviewed for this project, and through his conversations with the link worker, that he has begun to discuss feelings and emotions with others. As we have seen in earlier chapters, much of this is down to some of the perceived "vices" discussed around male norms, especially those that connect to masculinity and male socialisation; again, however, we can see that the stoic ethic many of the men interviewed discuss interacted with the relationships involved in social prescribing. This is substantiated in the following where the interviewee claims that he has never told anyone about his problems.

> *. It's wrong really. I should share things, but it's very hard for men to share things. A couple of years ago, I wouldn't tell you what I think, whether it's because of my culture {*born in a Muslim country], *I do not know*". (Batosh)

The link worker's role in helping the participant talk about his emotions, given a reported history lacking in this, represent a positive and innovative element of the relationships built in social prescribing. As we have seen in the previous chapter, these relationships seem built on closer bonds than others experienced in the interviewee's journey through other forms of healthcare and better resourced areas of the public sector. Despite this positive pole of social prescribing, the interviewee proceeded to describe an ultimate regret at finding himself in his current predicament. This was combined with a regret that he needed social prescribing's help at all. This report substantiated the central argument of the chapter, that the subjective appraisal of social prescribing is often accompanied by a broader social form of distress:

> *"The only thing I wish I would have improved is I never should gone to social prescribing in the first place. None of this should have happened to me, full stop, but they have been very good."* (Batosh)

In addition, Howard noted how social prescribing impacted them by drawing more extensively on the need for more funding and scale for policies associated with care and relationships, combined with a common theme that men often find it hard to discuss their problems in more formal healthcare settings:

> *"She's helped me so much, Gillian so much I do think there needs to be more money poured into people who can listen and understand a bit. Sometimes you go to your G.P. but you can't really chat to them. You need people like Gillian and more of them. I think we're very lucky to have them. I mean the talking therapies she put me on to have been*

> *useful, but for me we need more people, especially after Covid, more face-to-face conversations."* (Howard)

Like other data presented earlier in this theme, however, the positive report of the link worker relationship is combined with an indication of his own personal malaise. This was intensified by Covid, but pre-existed it:

> *"I mean I was going out for walks nearly every day, you know going the Asda, but I've got a bit of anxiety at the minute with it all (Covid and furlough). It's like cabin fever to be honest, staring at the walls."* (Howard)

The section demonstrates that despite several positive evaluations of social prescribing, many of the men also report a broader context of social isolation and negative emotion; that is not to say that the positive experiences and evaluations men report should be distrusted, but when they are cross - referenced with other data from their lives, the impact of social prescribing seems less impressive in improving the health and wellbeing of the men. The following section describes how the men report the impact of social prescribing through forms of meaning and activity engagement, with much of this representing more positive and sustainable connections made through social prescribing.

10.2 New forms of meaning and engagement within a context of relative inequality

The following section examines the way several men described the impact of social prescribing by cultivating new forms of meaning and engagement. In the first subtheme, the men described the cultivation of skills through new activity engagement. In doing so, the men described how the skills learned through social prescribing engagement transfer to the context of their everyday life, demonstrating some clear movement towards sustainable engagement

in practices that support wellbeing. The first sub theme discusses the skills learned by men who engaged in Yoga and poetry through social prescribing. The second subtheme discusses the emotional impact of practice engagement that some of the men described as a new sense of direction.

10.2.1 Yoga and poetry: the negotiation of masculine norms when participating in new activities

Some of the men described the impact of social prescribing through the skills, learning or emotional regulation they gained through participation in activities. Batosh, for example, described how his practice in Yoga had allowed him to regulate his breathing, even in his own personal time, helping him to manage his emotions:

> *"After taking part in the classes, I can control my breathing and you know and I can sit down now and do it myself and the movement, and the movement you're moving all your muscles while you're sitting down believe it or not."* (Batosh)

This impact is again noted through the positive emotion which he describes from his practice engagement; in line with the broader theme of the chapter, however, this positive appraisal must be read in connection with the broader context of the men's lives:

> *"It makes me feel happy when I come out. I'm relaxed. Sometimes I'm not, it depends what I'm thinking about. But it makes me relaxed, makes me feel good."* (Batosh)

In addition to this example of seated yoga, others described how, through their engagement in poetry, they could now write their feelings and emotions down on the page. This helped some of the interviewees to manage their feelings, thoughts, and emotions; thus, getting them down on paper helped them to communicate their feelings to both themselves and others:

> *"I don't write for anyone else; I write for me, and the way it makes me feel. My head was jammed full of thoughts I can capture my feelings and put pen to paper."* (Cliff)

Similarly, Arthur notes the pleasing experience of getting their emotions down on paper:

> *"My head was spinning around with stuff and now I can get it out and do something with it - channel it."* (Arthur)

Arthur also describes how this management of emotions or thoughts has given them more confidence and has provided them with more structure throughout the day:

> *"I can be up to three to four in the morning to get something on paper. If I don't get it down I'll forget it. Since I've been involved in the groups, like my days are full of ideas, because I have a bit more confidence now in doing something with them."* (Arthur)

Some also described how through the practices connected to through social prescribing they had implicitly tried to negotiate masculinity. For example, when asked why the content of the poems seemed focused on masculinity or men's mental health, with metaphors like the "warrior" used repeatedly in the title of their poems, the following male interviewee replied:

> *"I never gave it any thought of the time, I just started writing and it flowed. I don't remember thinking, oh I will write about this, it just sort of happened*." (Cliff)

Arthur discussed similar themes:

> *"Ermm I haven't really given it any thought. It might be because were from Northern towns and that, you've gotta fight to get your place in society, you've gotta fight to keep your place in society, you've gotta fight to get jobs, everything's a struggle really. So I suppose it's that way of thinking about it."* (Arthur)

The need to fight within the social context was followed with a description of an internal fight against himself:

> *"And also it's fight or flight with yourself init. I sometimes feel like I'm fighting off an inner demon inside. Some days it wins, but other days you just about beat it to the punch... but it's a fine balance. My tendency is to keep locked away when I get like that."* (Arthur)

As shown, through engaging in social prescribing, some of the men used creative practices like poetry and Yoga to help them make sense of their emotions. Importantly, and as stated, this was often done through images and theme like the "warrior" that are drawn upon to make sense of the struggles of everyday life, both internal and external.

Moreover, some of the men described how they had participated in a course on Stoicism through social prescribing. It was then reported that this philosophy fitted with their own worldview and norms of emotional restraint, although as discussed in the chapters on the male cultural context, often this seemed closer to emotional denial and rugged individualism:

> *"We've had guest speakers in like local poets and we also did a course on Stoicism. Although I didn't understand a lot of the terms, when you unravelled it, I was already doing this but I didn't know it, it was just what was passed down to me. So I turned round and said to them, I've been doing this for years but I didn't know use called it that."* (Arthur)

In the following the interviewee is critical of the perceived overuse and misuse of mental health prevention, combined with a broader criticism of a culture deemed to have become "namby pamby":

> *"I do think we are living in a bit of namby pamby culture at the minute. I've noticed it at the football. You're scared of saying things to lads in case you upset them or their mental health."* (Cliff)

Going further to report how social prescribing interacts with masculinity:

> *"Before I went on the courses, I have never heard anything about mental health and wellbeing. It pisses me off to a certain extent, it's like a catchphrase at the moment. I mean I think it's great bringing the attention, but I think it's being abused for financial gain. Everything is getting put down as mental health."* (Cliff)

With the interviewee further elaborating on how claims on mental health are misused:

> *"It's making it harder for genuine people to do something about it. Yes, of course, protection is better than cure, but don't be just saying things because you think it will get you a grant."* (Cliff)

As we can see, the positive impact of social prescribing is connected to the way in which nontraditional masculine practices like poetry have allowed the men to creatively rework traditional masculine themes like the "warrior", and connect to philosophies that stress resilience. This seems to both have positive and negative qualities: whilst it may connect men to philosophies they are familiar with, allowing them to rework them towards ends that better support wellbeing, this continuation of emotional restraint may be problematic. If it highlights discipline and restraint without social interdependence, it may reproduce patterns associated with individual self -reliance, even in contexts of deprivation where collective solutions are required. In addition, despite some of the men claiming that they now have a better relationship with their emotions, largely because of the practices involved in social prescribing, they often remain sceptical about some of the broader claims of the emergence

of "wellbeing" and the concepts used in policy rhetoric. This is an important point in ensuring the design of social prescribing programmes and other public health programmes can navigate the balance between engaging men on themes of wellbeing without alienating them. This will be picked up in further detail in the discussion.

In addition, the interviewee reported feeling like he has changed substantially, again through an expression that seems to convey a feeling of greater trust in others, and a more positive view of others and society:

> *"One thing I've learned through all this is the world's not a bad place when you put a bit of time in it; you know the saying, a leopard doesn't change its spots, I would disagree with that now."* (Cliff)

There is, therefore, a recognition of the positive impact of social prescribing (through its ability to enhance understanding of relevant issues) but also somewhat a scepticism and wariness, like some variants of critical theory, of how the rhetoric surrounding these policies may be hijacked for financial gain or ulterior motives.

As we have seen in this subtheme, some of the men clearly gained some new skills and knowledge through social prescribing. This was often demonstrated through a negotiation of masculine themes with a traditional emphasis like the "warrior" and stoicism reported. The following subtheme will discuss other forms of positive perceived impacts of social prescribing in the form of men reporting legacy and new forms of meaning. Again, in following on from the argument in the earlier theme, there are times when this perceived positivity seems at odds with other reports.

10.3 Mission, legacy and "unleashing a beast": partial forms of meaning and purpose

Some of the men described a social prescribing experience that led to renewed purpose and mission. Like earlier data discussed, these empathic statements are often combined with implicit indications that convey a lack of power or capital. As with the positive evaluations of social prescribing explored in the earlier sections, the men's reports on finding new forms of meaning and purpose takes a different shape when read within the broader context of their everyday life. For example, an interviewee described a commitment to social prescribing with zeal, as both a previous user and now deliverer of social prescribing, whilst also drawing implicit attention to his lack of income, wealth or economic capital:

> *"I don't wanna sound like I'm slipping back into my old arrogant ways. But I'm not prepared to stand by and let Westerdale* [anonymised] *do without social prescribing. It's too much of a powerful tool. We know it's working. The changes that we have had in Yorkshire, not only the devastation of the unemployment, but the changes that things that have been put in place to support people, have not supported them and they they've disappeared. Now with social prescribing we have something that is working and is supporting them."* (Andy)

Moreover, the interviewee connected his mission to drive the social prescribing agenda forward in his local area, with some fundamental changes he describes as associated with social prescribing. In particular, he identified that the compromises and adaptations he had made along the way to protect himself from pain or fit in (documented in earlier chapters) had been brought to consciousness and examined, with this again connecting to his everyday work in social prescribing:

> *I've learned, through my time in social prescribing that my mental health problems don't define me. I can get up and go to work and help people, help people like me, by trying to cut through that table cloth of pessimism. It's that what destroys the trust. And I think it's that what were* [*social prescribers*] *good at trying to breakthrough."* (Andy)

Here, Andy described how his own personal development of breaking through the "masks" he wore to fit in, connect to his own empathic practice in social prescribing. As we have seen in earlier chapters, the masks are connected to the defences against his emotions he later reflected on. Culturally this was connected to masculine norms of hard work and risk-taking behaviour, before experiencing a breakdown.

In continuation of the themes developed in the earlier chapter, other interviewees also described their experience of social prescribing through a powerful metaphor of "unleashing" a new aspect of himself. This is described by Arthur within the context of a public reading of his poetry. Whilst experiencing doubt and fear before his performance, the interviewee reflected how the performance of his poem on male suicide was met with positive emotion, applause, and recognition. This seems to be felt as a powerful experience, with the interviewee referring to it as one of the most memorable experiences of his life, substantiated through his account of stretching himself through challenge into new areas previously deemed off limits:

> *"The drama stretches you. To stand up in public and speak, that was never my bag. I'd be the one in the back of the room".* (Arthur)

Before going on to describe his involvement in a production with social prescribing:

The place was packed, it was heaving. They got us up on stage. I have never felt so physically scared. Me knees would not keep still, I thought I was gunna collapse. And I'm thinking don't blow it don't mess it up." (Arthur)

With the interviewee performing a poem which like the above, reported topics of male mental health, both privately and as a broader social issue:

"I wrote this poem called "war cry". It addressed male suicide and the Regent [anonymised] *theatre group asked me to perform it. I was like no chance, no way. Anyway, they trained us up. I was buzzing when I come off that stage. There were people crying and shaking my hand and I just said you've unleashed a frigging beast here."* (Arthur)

Extending his response, the interviewee stressed the importance of this moment through reference to other positive and celebratory areas of his life:

"Next to my kids being born, I'd say it was one of the best feelings I've had." (Arthur)

In addition to claiming that the poetry allowed him to rework masculine themes (as noted earlier), the interviewee also noted how the publication of his poetry would enable him to pass something on to his children, leaving behind a tangible trace of his achievements and a "legacy".

"I've always said with me poetry, now I've got something I can leave behind for my kids if nothing else. I've got 3 or 4 published, and I've got the hard copies here. When I die, as everyone does with their parents, you look through the photographs, and they can say when they pick up my poetry, my dad did that." (Arthur)

Arthur developed his response by commenting upon his achievements through social prescribing and stating his motivation to leave behind something he could be proud of:

> *"It's not a very big legacy but, it just gives you that warm feeling, that self-worth, that you've done something that can affect other people."* (Arthur)

This example, then, provides a notable, positive impact of social prescribing. This powerful experience, however, is still combined with moments of intense private despair and pain at their lack of employment and routine:

> *"I wish I had my health instead of any money. I want the routine of going back to work because sometimes I'm at my wits end just trying to fill my day. There's some days where the pain isn't worth it and you think, I'm a hassle, I'm a burden, who would notice if I wasn't here life would carry on. You get yourself out of them ruts but they can be very dangerous at times, and it all comes from not having a set routine."*
>
> (Arthur)

The positive appraisal is once again, therefore, set within a broader context seemingly dominated by negative emotions and experiences, alongside a lack of structure and social integration. Indeed, the above narrative is combined with another metaphorical description of his psychological pain and lack of connection:

> *When that black cloud descends you get yourself in a very dark place, and you just cannot convince yourself things are going to get better."* (Arthur)

Similarly, other interviewees, rather than noting their desire to leave a legacy, also claimed that loved ones who they have lost, such as their wives, would be surprised at their changes and achievements through social prescribing:

> *"My wife would have fell out of her chair some of the things I've done with the group, she would have been absolutely shocked."* (Cliff)

As this section has discussed, often the men described renewed forms of purpose and meaning through social prescribing; but these are often coupled with certain tensions like a lack of economic capital and a loss of routine and meaning associated with employment. The final section will describe examples when social prescribing was experienced as unsuccessful or lacking in several ways. Some of this is like the above data as the men report forging some slender connections through social prescribing. Where it is undoubtedly different is in the overwhelmingly negative way that the social prescribing experience is described by the following small number of men.

10.4 Failed and unsuccessful social prescribing experiences

As documented in the previous themes of this chapter, the men reported mixed experiences of social prescribing. Some of the reports from the men, whilst on the surface seem positive, often seem to be the only forms of connection in the men's lives. Nevertheless, even within this context some of the men describe sustained connections to practices that seem to be enabling some progress towards health and wellbeing. Of course, these negative responses are only partial insights as the interviewees who are discussed here may have later re-negotiated their failed experience of social prescribing; whilst, conversely, others who initially may report more positive experiences, may find that in time their experiences of social prescribing worsen. For example, Fred described a negative experience with his link worker, where he was misunderstood and offered care perceived as ill-suited to his needs:

> *"I was referred again on a so-called social link worker. He rang me up and I was told he would send a form out to me in the post with a questionnaire in the next two weeks. Anyway, I heard nothing back from them. So, I rang them up. I said, I haven't heard*

> *from you and you said you'd be in touch. Then he proceeded to tell me that he'd referred me again to Mental Wellbeing* [anonymised] *for another course of C.B.T, which he said would help with my P.T.S.D. I said, firstly I have never been diagnosed with P.T.S.D and secondly, I've already just done a course of C.B.T and I didn't think much of it."* (Fred)

The interviewee's experience of social prescribing was therefore negative for two reasons: firstly, it required him to chase and contact the link worker; secondly, this resulted in him being referred to an activity which he felt had no relevance to him. Indeed, the negative impact of social prescribing is remarked by spiralling negative emotion,

> *"So what this person has done* [link worker]*, instead of making me feel better, has made me feel significantly worse – how goods that."* (Fred)

This negative experience is not, however, coupled with an ethical or attitudinal complaint about social prescribing as a policy idea, but a positive one. This is evidenced with reference to a hypothetical positive endorsement from his recently deceased mother:

> *"I think my mum would have been in favour of social prescribing as a very good thing that can help people meet up with people, when it is used in the right way. She was a very sort of positive can-do type of person. Whereas in my experience, I don't trust them one iota – not at all."* (Fred)

In contrast, however, the interviewee then described how social prescribing connected him with social connections that are just about helping him buffer the pain he feels:

> *"I've got two friends who I met through the befriending service, and they ring me every evening. And their phone calls are just about keeping me a float."* (Fred)

Therefore, despite the initially negative experience, the interviewee also described some perceived positives of social prescribing as a policy. Indeed, the interviewee reported a sense of hopelessness when asked if he will ever seem better, referring to the conversations he has with the two women he met from the befriending service:

> *"I mean they are quite spiritual and they will say you know they have prayed for and stuff which is nice. But I keep telling them don't waste your time. I mean to be honest; I don't expect any transformation from feeling absolutely dreadful."* (Fred)

Similarly, another interviewee claims that, after an initial successful experience of social prescribing, he had reverted to a negative cycle of loneliness and negative emotion.

> *"I'm just done with people mate. I'm done with it all. I didn't even pick the phone up to her (the link worker) the other day. I wake up, and I just want to stick my head back under the pillow and let the world go by. All's they all seem to be doing is telling us to go for a walk outside my house but I can't. I've told em, it makes me feel too paranoid."* (Lenny)

This was despite earlier positive claims made in his first interview, which was conducted a month before, on the impact of his link worker. In this interview Lenny stated that:

> "*She's only been dealing with me a couple of weeks, but she's made more difference in that time than any of these talking therapies or doctors or anything like that have in years*." (Lenny).

This contrast between the positive reaction in the first interview versus the second interview is clear, with the gap between the two interviews a month in total. In the above instance, it is the perceived inadequacy of support from both social prescribing and the broader care and health sector that seems to have triggered Lenny's reversal. This substantiates the claims

made in the chapter that many of the social prescribing experiences are complex, and need to interpreted within the broader context of the men's lives to make convincing inferences of the reach and impact of social prescribing.

10.5 Conclusion

This chapter has presented evidence that social prescribing has a mixed impact on the men; even when social prescribing is reported as positive by the men, with this generated by mechanisms of trust, this must always be viewed within the antecedent contexts of the earlier chapters, like income, employment, participation in community and loss, whilst also being cross-referenced with reports of feelings from outside of social prescribing in the men's life. In doing so, social prescribing seems to be one of the few connections the men have in an otherwise disconnected life. In reference to the positive pole, social prescribing does seem to have offered care and durable forms of participation in cultural practices. Given the reports that men find it hard to talk about their problems in addition to other intense forms suffering because of poor mental health, these positive elements must not be too readily overlooked. The following chapter will draw the thesis together by discussing the findings of the project in relation to the theories discussed earlier, before offering some recommendations and suggestions for future research.

Chapter 11: Discussion

As the findings of the study have now been covered, the following chapter will discuss and summarise some of the key points of the findings, connecting these to surrounding literature in the field of social prescribing, but also beyond. In doing so, it will return to the theories outlined in chapter 3, connecting these findings to the theory on wellbeing and capital. As was highlighted in the findings from the review in chapter two, there is an inadequate coverage on gender, the contexts of relational and economic equality and social class in the social prescribing literature. Moreover, despite the claims that social prescribing can help to tackle health inequalities by connecting people to social capital, relationships and activities that promote wellbeing, as identified from the review chapter, many of the concepts in the literature focus on changes made through social prescribing at the level of the individual. Most of these focus on changes in emotions, cognitions and behaviour within the field are over reliant on concepts from psychology.

Through drawing on the concepts of PERMA (Seligman, 2013) and capitals (Bourdieu 1977; Atkinson, 2010; Savage et al, 2015) this thesis has looked to develop more substantive theoretical connections between different levels of analysis. When PERMA was used to explore the cultural context of the men's lives, it offered an understanding of how the activities the men participated through their life course mattered to them and offered them positive emotion meaning and relationships. When connected with capital theory, this focus on the inner emotional and relational side of the men was combined with how the activities the men reported participating in were often associated with the levels of capital associated with the working class. In addition, the fact that the men overwhelmingly drew on examples of activity participation much earlier in their life course was also revealing into the nature of social and political change and how their access to the social, cultural or economic capital to partake in certain activities seemed to be lacking for large parts of their lives. In terms of their referral to social prescribing, chapter six demonstrated evidence of what mattered to the men, with

efforts to trace if any of the activities previously documented were part of the social prescribing offering. The use of PERMA and capital theory enabled the interpretation that there was a significant absence of durable cultural and social connections in the men's lives at various junctures, with it following that social prescribing was then challenged with filling some of this absence.

When applied to the employment and community context, the theories of PERMA and capital enabled an understanding of how many of the men reported working lives devoid of positive emotion, meaning, relationships and often achievement. This was often combined with a lack of social capital in the space of communities, with very little feeling of democratic control over their own life, or over the direction of their communities. Following the latter, there often appeared to be low levels of bridging or linking social capital between the working class and precariat men, with it following from this that this gap is important in understanding their needs and their later engagement in social prescribing.

In focusing on the more immediate context of referral, the men reported various types of loss as a common trigger for their referral. Whilst the often loss connected to the positive emotion gained from the relationship with loved one, sometimes it was connected to the loss of employment or role. Understanding and explaining this often seemed better suited to PERMA. However all the losses reported, it will be argued in more detail below, were intensified with the absence of social capital discussed in previous chapters.

The ways in which these contexts interacted with social prescribing was analysed through the finding referred to as "the two poles of social prescribing". This finding was enabled through PERMA and capitals. The negative pole of social prescribing seemed connected to the theories in the following way: often social prescribing seemed under resourced to meet the needs the men reported, with much of this need connected to a lack of economic, social and cultural

capital. In relation to the positive pole of social prescribing reported, participation in social prescribing often generated positive emotion, meaning relationships and achievement for the men. It also sometimes developed opportunities for the men to create new forms of bonding social capital with other men who reported suffering from similar issues. Nevertheless, often the opportunities presented to the men seemed at odds with their previous activity engagement. In addition, whilst social prescribing did provide the emotional and relational support connected with PERMA, very rarely did it seem to provide the bridging social capital needed to challenge the current distribution of economic capital or power. Whilst the sectionsbelow explores this in more detail, the recommendations section discusses how social prescribing could be connected to deeper levels of direct democracy in the NHS or other ideas on community wealth building. Both would provide meso/ macro level bridging social capital that could build momentum through the positive emotion of PERMA but drive more durable forms of structural change that can challenge health inequalities.

This thesis has, therefore, looked to fill this gap in coverage through focusing on working class and precariat men's journey through social prescribing. In addition, through the coverage on the cultural context and loss, two substantive original contributions have been added to the field of social prescribing, that, to the researcher's knowledge, no other studies focus on. The following section will restate the research questions in order ascertain how they have been answered in the study, before presenting the findings. The chapter will then present recommendations, before concluding with some areas of further research that could be potentially developed in future studies.

11.1 Restatement of research questions

1) What cultural, social, and material contexts do working class and precariat men report, and how do they relate to need and referral to social prescribing?

2) How do these men perceive and experience social prescribing, and why?

Summary of findings:

As the following section will argue, whilst there is some evidence that social prescribing has impacted the men positively in improving their wellbeing, especially within the Covid-19 context, social prescribing often seems to lack the scale of resource to reverse some of the legacies of context described in chapters six to eight. For the NHS to become more proactive in facilitating participation in activities and social capital, more resources need to be circulated towards communities in the North, which the men's reports seem to substantiate as socially isolated and lacking in capital, with more imaginative ideas and measures on how to genuinely stimulate the growth of the VCSE under tight funding constraints.

11.2 Link workers and male users of social prescribing: agency enablers or swimming against the current?

Calderon-Larranga et al, (2022) have observed the contradictory goals and priorities of social prescribing. These priorities range from goals described as moving service users to "what matters" to them to reducing health inequalities, but also, "self-management, independence behaviour change and reduced demand in primary and secondary care health service" (Sanderson, Kay & Watts (2019, p24). These conflicting priorities associated with both social prescribing and the link workers' role have led to understandable "scepticism about its transformational promise" (Griffith et al 2022, p294). In order to further the understanding

of these concerns, the following two sections will discuss the implications from the findings on link workers in this study. The coverage of link workers in this research adds to an emerging literature on link worker views and experiences, with recent papers on link worker experiences concluding that there are very few detailed qualitative studies on the link worker experience of social prescribing (Griffith et al, 2022). Through the data collected and analysed in this thesis from link workers, the first focus is to examine link worker experiences and perceptions of social prescribing as they connect to the experiences and perceptions of male users of social prescribing.

11.2.1 Link workers: stress and low income as barriers to their role as promoters of wellbeing and capital(s)

The link worker sample interviewed reported mixed experiences of working in social prescribing. This ambivalence impacted the men in what the link worker offered to support them. For example, in relation to contexts of deprivation, the link workers interviewed sometimes claimed they were underpaid and overworked. Features of the pressure and strain of link workers' employment have been identified in literature on link workers (Griffith et al, 2022). Here, researchers describe how reductions in funding and increased demand for other services, especially those related to mental health, can leave link workers "dealing with complex caseloads for which they feel unprepared" (Griffith et al, 2022, p281). Further to this, some link workers often claimed there was very little on offer in the surrounding VCSE sector, or capacity within services, for men suffering from mental health issues. This finding is supported in research by White et al (2022, p5111), who found in their research that link workers were worried that people with mental health needs may be "falling through the gaps" in services. This is combined with claims that link workers interviewed for their study reported undiagnosed mental health disorders in their clients including trauma, chronic anxiety, ADHD and Autism. Given this level of unmet need, White et al, (2022, p5112) argue that the self-

management associated with some rhetoric around social prescribing often overlooks that "hand holding" and intensive relational support is needed before autonomy can be achieved, with it taking considerable time to build confidence in the men. Moreover, link workers interviewed in this study often claimed that social prescribing was in danger of being a dumping ground, with referrals being made from services unsure what to do with clients or simply being unable to meet demand. Added to this, it has been identified that services in the most deprived areas are the most likely to be overwhelmed (Frostick and Bertotti, 2021). Both of these findings in the link worker literature are consistent with the findings here, with some of the link workers interviewed claiming that they too felt like they were receiving referrals that were not appropriate for social prescribing, perhaps requiring more intensive specialist support. Link workers interviewed in Frostick and Bertotti, (2021) claim that the complexity of these clients and their needs often leaves the link worker feeling uncertain about the boundaries of their role, and in need of further support to avoid exhaustion.

In addition, the pressure and strain link workers are placed under have been identified through evidence of "poor support, high staff turnover and emotional drain" (Griffith et al, 2022, p280). With this strain tied to macro level economic policies and their negative effects, it is reported that link workers cannot reverse the forces that reproduce health inequalities and that they themselves are caught up in these forces (Griffith et al, 2022).

Link workers: committed to caring under strain

Despite this, Griffith et al, (2022, p284) report that link workers who they interviewed demonstrated levels of care, where they paid "impromptu visits" to clients between scheduled appointments or texted them out of hours. This tension between being pressured and stressed and yet often being highly committed to ways of caring was well supported in this thesis' research findings. For example, link workers frequently described perceived positive

examples of practice where they reportedly helped male clients in difficult situations. Often, these examples offered compelling examples of where link workers had made some progress with men who appeared closed off to discussing their needs, preferences, and emotions. Examples of this were presented when link workers helped their male clients discuss troubling emotions or social issues like indebtedness or unemployment, with the link worker sometimes reporting that the men had not discussed these issues to anyone else.

Some of the reported progress made with men offers evidence of the two poles interpretation of social prescribing, with this a positive feature of social prescribing. There are, however, some further qualifications of this more positive pole to be made. As key literature informed by the theory of Pierre Bourdieu argues care workers in low paid roles may feel compelled to over stress their skill and ability in conversations with others (Skeggs, 1997). It is argued that this serves to reassure themselves and others that they are of value and are competent carers even in contexts that are objectively under-resourced with relatively low pay (Skeggs, 1997). Some evidence of this was found in the current study, where the link workers' need for economic and social recognition seemed to outrank the need to bring awareness to their reported poor pay and overwork. These dynamics may prevent the link workers from acknowledging their lack of power under the constraints they face; to do this would be to violate their emotional investment in being a good carer and someone of value.

The next section will further develop the mixed findings on the link workers by arguing that because of some of the pressures stated previously, and perhaps other factors, their work sometimes, though not always, drifted towards interventions representative of behaviour modification alongside cognitive changes associated with changing patterns of thoughts. This was often at the expense of a robust and adequate understanding of the social determinants of health. This commitment to caring under strain is consistent with other findings that claim

that link workers need further support and buy in from other health care professionals, particularly general practitioners, if social prescribing is to be successful (Moore et al, 2022)

11.2.2 Link workers, "lifestyle drift" and placing sticking plasters on social problems

Often, the interviewed link workers discursively framed their priorities or care philosophy through reference to providing access to the social determinants of health. Despite this, this claim was often combined with understanding of their work as more suggestive of a cognitive, or behavioural model of change. Given the contexts of the men's lives, whilst cognitive and behavioural interventions may help in some areas of social prescribing, on their own they are likely to be inadequate to help the men repair a history and context where power and control seem lacking. Examples of this derive from data where the link workers discussed cultivating a change in mindset or developing resilience in response to stressors with the men who use social prescribing. Both represent cognitive interventions without any focus on the structural determinants. Whilst resilience, "grit" (Duckworth, 2019) and "character" (Sayer, 2021) have their place in the pursuit of any meaningful endeavour, including those that transform the status quo, when social problems are viewed through this lens alone, they risk blaming the victim (Ulsanoff and Pickett, 2019).

Moreover, asking men and social prescribing users to discipline themselves may individualise their issues, encouraging them to make changes without recognising the broader structural or relational drivers of their poor mental and physical health. This finding is connected to literature that suggests that often health policies purporting to work towards the social determinants of health begin with honest intentions, before reverting to an individualised focus on lifestyle. This process is well documented in the literature on the presence of "lifestyle drift" (Fullgar & Williams, 2018) in public health interventions. This finding is also

supported in a recent paper that finds evidence of "contradictions" and "tensions" (Griffith et al, 2022) in link worker practice, with additional research arguing that link worker practice and the implementation of personalised care is at risk of forcing superficial choice on individuals who use social prescribing, often at the expense of a deeper and more time intensive relationship based on "care" (Calderon-Larranga et al, 2022 p293). Added to this Calderon-Larranga et al, (2022) point to how this movement of personalised care away from care to superficial forms of choice, is connected to the reigning assumptions of neoliberalism, which is largely driven by a theory of individual choice orientated to consumption. In this research it frequently seems that link workers are subliminally or tacitly persuaded that encouraging individual responsibility is the only legitimate way to proceed in practice. Whilst this may sometimes be the case, often it seemed that the link workers interviewed in this study were merely patching together pragmatic ways to help the men, and, as mentioned in the previous section, achieve value (Skeggs, 1997), in challenging contexts.

Lastly, some of the findings focused on link workers are suggestive of how supporting people in caring relationships can be threatened by elements of motivation that are partly unconscious. For example, one link worker claimed that they sometimes think of themselves as "mothering". Whilst a rushed form of encouraging "choice" may violate the quality of relationships contained in link worker interactions, some link workers may be partly colluding in a form of "paternalism", with some of these dynamics identified in literature on social prescribing (Carnes et al, 2017). Whilst dependency on others is often legitimate as a form of repair, especially for those with long histories of trauma or abuse (Van Der Kolk, 2015), an unconscious form of paternalism is also a threat to more democratic relationships in personalised care. The above points support claims that many public services are stuck in firefighting mode (Curtis et al, 2023), with short-term measures of proving effectiveness in their role working against longer-term thinking. Having a more robust plan on how to ensure

the link workers can better meet prevention rather than putting sticking plasters on social pain would improve the ability of social prescribing to meet its aims. The later sections on recommendations will offer some suggestions derived from the findings on how some of the problems associated with the link worker, as found in this study, could potentially be tackled.

11.3 Original contribution to knowledge: Men and the antecedent cultural context of "what matters" through Habitus and PERMA

As the NHS Guidance on Personalised Care sets out, personalised care "represents a new relationship between people, professionals and the health and care system. It provides a positive shift in power and decision making that enables people to feel informed, have a voice, be connected to each other and their communities" (Sanderson, Kay and Watts, 2019, p6). A central component of the personalised care agenda which connects most centrally to the activity of social prescribing link workers, is connecting people to "what matters" to them through referral to "cultural activities" (Sanderson, Kay and Watts, 2019, p5). Guidance sets out that this referral should be based upon "the person's assets, needs and preferences as well as making the most of community and informal support". Whilst recent research has been published on the perceptions of link workers of the cultural sector (Tierney, et al, 2023); along with additional research that examines the need to "tailor" the "cultural offer" of social prescribing to certain populations (Tierney, et al, 2022), very little research examines the antecedent cultural context of social prescribing engagement. This gap is despite the aim of social prescribing to connect people to what matters, no studies were identified in the review that focus on the antecedent cultural context of the social prescribing intervention for users As a result of this gap, coverage of the cultural context was deemed important. This context helped frame the questions of what matters to the men, but also illuminated elements of why the men needed to engage in social prescribing, with some of them expressing a lack of cultural participation, with this only on some occasions a result of Covid 19 and lockdown. This

seems to be an assumption that is underexplored in the literature, as members of society who engage in a rich diet of cultural participation and have found solutions to this need in the market, for example, would not require a social prescribing referral.

In further connecting the above to surrounding research, theoretical and empirical work (Dolan, 2011) informed by the work of Pierre Bourdieu's model of socialisation claim that for interventions like social prescribing to have any success they must, in some way, connect to these earlier forms of activity engagement. Sayer (2011) claims that interventions must, in some way, connect to our pre-existing skills and capacities, stored in the habitus. As this approach often undervalues our need for novelty and our ability to try new creative activities, Bourdieu's habitus was also combined with the more agentic elements of PERMA theory to explore the men's negotiation of their context to asses if the men's socialisation led them to examine how their values, activities and norms provided them with positive emotion, relationships or meaning as associated with wellbeing (Seligman, 2011).

11.4 Cultural context: class and masculinity, men's norms and values

The men interviewed reported the negotiation of values that were supported by an ethic of male stoicism, valuing independence, emotional restraint and often denying the need for others. On some occasions this was discussed in reference to the presence of a male role model who instructed them into values and activities associated with masculinity. The ramifications of this context were later carried into the initial social prescribing referral with men claiming that they could not convey their emotions or "open up", in addition to other challenges reported in the initial stages of social prescribing. On some occasions, it was reported that the male role models motivated the men to take part in activities like football, weightlifting, boxing, and comedy. Whilst many of these activities can, and do support health and wellbeing, on some occasions it seemed the way they were participated in was perhaps

not consistent with health or wellbeing. A notable example in the data derived from one man reporting weightlifting and bodybuilding. Whilst this practice can certainly support health (Hefferon, 2013; Scambler, 2023) the interviewee reported the desire to be like the Incredible Hulk and other notable celebrity bodybuilders. This was combined with another example where the men reported images and values associated with aggression and independence.

On many occasions, as will be examined in other themes, the men discussed the power of these norms retrospectively, with some of the participants examining the shortcomings of these norms through reflection. One interviewee, for example, now claiming that they were "totally wrong" in thinking that suffering mental health problems was associated with being "nuts". These findings are well supported across a range of literatures, including Dolan (2011) who, drawing upon elements of Bourdieu's conceptual toolkit, discusses how the implicit and explicit socialisation and learning associated with masculine norms, values and activities become part of accumulated experience of the masculine habitus. In doing so, the researchers draw attention to the tacit and largely unconscious socialisation and negation of norms that shape men's engagement with health. For example, Bunn et al (2016, p812) provides evidence that masculine norms "become embodied and enacted through performances that reflect the cultural roles and narratives that we learn as we grow up and move between social spaces". These masculine norms are associated with the "the ideals of fitness, strength, competition, power and domination' (Bunn et al, 2016, p812).

In addition, additional research has linked the social and cultural context of "working class" masculinity to "characteristics [...] of physical and emotional toughness, coupled with achievement and authority" (Dolan, 2011, p589). Evidence also suggests that these characteristics are often encouraged and rewarded in masculine working-class occupational life and leisure where often risk-taking behaviour is a way of gaining self-esteem when income

is low and occupational conditions deny control. Here, working class men learn that asking for help is a sign of fragility, preferring to keep their emptions private or suppressed (Dolan, 2011). Failure to live up these expectations often leads to fear of ostracization (Dolan, 2011).

Moreover, in using the more agentic theories from the field of wellbeing, putting elements of the PERMA to use in men's health, researchers like Lomas, (2014) have examined how a group of men renegotiate masculine norms associated with emotional denial and hyper independence, by engaging in health activities that help reframe these norms in more health promoting ways. Likewise, sometimes the limitations of these norms were challenged through engagement in social prescribing, with the men often sharing emotions with link workers that they reported previously denying. Evidence of the link workers ability to navigate men's emotions where often regarded as of a strength of social prescribing and part of the positive pole identified in this analysis. Men often reported that they could not open up to other health professionals but that they felt safe with the link worker, with this connected to greater level of informality and deeper connection to the grain of the men's everyday life, as associated with the link worker role.

11.5 Cultural context: tracing "what matters" through the men's activity engagement prior to social prescribing

None of the practices which the men reported engaging with prior to social prescribing were engaged with through social prescribing. The male participants reported cultural engagement up and down the life course, ranging from football, rugby league, boxing, weightlifting, gambling, reading literature, woodwork, listening to music, and comedy. Whilst gambling and forms of boxing, may not have their place in a set of activities offered through social prescribing, there is no reason why others would not. For example, reading literature, football, rugby woodwork may be part of a social prescribing offering. As shown later in the research,

some of the men interviewed did initially report a lack of perceived cultural fit between what they were offered and what they felt was appropriate. Whilst some of the men progressed beyond these apprehensions on the cultural fit because of the persistence of the link worker, none of the activities from the men's antecedent cultural context were offered through social prescribing. For example, in all the social prescribing pathways sampled, the men described being referred to activities either funded through social prescribing or through the referral to activities in the VCSE. These ranged from poetry and drama, chair assisted yoga, a music group and nature walks. One interviewee described the potential of a sports memory and history group possibly forming, but at the time of interviewing this had not begun.

Interestingly, many of the men seemed to transcend their initial doubts about the activity referred to, but in making inferences beyond the sample of men interviewed here, many other men may not. The problems associated with this will be discussed in the recommendations, where it is advised that part of social prescribing's aim to connect people to "what matters" through "community groups" must be genuinely democratic (Sanderson, Kay and Watts, 2019, p19). This is not aimed to suggest all cultural activities are of relative value to health and wellbeing. Some of the activities the men reported like gambling or boxing are clearly not likely to be supportive of health and wellbeing in a sustainable way and these activities are not likely to be commissioned or connected to through social prescribing. But as social prescribing seems likely to continue to develop, efforts towards genuine democratic co-production must be made that look to connect men with a wide variety of cultural activities. This should be undertaken alongside endeavours to make what were traditionally framed as higher culture activities as accessible as possible (Savage et al, 2015), something that the positive pole of social prescribing was found to do reasonably well in this study, through assuaging the men's doubts that they were getting their participation wrong.

In addition to the above, notable large research projects driven by the work of Pierre Bourdieu have identified clear cleavages in cultural participation in British Society (Bennett et al, 2009). This cleavage is separated amongst those who are "engaged" versus those who are "disengaged" in terms of actively participating in and pursuing activities. It is reported that causes of this cleavage are connected to income and social inequality, with the "social bases of participation" linked to the distribution of "material and educational assets" (Bennett et al, 2009, p147).

The authors also note that "the most important axis differentiating cultural life in Britain is associated with occupational class" (Bennett et al, 2009, p147). In the sample of men interviewed who live in the North and as members of either the working class or precariat, there is clear indications in this data that the context of inequality is important for shaping further cultural engagement. Whilst chapter five aimed to understand previous hobbies and activities as a way of tracing what matters to the men and what activities they had engaged with, it was not the explicit aim to gather data from adolescence or earlier life. It seems that men naturally reverted to this period because for many years in the middle of their life they lacked some notable present-day cultural engagement. Moreover, a smaller number of the men reported no active participation or hobbies and claimed to almost never leave the house. This is further substantiated by studies that report a social gradient in certain types of cultural participation (Fancourt and Steptoe, 2019), exercise and sport (Wiltshire et al 2019; Scambler, 2022). As a result, these findings offer a substantial original contribution to knowledge by offering a rich and detailed account of the norms, values and activities the men who were interviewed reported partaking in prior to their social prescribing engagement.

11.6 Context: men and the social determinants of health, the distribution of capitals and power as barriers to wellbeing

In addition to the above findings on the antecedent cultural context, as a result of the gap in the literature identified from the review, the antecedent context of the men's access to the social determinants of health was explored in the places where the men live and work (Marmot and Wilkinson, 2005). This was done through focusing primarily on three areas: employment, community, and power. These three areas were driven by Bourdieu's capital theory, as well as Marmot's (2016, p132) claims that health inequalities are driven by "material, psychosocial and political" mechanisms, and processes. As shown in the review, research in the field of social prescribing needs to better understand unmet needs through examining in detail what these needs are, where they come from in affluent societies, how economic and political system reproduces them. This is coupled with strong opinions from some like Moscrop (2023) who claim that unless social prescribing develops a better understanding of the historic nature of need and context, it will not meet its aims either of connecting people to what matters, reducing health inequalities or "empowering" those who use social prescribing (Sanderson, Kay and Watts, 2019, p4). The methodology of critical realism with its focus on context and stratified ontology was vital in enabling this focus.

Although Bourdieu's theory on the distribution of economic capital was used to understand the men's experiences, it was the men's relative control in employment that was repeatedly referred to in their accounts. Many of the men reported displeasure with their work, with accounts describing stress and little control or power in their occupation. This finding is consistent with other studies in the field of health inequalities that describe a social gradient in the distribution of control and participation through society (Marmot, 2016). Whilst this context is under-examined in the social prescribing literature overall, the findings are consistent with a small number of published papers in the field that focus more attention to

the social, cultural and economic context that interacts with social prescribing as an intervention (Gibson et al, 2022). These papers present data that suggests that the "bureaucratic time" of social prescribing, represented by the duration, availability, and quantity of care, is often ill fitting with "temporal ruptures" associated with the structural conditions of class, gender and ethnicity (Gibson et al, 2022). Data is presented in this paper to show these temporal ruptures are evidenced through the lack of income and perhaps control felt in employment. This causes stress and insecurity, with some of these directly associated to economic stressors which working class men face, and how these may interact with the intervention of social prescribing and reduce the ability of those positioned lower in social space to partake in forms of social capital and activity participation that are democratically responsive (Gibson et al, 2022). For example, data reported in these papers suggests that men who participated in the study were unable to make their social prescribing referral because of working the "nightshift", with it implied they would sleep through the day, and "needing the money" (Gibson et al, 2022). Some of the findings in this thesis would be supportive of this; where they differ is through the deeper ontological focus offered through critical realism. Rather than exploring how the context in present time interacts with uptake or experience of the intervention, the findings in this section of the chapter are more historical, with the occupational context leading to a lack of power and control in the men's history. This was even the case for the older men in the sample who entered employment in post-war labour market, associated with relatively high levels of economic growth (Todd, 2019). If social prescribing looks to "empower" (Sanderson, Kay and Watt, 2019) users through personalised care by cultivating relationships where people voice their priorities and share their goals, then both the literature and practice need richer understandings of the distribution of power through society, and the historic effects of this as stored in the men's habitus.

11.7 Context: the antecedent context of social capital, trust and power

An additional context studied was the way in which community and participation in community was discussed by the men, with many of them reporting loneliness, isolation, and experiences of stigma. These experiences were often connected to macro - social changes associated with neoliberalism, the transition from an industrial to a post-industrial/service economy and consumerism. These reports were sometimes accompanied with a nostalgia for older forms of working-class solidarity and reciprocity, with this supported in recent literature on the development of working-class communities (Lawrence, 2019). This finding corroborates evidence which reports that there is a social gradient of trust with lower income measured by area deprivation associated with lower levels of interpersonal trust (Wilkinson & Pickett, 2019). This is again an essential context for social prescribing to understand in research and practice. In some of the pathways sampled it provided a link or bridge to preexisting community resources, without generating any resources itself other than the support offered through the employed link worker. If this is applied to areas with legacies of perceived and actual low trust, the social prescribing community needs a theory of how to repair these relational barriers, tackling what one link worker and ex - user of social prescribing working in an ex - mining town in the North referred to as a "table cloth of pessimism".

Although, again, largely underexamined in the social prescribing literature, a small number of papers have begun to discuss some elements of the community context. In doing so, they draw attention to "temporality" of context, but rather than the time poverty pointed to in the last section, when these papers discuss loneliness, they refer to the slow pace of life for those that are highly socially disengaged, and devoid in social connections and purpose (Gibson et al 2021). This is drawn out by data on men with long term health conditions "waiting" for referrals from a range of services so that they can ease their pain and progress (Gibson et al,

2021). In support of this, some of the men interviewed reported high levels of distrust and community disengagement, with some clearly feeling profoundly let down and ignored by others in the community.

As stated earlier, a primary aim of social prescribing and the personalised care agenda is "empowerment" (Sanderson, Kay and Watts, 2019). In the guidance, empowerment is often connected to the voicing of priorities, choice and goal setting, by exploring the men's histories of power as connected to both the politics of everyday life and more formal party politics (Miles and Savage, 2017). Coverage of this in chapter 7 explored to what extent the men had experienced power in their lives and how claims of empowerment connected to this history.

In addition, in adding more substance to the lack of trust the men reported, many of the men appeared cynical about democracy, politics and democratic involvement. It is only by tracing the lack of power in the men's everyday lives, as the chapter did, that we can ascertain if social prescribing can repair legacies of lives lacking in power, as described by most of the men. The main finding to emerge from this exploration is that the men reported contexts that lack the power to do otherwise, with one clear example derived from a man who "did anything to put the bread on the table". Linking this with the theory of Pierre Bourdieu, it is argued that these conditions are taken with the men as a form of stored learning in the habitus, as a lack of reciprocity, power, and control. Evidence supporting this is reported by the men in a sort of learned fatalism in the men interviewed, with this theoretically supported by the work of researchers such as Scambler (2018).

11.8 Original contribution to knowledge: the trigger for referral to social prescribing and men's experience and perceptions of loss

The next finding identified is that the men often claimed that the main driver for the referral to social prescribing was through the experience of and negotiation of loss, with this taking

various forms. Most of the men interviewed reported experiences of multidimensional loss: these range from close family members, to work injuries and the loss of employment. When the men reported the outer loss of another person, this also had the double effect of altering the men's feelings about themselves or changing their role in the world. Recent literature has referred to how loss can then be viewed both vertically in our relationship with our identity through time and horizontally in our relationships with others (Fang et al, 2023). For example, when employment was lost, the men clearly lacked the esteem, structure, and pride in themselves, with this seemingly bolstered by norms around being a male provider. Support for this is found in literature which claims that working class men aspired to be "good husbands/fathers" who aspired to provide good standards of living for their families (Dolan, 2011, p590).

In other examples, when the men reported losing wives or parents it was the actual emotional and visceral pain of the loss that was, understandably, reported as important, alongside the obvious loss of role as well. Whilst research on social prescribing has identified bereavement support as part of the prescribed services and activities offered, (Sandhu et al 2020) no coverage of death, grief or bereavement was found in any of the papers sampled for the review in chapter two. The detailed coverage of the context of loss, which includes accounts of bereavement, therefore goes some way towards offering new findings on how social prescribing helps to deal with bereavement and grief. As a result, the context of loss treated in detail in this thesis plugs a notable gap in the social prescribing literature. To the researcher's knowledge, the coverage of this in this study provides an original contribution to the literature.

As some complimentary literature on health inequalities and bereavement have acknowledged, bereaved adults experience high and unexpected levels of illness and mortality

after the death of their spouse (Stansfield, 2014). Moreover, it is also suggested that bereaved persons, without a network of friends or relatives to whom they could turn for consolation, were also at greater risk of mental health problems (Stansfield, 2014). As shown, many of the working class and precariat men interviewed seem to report low levels of trust and social capital along with cultural participation. Social prescribing was often the only notable social relationship the men could draw upon. As a result, when the men report suffering losses, it severely frays at the fabric of their existence, leading to the need to generate new forms of connection and meaning. It seems that social prescribing later rechannelled this need. The scramble and search for understanding and meaning typically took the form of existential questioning about the meaning of the loss, nested within broader questions on the meaning of life. This was especially the case when the men had experienced bereavement. Some of the men described searching for answers in cultural forms like podcasts, books, or websites. Importantly, many of these musings, reflections and ruminations contain a quasi-spiritual element or desire of wanting to be reunited with loved ones. For some of the men this took a spiritual form. A notable example is where some of the men reported seeing their wives communicate to them after they had passed away. Whilst the men recognise that these experiences may seem odd to others, they were often described as accompanying positive emotion, "it feels good, she hasn't forgotten me and I haven't forgotten her." Others expressed the desire to now die and be with their wife, or a belief in reincarnation.

Bourdieu's work on capital and practice was of no real descriptive or explanatory value here. Nevertheless, these experiences are interpreted here as consistent with the PERMA theory of wellbeing, as the men seemingly disconnected from patterns of meaning and direction that had previously sustained them. The search for new forms of meaning and understanding were often then taken into the social prescribing pathways. Other scholars in the field of wellbeing claim that spirituality is an ingredient of wellbeing (Ben Shahar, 2022), along with religious

participation (Layard and Neve 2023). This connects with contemporary and classical analysis of modernity (Weber, 1976; Durkheim, 2017; Alexander, 2013), where rationality and technology have eroded some of the emotional glue that connected people historically. In connection to this, some have claimed that the institutions and culture associated with liberalism and neoliberalism, including the NHS and welfare state, committed to valorising the rights bearing or individual consumer have hollowed out deeper forms of meaning and emotional connections that could support the common good (Fukuyama, 2022; Stears 2021; Pabst, 2021). There is some evidence here that social prescribing could provide an oppositional force against some of these trends. Recent research (Fang et al, 2023 p14) have found, following Antony Giddens earlier work, that Covid-19 and the death and illnesses experienced through it had caused "biographical disruption" leading to "existential questions" on the meaning of life (Fang et al, 2023). There seems to be some evidence of that here as this type of questioning seemed to be a significant feature of most of the social prescribing experiences the men reported. When the men connected in the groups, their experiences of the various losses were shared with others and processed. An example of this can be found in the poems authored through an art on prescription pathway that centred on loss and grief. It seemed that sharing these experiences helped cultivate group cohesion around a common form of emotion and experience. This is supported in accompanying literature that describes the power of sympathy groups, where people who have experienced certain hardships come together in solidarity (Costello, 2018; Stears, 2021). Other commentary in the social prescribing literature has noted that it can help foster "spiritual wellbeing" (Polley et al, 2020, p46). this may readdress the fact that rationalist, and professional forms of medical knowledge are often committed to procedural neutrality; through this lens, the concerns of death, meaning, and often mystical musings that seem here to accompany it, are, under the

assumptions of liberal neutrality, beyond the remit of practitioners and policy makers and bracketed off as part of the private good life (Reeves, 2010).

In contrast to professional knowledge and expertise, social prescribing seems to have made progress in providing a space for some of the responses listed above to the men's loss. Moreover, if it continues to grow as a policy and is committed to connecting people to practices that can assist in moving to meaningful participation in community, then this data cannot simply be overlooked; if, indeed, many of the men are describing various quasi spiritual and existential forms of dealing with the pain of loss, then these perhaps can be harnessed by channelling some of the emotion to more prosocial, life sustaining connections, with this discussed further in the recommendations section.

11.9 The two poles of social prescribing and the perceived gap in the literature: the cultivation and exploitation of trust in connection to wellbeing and social capital

Fancourt et al (2021, p19) argue that despite literature in the field of social prescribing gradually growing, theoretically informed research on social prescribing is "still scarce". Additional papers have made a similar point, that at the time of writing "there is no theoretical analysis of the social prescribing pathway" (Fostick and Bertotti, 2021 p.412) This is combined with claims by Marmot et al (2020, p131) that further research is needed into social prescribing before making claims that it can help to reduce or tackle health inequalities. In investigating the perceptions and experiences of men who have journeyed through social prescribing, and offering exploratory theorisation on the mechanisms in play through their journey, this research adds to the identified gap in the

literature.

In order to understand and explain the men's experiences of social prescribing, the thesis developed a typology referred to as the two poles of social prescribing. The positive pole seems to come through the men's accounts of emotional connections to those met through social prescribing, either link workers, other men or otherwise. These accounts have more power when they are compared with other services and care interactions that they deem lacking and inadequate. Despite this more positive pole of social prescribing, in contexts of deprivation, it is worth considering if social prescribing is adequately equipped to tackle health inequalities, challenge the effects of an economic model orientated around the extractive growth of financial services, decades of neoliberalism, and widening income/wealth inequalities as outlined in the introduction (Savage, 2021; Picketty, 2022). The evidence here often suggests that on the negative pole it lacks the infrastructure and resources to challenge the maldistribution of power, income, and wealth and status in society, as discussed in the contextual chapters. This is combined with a cultural ethic that has celebrated and rewarded "you are on your own" individualism at the expense of sociability and community (Jackson, 2021, p17).

It then follows that the system imperatives of current models of growth and accumulation at the macro level run profoundly in the opposite direction to the social orientation of social prescribing (Scambler, 2018). This in turn influences the two poles interpretation. The efforts of sharing and trust in the form of the positive pole represent evidence of efforts that forge relationships of care in contexts blighted by some of the previous macro system constraints; nonetheless, from the evidence here, this sharing offers only small levels of support in contexts of social and material deprivation. It follows from this, that when social prescribing acts as a form of bridging, linking and institutional social capital, it is unclear if these experiences are going to increase the power the men have or maintain and reproduce the social order that perpetuates the empirical facts of health inequalities and the various social

gradients in participation associated with them (Fancourt and Steptoe, 2019; Scambler, 2023; Wiltshire et al, 2019).

Whilst the two poles interpretation of social prescribing here is new, other notable literature in health has discussed how interventions focused on health promotion contain elements that go "with and against the grain" of neoliberalism (Wilthsire et al, 2017). With the added qualification that social prescribing provides elements that reproduce negative cultural and material patterns associated with widening health inequalities, whilst also containing elements that possess the agency to rework, challenge and perhaps transform these (Wiltshire et al, 2017). Moreover, others in the field of social prescribing research, have identified "tension" (Calderon-Larranga et al, 2022, p860) in the implementation of social prescribing whereby interventions "tended to acknowledge structural injustice but then offered health service innovations and individualised strategies as 'solutions' for them". Indeed, Calderon-Larranga et al, (2022 p860) further argue that although individual and community-level interventions, such as social prescribing are well-placed to "reduce the consequences" of such inequalities through the provision of enhanced care and support, "they fail to tackle the system which generates (and reproduces) maldistribution".

In returning to the petal analogy used to outline critical realism in chapter three, social prescribing cannot intervene at the roots of the problems associated with health inequalities under the soil. As we have explored in rich contextual detail, the roots of the reproduction of health inequalities are connected to the antecedent context of the men's lives. Despite this negative assessment of social prescribing, some of the more positive perceptions and experiences reported by the men seem to evidence that social prescribing is often successful in connecting with the context of the men's everyday lives in relationally responsive ways, connecting them with groups and activities that seem to have cultivated the creation of

meaning, emotionally engaging practice engagement and social capital. This can certainly help mediate some of the negative elements of context but some of the patterns in the data seem mixed on this. In line with the theories discussed previously associated with Pierre Bourdieu and Robert Putnam, the social capital created through social prescribing seems more connected to Robert Putnam's pluralist model of social capital, were forms of sociability are seen as a net good for society, with social capital less concerned with how the formation of social capital can be transformative of the social order or reproduce it. Towards this, the bridging and linking forms of institutional capital created through social prescribing, for example when the BBC came to visit the men's group, requires further critical scrutiny, with deeper questions needed to be asked on if the forms of connection created are genuinely enhancing the power of the men or exploiting their cultural participation and merely reproducing their position.

There were also ambivalences with the bonding forms of social capital cultivated, with some men reporting sharing the poetry on loss and mental health with other groups, but with other examples demonstrative of volunteering in contexts of unemployment and deprivation. When the examples of social capital created seemed more positive towards sustainable wellbeing and power, these findings seem to connect to theorising of welfare state thinking (Stears, 2021; Cottam, 2019). This evidence does suggest that social prescribing represents some positive learning points for the broader health system, NHS and welfare state. These positive learning points connect with recent theorisation on the welfare state by political thinkers from across the political spectrum that claim that, whilst the growing inequalities of income, wealth and health need urgent treatment, the industrial design of our care institutions that have shaped health policy delivery for decades will not provide answers to our 21st century problems (Cottam, 2019; Miliband, 2022). A central part of this argument derives from the observation that the NHS and broader health system must create better state - society

linkages, through partnership and perhaps personalised care. Indeed, recent notable politicians have called for a new NHS through a "Neighbourhood Health Service" (Starmer, 2022) to move away from the paternalistic ideal of a remote or technocratic bureaucracy associated with 20th century welfare thinking (Cottam, 2019). In order for these partnerships to work, however, a bigger regulatory and enabling role of the state needs to be achieved to scale back the decades of poor investment in key goods and services. Recent arguments for a mission driven "preventative state" (Curtis et al, 2023) that will not only reorientate public services and VCSE partnerships towards prevention (like social prescribing) but take a more active role in directing investment and regulating economic activity seem required to make social prescribing more successful in meeting some its stated aims.

The evidence derived from the men's experiences and perceptions of social prescribing suggests that these thinkers may be correct with the mechanisms of trust, combined with the experience of safety connecting the men to activities and social capital is supportive of a positive pole of social prescribing, but more support is needed to avoid the tokenistic negative pole touched on above. Of added importance in this is when the social prescribing research and practice community refer to "unmet needs" (Tierney et al, 2022) they do so in a way that is more alert to the way in which "wealthy elites act in ways that are divorced from wider social needs" (Savage, 2021 p 318). This is combined with the added proviso that social prescribers, if they are serious about reducing health inequalities, may then need to think more strongly about how they could be a part of "scrutinizing, criticizing and holding to account those with undue resources, power and authority" (Savage, 2021, p319). Furthermore, there is also a further need to examine how the policy could be more genuinely transformative in generating new forms of new ownership and social capital.

Summary and conclusion of findings:

As the previous sections have argued, whilst there is some evidence that social prescribing has impacted the men positively in improving their wellbeing, especially within the Covid-19 context where link workers provided agile and responsive forms of support, it lacks the scale of resource to reverse some of the legacies of context described in chapters 6 to 8. For the NHS to become more proactive in facilitating participation in activities and social capital, more resources need to be circulated towards communities in the North that the men's reports seem to substantiate as socially isolated and lacking in capital, with more imaginative ideas and measures on how to genuinely stimulate the growth of the VCSE under fiscal constraints. The following section will offer some recommendations on how the knowledge from these findings could potentially improve the practice of social prescribing.

11.10 Practice and policy recommendations

11.10.1 Link workers need to develop greater awareness of social and political structures: implications for the supply side and delivery side of social prescribing

One way in which social prescribing could potentially go some way towards helping to become part of social change, which would help to recirculate and allocate more resources and assets down society, could be through greater link worker awareness of the social and political constraints that both they and their male clients face. As recent industrial activity has demonstrated, there is now a rising awareness of NHS staff being underpaid and overworked. This recent industrial action may have even persuaded some of the link workers interviewed, who were optimistic about their work in social prescribing, to re-evaluate their ability to effect change, with their negative emotion latent at the time of interviewing. Through this, link workers would recognise the persistence of patterns of health inequalities and that social prescribing seems to need more support if is to meet its aims. As seen, many link workers,

especially in the North, realised that the nature of the social prescribing they undertook differed to that offered in more affluent areas of Britain.

Building on this, as the key staff involved in the referral pathways of social prescribing, a part of improving social prescribing may come from the link workers perhaps building on the initial disquiet expressed in the study, and realising their self-interest "properly understood" (Putnam, Leonarndi & Nanetti, 1993, p171). That is, a recognition that in order to do their job properly they need more support, pay and training. As seen in the link worker data, the link workers were clearly proud of the care they were offering, but often recognised some of the barriers standing in their way. The need to feel and appear competent and of value, especially in the culture of individual achievement of neoliberalism, can often run against the grain of the need to acknowledge change and inadequacy. In order to reach the care, they clearly aspire to they recognise that greater staffing levels, support, and funding are vital to them having a transformative effect on people's health and wellbeing. Part of this recognition of the need for support and ultimately policy change in their own role, could have the potential to spill over into their practice on the delivery side of social prescribing whereby the link worker realises that whilst perhaps volunteering and behaviour change have their place in getting men to move forward in small steps, without an accompanying vision of social change and transformation, these steps alone risk individualising social problems. As we have seen in findings from the study, volunteering, community participation, and increasing social capital have their place, but they require an accompanying vision of how more redistributive and regulatory measures can tackle wealth and income and reallocating power more equitably throughout society. Only a combination of these is likely to help social prescribing meet its rhetorical aim of tackling health inequalities; without a recognition of power, wealth, and income distributions, social prescribing risks misunderstanding the real drivers and legacies of health inequalities, in material, psychosocial and lifestyle form, and how to tackle them.

Lastly, whilst this recommendation offers a focus on macro policy change as a corrective to some of the initialising shift in link worker practice, this recommendation also notes that to focus on macro changes alone also has its risks. We have seen how social prescribing link workers, especially during the Covid-19 pandemic, worked on the front line of communities offering much needed forms of social support. Focusing on macro social change at the expense of these small moments of agency and sociability risks misunderstanding the actions to be taken here and now to create a more socially connected and healthy society, with findings from the positive pole of social prescribing perhaps a part of this.

11.10.2 Enlarging, consolidating, and enabling the positive pole of social prescribing and men through a more detailed examination of the strength of informal relationships in services

Building on the analytical claims and evidence made in this thesis, this section will build on the two poles argument. It will recommend that the positive pole of social prescribing, namely the care and trust forged through some of the pathways, should be expanded and consolidated, with evidence, for example, that it may help men discuss their emotions outside of professional settings. This will develop a more relationally responsive health service that connects deeply with the grain of people's everyday lives. It may also help to launch a shift away from decades long obsessions on market logics more reminiscent of the work of accountants than the care sector. When social prescribing is reported as impactful, it is these qualities that seem responsible. Recent decades have seen calls for a new form of NHS and welfare state, more densely connected to surrounding communities, cultivating different models of provision to traditional state provided services (Giddens, 2000; Blond, 2010; Cottam, 2019). Recent theorists and policy advisors have also argued that "If political parties, public service providers and campaigners had attended more to the…pleasures and ordinary rhythms of life in the last few decades, then trust in our nations would be higher, our nation

would be less unequal, and our communities would cohere more strongly" (Stears, 2021, p182).

These arguments from across the political spectrum are combined with observation and critique that the industrial model of the NHS is no longer fit for purpose for the 21st century.

With much of its design inherited from a different era, it can no longer adequately deal with the epidemiological changes of the 21st century (Cottam, 2019). The industrial model was driven by an authoritative deference to medical expertise (Miliband, 2022) that is no longer culturally tenable or desirable for the 21st century where the treatment of mental health and chronic diseases requires long term collaboration between patient or service user and medical expertise. The findings from this study suggest that social prescribing is often very successful in enabling key relationships to form through trust and care; there is even some evidence that this is the case in poorly resourced contexts. Data connected strongly to this recommendation often came from men who were comparing their experience of social prescribing to other areas of care or policy experienced in the public sector. In these reports, social prescribing was deemed more socially responsive and empathic, with other services like the Job Centre, cognitive behavioural therapy, and a local council all criticised. Much of this criticism connected with the theoretical critiques was mentioned previously where a cold, detached bureaucracy presides over the delivery of services with little democratic input from service users. In contrast, the positive pole of social prescribing was often celebrated for its greater level of informality. For this positive pole of social prescribing to grow, these qualities contained in the relationships may help men especially deal with emotional content. In order to ensure these positive relational qualities are leveraged and broadened they need to be made more explicit as key indicators of a relationally responsive health service.

11.10.3 Social prescribing needs to develop genuine coproduction through personalised care

The following recommendation is connected to the finding that little evidence was found of relationships built around personalised care and finding out what matters to the male social prescribing user. Often, in the initial phases of the men's involvement, little evidence could be gleaned of genuine democratic voicing of priorities from the men interviewed. Whilst the levels of care and trust developed often seemed robust, more honest conversations on this deficit are likely to be needed for the social prescribing community going forward. Link workers reported mixed amounts of time that they could afford their clients. On average, however, longer time seems likely to be needed to cultivate stronger relationships with the men where they feel empowered to express their needs and demands to the link worker. This is a very different quality of relationship to that of being briefly referred to a service. Part of this may be a result of the high number of clients relative to numbers of link workers. This is combined with the fact that efficiency and other market values often run up against the slow and patient work required to build power and agency in men who have at best had a mixed history of exerting power and control in their lives. As stated, whilst the emotional and caring components of social prescribing have been acknowledged as positive in the last recommendation, this recommendation adds a note of caution that those in the policy need to think more creatively about how to foster more genuinely democratic relationships. This deficit needs to be made transparent if it is to be improved.

11.10.4 Social prescribing needs to improve democratic relationships and forms of commissioning services

Whilst the personalised care agenda offers a recognition of greater democratic relationships in the NHS, more effort should be made to provide democratic feedback loops all through the process of policies of social prescribing. This would span not just in the initial consultation, but

as they pass through, having greater say on the commissioning of services through social prescribing. This would involve genuine, not tokenistic, elements of co-production that help slowly and gradually build up the skills and capacities of the men who use social prescribing as decision makers, owners and creators and assets in their community.

In doing so, social prescribing (that is, our need for our sociability to be prescribed for us), may in time become obsolete and replaced by better connected state - society partnerships as envisaged through agendas like the "well-being economy" agenda (Allen et al, 2021). The details of how this would be financed will not be discussed here; nonetheless, the means of financing this should be, following Sayer & McCartney (2021, p103) and Picketty (2020) focused towards regulating the unproductive "rent seeking" activity of elites. Moreover, there is a greater need for better conversations on how the "asset-based development" (Fox and Mason, 2022) elements of social prescribing, as envisaged in some key documents, seems to be have drowned out, with the focus placed on how social prescribing can be a part of local economic development, sometimes drowned out by superficial rhetoric's of choice. In a timely paper on the financing of social prescribing, Sandhu et al (2022 p393) argue that "investing in community-based organisations and wider public services will likely be crucial to both long term effectiveness and sustainability of social prescribing". As a result, the social prescribing community may need to consider deeply how it can move from not just providing and commissioning services, but enabling and incubating the growth of the local VCSE sector. There was some evidence of this in the data through microfinance, but very little clarity on the links between referral and funding of the activity and who pays for it. One additional idea is the way in which the National Health Service can become part of community-based wealth building, with a key evaluation of this policy (Rose et al 2023) exploring the way in which public services in Preston have given priority to procuring local services and supply chains and the impact this had on health inequalities through generating better and more employment in

deprived local economies. A deeper connection of social prescribing to a model of community wealth building could be one way in which social prescribing could develop a more robust model of social value creation that recognises the urgent need for stimulation of growth in areas of the North.

11.10.5 Social prescribers should ensure a greater pluralism/choice of activities are connected to and commissioned

Lastly, the literature on social prescribing seems biased to cultural activities associated with the arts, for example, "museums, dance, crafts and poetry" (Tierney, et al, 2022, p1466). Despite this, there are some promising linkages with Sport England and social prescribing discussions that may remedy this (Burton, 2022), alongside innovative examples covered in the press with surfing and dancing for younger people offered in Cornwall (Campbell, 2022). However, from the evidence offered in this thesis, the men reported activities more likely to be historically associated with traditional forms of high culture (Bennett et al, 2008). As a result, more imagination, not least resources, is needed on the commissioning and connection to services and activities.

Moreover, in order to improve the pluralism and democratic provision of pathways connected with social prescribing, a greater effort might be made to connect with activities that are associated with working class communities and culture. This is especially the case with men who connect to sport, without reverting to stereotypes. Efforts like this could help meet men where they are, giving them a comfortable space to land.

Now that the above has presented some recommendations derived from the findings, the following section will reflect on the method.

11.11 Reflections on methods

11.11.1 Adaptations made to guidance on critical realist interviewing: men in distress

Whilst the study initially followed the guidance on critical realist methodology (Bronnimann, 2022), it quickly became apparent that some adjustments needed to be made on this. For example, guidance on critical realist interviews suggest that researchers ask strongly analytical questions to explore and uncover the causes of events. Whilst this approach to phrasing the interview questions was certainly used to understand the mechanisms with some success, it sometimes felt unsuitable to certain members of the men sampled. There are several reasons why this may be the case, with the most obvious one perhaps that, unlike people working in business (to give one example derived from a population studied by realist interview guidance) some of the men within this thesis' study were perhaps not used to reflecting on their experience in such a way.

As stated, the realist guidance encouraged the interview to become a way of exploring outcome patterns at the level of the empirical, through retroductive questioning: that is "how" and "why" patterns have occurred. In connection to other methodological reflections, this from of questioning is designed to prompt slower, more deliberative forms of cognitive processes (Kahneman and Tversky, 2012), asking the men to deliberate on the theoretical validity of certain mechanisms as consistent or otherwise with their experience. Analytically speaking, the habitus of the men interviewed (Bourdieu & Wacquant, 1992) was largely connected with manual occupations. In many of the men's accounts, the skill and learning they were most proud of was developed through the body. As a result, some of the men were more inclined to faster cognitive processes associated with doing things with automaticity. Prompting these more deliberative processes often seemed to make them uncomfortable.

For the purposes of the study, the guidance on critical realist interviewing often seemed to disrupt the flow of the interview. When responses came on the mechanisms involved in social prescribing, they often came in unimpeded forms of what early psychoanalysts referred to as free association (Freud, 1983; Yalom, 2010), rather than slow and deliberative responses. Moreover, for some of the men interviewed, it seemed that the recursive asking of how and why questions, as connected to their social prescribing experience, evoked feelings that their accounts were being scrutinised. This sometimes seemed to briefly evoke an emotional arousal. It must be stated, however, that this response only occurred on a small number of occasions, and was quickly remedied by moving on to another area of inquiry. Similarities of the above have been noted in other research that interviews working class, blue collar or "left behind communities" (Wood et al, 2023, p2) populations in the North of England and beyond. Some have noted that those interviewed in these projects were more comfortable talking about topics like class, inequality, and poverty "out there", as opposed to a feature of their everyday life.

In order to circumvent the reported unease of talking about these issues, the interviewers asked the samples to talk about cues like photos and newspaper cuttings to discuss these issues indirectly as a more abstract phenomenon. Elements of this approach and sensitivity was taken into this research, with questions on broader attitudes to the NHS and social prescribing used as a forerunner to tapering down to their experiences of social prescribing and how the stated patterns that result from their experience where potentially caused by mechanisms. This strategy was often used in the current project; for example, on some occasions the researcher would ask general questions on their attitudes of social prescribing as a policy initiative, then this response was used to explore the participants experience of social prescribing. Questions which were asked included: "do you think social prescribing should be part of this better funding model that you describe?". Often these types of questions

would bring general responses somewhat partially tied to personal experience. This response was then used to explore the participants' experience of social prescribing. This helped the interviewee talk about social prescribing "out there" with this more attitudinal question used to scaffold their responses on their perceptions and experiences.

Some of this then moved the interview toward understanding and discussions of how and why they had experienced social prescribing in positive or negative ways. More detailed questions on this involved, "why were you able to open up to the link worker and not your G.P?", "how did you manage to achieve this release of emotion on the loss of your wife?"; and, lastly, "why do you think that you have been involved with the poetry group for this length of time?". It must also be noted that these are not just methodological musings. If the men seem to not like slower more deliberative forms of reasoning, then we may also think about how to provide more emotionally attuned democratic relationships not based on procedural rationality as some dominant current models are (Rawls, 1977).

11.11.2 Strengths and weakness of the method

The semi-structured interviews undertaken offered two notable strengths. Firstly, during the period of Covid-19, the interviews allowed the researcher to gain detailed and rich data on both the link workers and men's lives and involvement in social prescribing. Moreover, for the men interviewed, interviewing them twice allowed the researcher to generate an empathic relationship with many of the men also commenting that they really valued the opportunity to participate during a period where other forms of social participation had been taken away from them. Some of the men went as far as to say that alongside their interaction with their link worker, the interview was the first time they had shared narratives on the events of their life with anyone, which is a real strength of this method.

Secondly, the interviews allowed the researcher to explore the perceptions and experiences of link workers and men of material and relational inequality, social class and culture, along with the referral, experiences and processes pertaining to social prescribing at the subjective level, without over applying theory too readily. This arguable helped to aid a more sensitive discussion of topics that are often emotionally valanced. Despite these strengths of the interview method, weaknesses arise from the lack of broader inferences that can be made from the evidence.

11.12 Potential Areas for future research

11.12.1 Comparative qualitative study on working class and middle-class men who use social prescribing

Further research could compare the way in which social prescribing is used and experienced by those with different levels of capital. Indeed, other notable research studies in health inequalities have taken this approach (Wiltshire et al, 2019). In these studies, those who possess more economic, social, and cultural capital (for example, middle class men) are compared with men like those interviewed for this study. This would add to the rich data in this study by allowing further inferences to be made on if and how social prescribing can meet its claim of reducing health inequalities. Further examples of this (Atkinson, 2010; Devine, 2004) have been drawn on in the field of education where policies have been compared across working class samples and those with more capital, to see how policies interact with these contexts. This would test the limits of the claims that social prescribing can help tackle health inequalities.

Studying up towards decision makers and elites employed in social prescribing

A further avenue of research could relate to what Savage (2021, p9) refers to as ensuring that researchers who focus on inequalities study up towards elites, followed by the claim that too

often researchers have focused their "telescope" downwards to those at the bottom of income, wealth, status, and health distributions. As applied to social prescribing, research could use the qualitative method to study up and explore impactful policy decisions made around social prescribing. A key part of this would be the way scarce resources of time, staff and money are allocated in different areas, further exploring some of the complaints made by link workers in the study, who often claimed they were being underpaid, overworked and under resourced. The focus of this study would be on the organisational processes involved in key strategic decision making in social prescribing, including on how and who decides what activities to offer, how they are funded and so on. A study like this would enable a more granular understanding of the micro decisions made in day-to-day operational decisions pertaining to the policy and how it is complicit in perpetuating the current paradigm of multidimensional inequality or in turn challenges it.

11.12.2 Discourse analysis: "rational recreation", individual responsibility, and social prescribing

Further research could build on recent papers that have used discourse analysis to understand what is meant conceptually by the term social prescribing (Calderon-Larranga et al, 2022). There is scope for a historical examination of policy discourse that fixes its gaze on the level of community whilst at the same time income and wealth inequalities intensify within and between countries. There is a rich source of similar examples seen throughout history where reformists in the 19th century promoted "rational recreation" to civilize the leisure time of the working class, many of whom were enduring long hours and low pay in their occupational life (Snape, 2019). Similar "tensions" and ambivalences have been identified in the discourse on social prescribing where aims like "self-activation of patients" and "taking control of the individuals health" are used casually alongside aims to "tackle health inequalities" (Calderon-Larranga et al, 2022). Whilst individual behaviour change does have its place, it seems this is

often used as a foil for neoliberal assumptions where the legitimate functions of collective institutions are discredited with risk in turn distributed to the individual. Parts of this study could develop and deepen some of the initial material outlined in the introduction where social prescribing is connected to broader policy agendas like the Big Society, amongst others.

11.13 Conclusion

The chapter has surveyed the major findings from the study, connecting these with previous literature on social prescribing, as well as to the theories listed in chapter 3. It has shown how the findings connect to the research questions that were formulated after completion of the review, with this helping to move the research field of social prescribing forward. It is argued that the completion of this thesis has moved the field of social prescribing forward in two ways. Firstly, as demonstrated in the review, it has plugged a gap in coverage by focusing on class and gender; to the researcher's knowledge, there is little to no coverage of this area in the social prescribing literature. Secondly, through offering a detailed examination of the context of the men's lives it can claim two areas that seem original contributions to knowledge in the field of social prescribing, namely the focus on the cultural context of what matters in the men's lives and the focus on loss as the trigger for referral.

Appendices

Appendix A: Ethics
Appendix B: Email to Organisations – Link Workers
Appendix C: Email to Organisations – Service Users
Appendix D: Introductory Letter of Thanks to Participants
Appendix E: Poster/Flyer Advertising Study
Appendix F: Participant Information Sheet
Appendix G: Consent Form
Appendix H: Confidentiality Agreement for the Transcription of Qualitative Data
Appendix I: Indicative Line of Questioning for Semi-Structured Interviews
Appendix J: Model Social Media Messages.

12.1 Appendix A: Ethics

Lancaster University

Applicant: Adam Mars
Supervisor: Paula Holland
Department: DHR
FHMREC Reference: FHMREC20015 (amendment to FHMREC19118)

30 September 2020

Re: FHMREC20015 (amendment to FHMREC19118)
How do working class men experience social prescribing?

Dear Adam,

Thank you for submitting your research ethics amendment application for the above project for review by the **Faculty of Health and Medicine Research Ethics Committee (FHMREC)**. The application was recommended for approval by FHMREC, and on behalf of the Chair of the Committee, I can confirm that approval has been granted for the amendment to this research project.

As principal investigator your responsibilities include:

- ensuring that (where applicable) all the necessary legal and regulatory requirements in order to conduct the research are met, and the necessary licenses and approvals have been obtained;
- reporting any ethics-related issues that occur during the course of the research or arising from the research to the Research Ethics Officer at the email address below (e.g. unforeseen ethical issues, complaints about the conduct of the research, adverse reactions such as extreme distress);
- submitting details of proposed substantive amendments to the protocol to the Research Ethics Officer for approval.

Please contact me if you have any queries or require further information.

Email: fhmresearchsupport@lancaster.ac.uk

Yours sincerely,

E. Suri-Payer

Dr. Elisabeth Suri-Payer,
Interim Research Ethics Officer, Secretary to FHMREC.

12.2 Appendix B: Email to Organisations- for Link Workers

Dear [insert name],

I am a PhD student from Lancaster University. I am currently undertaking a study into men's experiences of Social Prescribing programmes in the North West region of the UK. I am particularly interested in understanding if men find it easier to engage with health interventions outside of traditional health pathways, and what meaning they derive from this experience through the programmes. Given the increasing rates of male suicides occurring in the North West, this research will offer an understanding of men's health in the area, helping community and third sector organisations consolidate what they are doing well and adjust, if needed, to help ensure that men in the area have a safe space in the community to attend.

I would be very grateful if you could help me with the study by sending out an email to the Link Workers, those who deliver courses, or anyone involved in a public facing role within the organisation. Alongside interviewing male service users, I am looking to interview a sample of link workers, or course deliverers, gaining their views and experiences of dealing with male service users.

Anyone wishing to take part will contact me via the details listed at the bottom, whereby an information pack will be sent. The structure of the interviews will consist of discussing some life history and biographical details, followed by a discussion of the link worker or participants experience with community health and wellbeing initiatives, specifically through the Social Prescribing referral pathway. The interview will conclude by asking the participant to reflect on their experiences and suggest if any improvements could be made in engaging men in Social Prescribing or programmes orientated towards improving wellbeing.

Upon completion of the research, your organisation will receive a report at the end of the project, outlining the findings of the study, as well as a summary of results from other organisations involved in the study. The findings will summarise ways to improve existing Social Prescribing pathways and community-based health programmes for men. I will also alert you to any relevant academic and practitioner literature around this issue which may be of interest. The study findings will be published in academic and practitioner journals. However, all data will be anonymised and your company name will not appear in any publications. Interview transcripts will not be passed on to any other person.

If you would be interested in helping us with our research then please contact Adam Mars on the following:

Email: marsa@lancaster.ac.uk
Mobile phone: 07952946292

With very best wishes,
Adam Mars

12.3 Appendix C: Email to Organisations – for Service Users

Dear [insert name],

I am a PhD student from Lancaster University. I am currently undertaking a study into men's experiences of Social Prescribing programmes in the North West region of the UK. I am particularly interested in understanding if men find it easier to engage with health interventions outside of traditional health pathways, and what meaning they derive from this experience through the programmes. Given the increasing rates of male suicides occurring in the North West, this research will offer an understanding of men's health in the area, helping community and third sector organisations consolidate what they are doing well and adjust, if needed, to help ensure that men in the area have a safe space in the community to attend.

I would be very grateful if you could help me with the study by passing my contact details on to any of your client base, or service users, who would be interested in participating. Anyone wishing to take part will contact me via the details listed at the bottom, whereby an information pack will be sent. The structure of the interviews will consist of discussing some life history and biographical details, followed by a discussion of the participants experience with community health and wellbeing initiatives, specifically through the Social Prescribing referral pathway. The interview will conclude by asking the participant to reflect on their experiences and suggest if any improvements could be made in engaging men in Social Prescribing or programmes orientated towards improving wellbeing.

Upon completion of the research, your organisation will receive a report at the end of the project, outlining the findings of the study, as well as a summary of results from other organisations involved in the study. The findings will summarise ways to improve existing Social Prescribing pathways and community-based health programmes for men. I will also alert you to any relevant academic and practitioner literature around this issue which may be of interest. The study findings will be published in academic and practitioner journals. However, all data will be anonymised and your company name and participants' name will not appear in any publications. Interview transcripts will not be passed on to any other person.

If you would be interested in helping us with our research then please contact Adam Mars on the following:

Email: marsa@lancaster.ac.uk

Mobile phone: 07952946292.

With very best wishes,

Adam Mars

12.4 Appendix D: Introductory Letter of Thanks to Participants

"**How do men experience social prescribing?"**

Thank you for expressing interest in taking part in my study.

Enclosed is a participant information sheet containing further details of the study and a consent form. Please read the enclosed information and if you are interested in participating in the interview, or if you have any questions about the study, please get in touch with Adam Mars who will be happy to help.

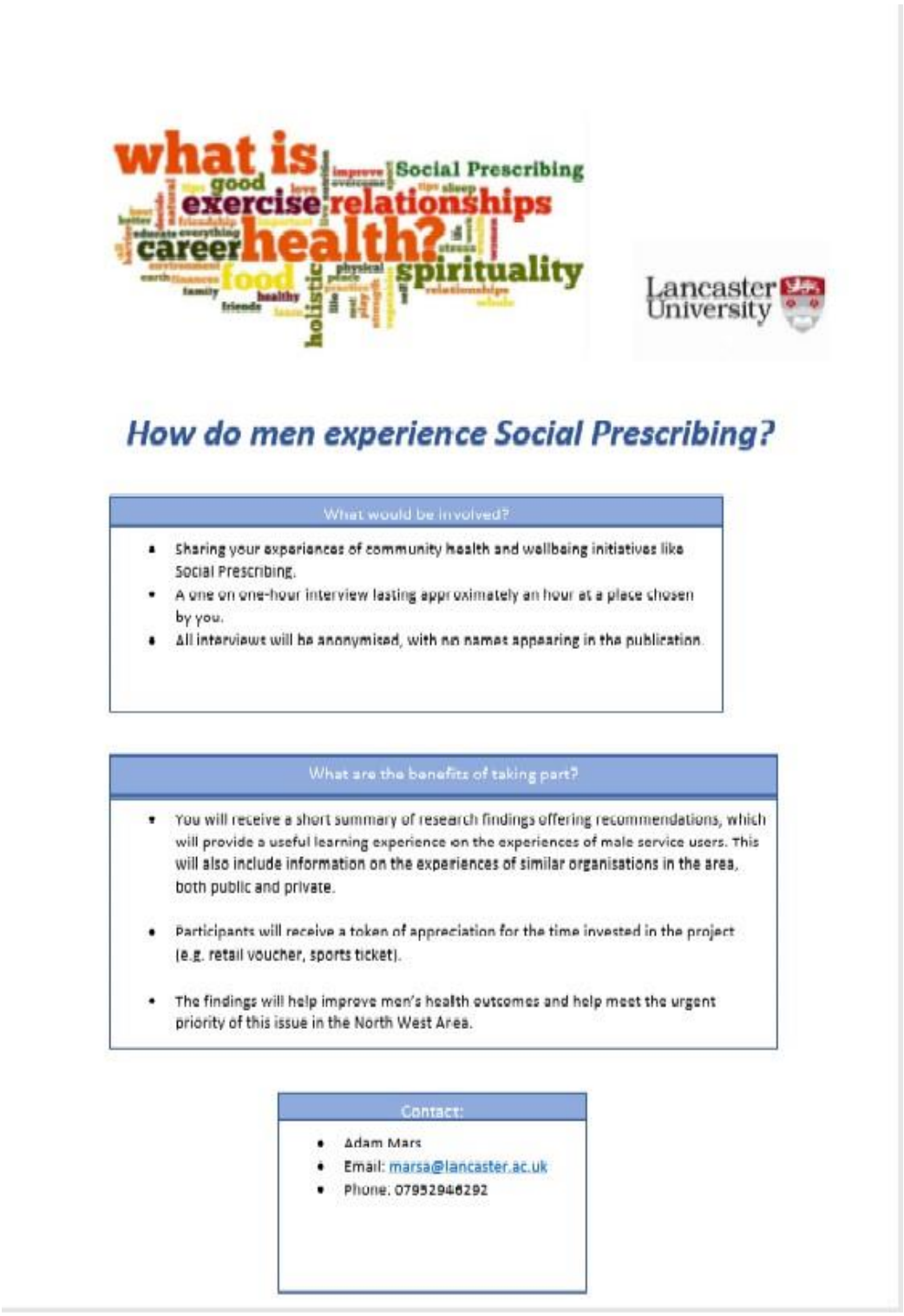
Email: marsa@lancaster.ac.uk

Phone: 07952946292

With best wishes,

Adam Mars

12.5 Appendix E: Poster/Flyer



12.6 Appendix F: Participant Information Sheet

How do men experience social prescribing?

You are being invited to take part in a research project. Before you decide if you wish to take part it is important you understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask me if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

For further information about how Lancaster University processes personal data for research purposes and your data rights please visit our webpage: www.lancaster.ac.uk/research/data-protection

My name is Adam Mars and I am conducting this research as a PhD student in the Health Research programme at Lancaster University, Lancaster, United Kingdom.

I am inviting you to take part in this study on social prescribing and men's health in the North West.

What is the study about?

I am interested in researching ways to connect more people to community interventions and voluntary organisations offering sport, leisure and creative programmes. One pathway associated with this aim is called Social Prescribing. This connects service users with community services. This research looks to understand the experience of men on their journey through social prescribing schemes, in order to gain a clearer understanding of what men value within the service.

The study will:

- 1) Explore when men value most within the social prescribing journey
- 2) Examine if this has any relationship to the lived experience of masculinity
- 3) Ask male users of social prescribing interventions if the service could be improved and how future programmes could re-orientate or consolidate these improvements

The data from this research will then be used to help drive better service design and delivery, with the broader aim of improving health outcomes for men. We hope that the information gained from this research will help to improve the experience of men who use or engage with social prescribing programmes.

Why have I been approached?

You have been approached because the study requires information from people who engage in social prescribing programmes.

Do I have to take part?

No. It's completely up to you to decide whether or not you take part in the study and if you decide to take part you are free to withdraw at any time during the interview or to withdraw your data up to two weeks (14 days) after you have completed your interview. There will be no negative repercussions for not participating in this study.

What will I be asked to do if I take part?

If you decide you would like to take part, you would be asked to complete a consent form and to take part in an interview which would last for approximately one hour, with the potential for a follow-up interview to be

scheduled at an agreed date and time. The interviews will be semi-structured and you will be sent a guide before the interview takes places which will contain information about some of the questions which may be asked. In the interview you will be asked about some life history, your experiences of social prescribing programmes, what you think about these programmes and if there is anything which could be done to improve them.

The interview will take place in a private setting in a location suitable to the participant.

To enable analysis of the data the interview will be audio-recorded with your permission.

Will my data be identifiable?

Your participation in this study and all the information about you will be kept strictly confidential:

- All your personal data will be confidential and will be kept separately from your interview responses.
- The research data collected for this study will be stored securely and only the researcher conducting this study and potentially a professional transcriber (who will sign a confidentiality agreement) will have access to your data. The files on the researcher's laptop will be encrypted and the computer itself password protected, with no-one other than the researcher able to access them. Data will be kept securely for up to ten years following publication.
- With your consent the interview will be audio-recorded to help with analysis. Audio recordings will be taken on a recording device such as a specifically designated Dictaphone. Recordings will then be transferred onto a laptop and deleted from the device after the interview. These recordings will be stored securely and will be destroyed once the data has been analysed.
- Typed transcripts of the recordings will be made and will be stored in a locked secure place at all times. Your interview transcript will be kept apart from your name and other personal details. You can request a copy of the interview transcript and audio tape. Transcripts will be kept in a locked cabinet for up to ten years after the end of the study in case they need to be referred to. After that time, they will be destroyed.
- The typed version of your interview will be made anonymous by removing any identifying information including your name. Anonymised direct quotations from your interview may be used in the reports or publications from the study. The researchers will use a pseudonym and if you wish you are free to select your own pseudonym.

There are some limits to confidentiality: if what is said in the interview makes me think that you, or someone else, is at significant risk of harm, I will have to break confidentiality and speak to a member of staff about this. If possible, I will tell you if I have to do this.

What will happen to the results?

The results will be summarised and reported in this PhD thesis and may be submitted for publication in an academic or professional journal or similar project. Any quotes from the interviews will be made anonymous and research participants will not be identifiable.

Are there any risks?

There are no risks anticipated with participating in this study. However, if you experience any distress following participation you are encouraged to inform the researcher and contact the resources provided at the end of this sheet.

Are there any benefits to taking part?

Although you may find participating interesting, there are no direct benefits in taking part. However, we hope the study findings will help to improve social prescribing programmes.

Who has reviewed the project?

This study has been reviewed and approved by the Faculty of Health and Medicine Research Ethics Committee at Lancaster University.

Where can I obtain further information about the study if I need it?
If you have any questions about the study, please contact the main researcher:

Adam Mars: marsa@lancaster.ac.uk Division of Health Research, Lancaster University

Alternatively, you may contact:
Dr Paula Holland: p.j.holland@lancaster.ac.uk Division of Health Research, Lancaster University; 01542 594672 or
Dr Siobhan Reilly: s.reilly@lancaster.ac.uk Division of Health Research, Lancaster University, 01524 594367

Complaints
If you wish to make a complaint or raise concerns about any aspect of this study and do not want to speak to the researcher, you can contact:

Professor Roger Pickup
Associate Dean for Research, Chair of FHM REC
Faculty of Health and Medicine
Division of Biomedical and Life Sciences
Lancaster University
Lancaster
LA1 4YG
Telephone: +44 (0)1524 593746
Email: r.pickup@lancaster.ac.uk

Thank you for taking the time to read this information sheet.

Resources in the event of distress:
There are no anticipated risks for taking part in this study but should you feel distressed either as a result of taking part, or in the future, the following may be of assistance:

Mind: A mental health charity www.mind.org.uk
St Helens Mind: 01744 647089. sthelmind@yahoo.com
Lancashire Mind: 01257 231660. admin@lancashiremind.org.uk
Manchester Mind: 0161 7695732. info@manchestermind.org

Citizens Advice: www.citizensadvice.org.uk
St Helens Citizens Advice: Millennium Centre Corporation Street, St Helens, Merseyside, WA10 1HJ Wigan Citizens Advice: Wigan Life Centre, The Wiend, Wigan, Greater Manchester, WN1 1NH

Wellbeing Enterprises CIC: Wellbeing Enterprises CIC, Bridgewater House, Old Coach Road, Runcorn, WA7 1QT; 01928 589799

St Helens Gateway: A community hub of information on health, social care and wellbeing information. https://www.sthelensgateway.info/organisations/wellbeing-enterprises-cic/

Creative Alternatives CIC: 07745 590 688; 07594 677 296. info@creativealternatives.org.uk; helen@creativealternatives.org.uk; sheryl@creativealternatives.org.uk

Skelmersdale Social Prescribing Service: Men's Bereavement Group: 01695 7333737 nicci@wlcvs.org

12.7 Appendix G: Consent Form

Study Title: How do men experience social prescribing?

We are asking if you would like to take part in a research project which looks to understand the experience of men on their journey through social prescribing schemes, in order to gain a clearer understanding of what men value within the service.

Before you consent to participating in the study we ask that you read the participant information sheet and mark each box below with your initials if you agree. If you have any questions or queries before signing the consent form please speak to the principal investigator, **Adam Mars**, email: marsa@lancaster.ac.uk.

1. I confirm that I have read the information sheet and fully understand what is expected of me within this study _____

2. I confirm that I have had the opportunity to ask any questions and to have them answered.

3. I understand that my interview will be audio recorded and then made into an anonymised written transcript. _____

4. I understand that audio recordings will be kept until the research project has been examined.

5. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my medical care or legal rights being affected.

6. I understand that once my data have been anonymised and incorporated into themes it might not be possible for it to be withdrawn, though every attempt will be made to extract my data, up to the point of publication.

7. I understand that the information from my interview will be pooled with other participants' responses, anonymised and may be published; all reasonable steps will be taken to protect the anonymity of the participants involved in this project.

8. I consent to information and quotations from my interview being used in reports, conferences and training events.

9. I understand that the researcher will discuss data with their supervisor as needed.

10. I understand that any information I give will remain confidential and anonymous unless it is thought that there is a risk of harm to myself

Name of Participant__ _____

Signature___ _____

_____

Date _____

Name of Researcher _____

Signature___ _____

_____

Date_____

Please initial each statement

☐

☐

☐

☐

☐

☐

or others, in which case the principal investigator may need to share this information with their research supervisor.

11. I consent to Lancaster University keeping written transcriptions of the interview for 10 years after the study has finished. ☐

12. I consent to take part in the above study. ☐

☐

12.8 Appendix H: Confidentiality Agreement for the Transcription of Qualitative Data

Name of Study:	How do men experience social prescribing?
Study PI:	Adam Mars

In accordance with the Research Ethics Committee at Lancaster University (UREC), all participants in the abovenamed study are anonymised. Therefore, any personal information or any of the data generated or secured through transcription will not be disclosed to any third party.

By signing this document, you are agreeing:

- not to pass on, divulge or discuss the contents of the audio material provided to you for transcription to any third parties
- to ensure that material provided for transcription is held securely and can only be accessed via password on your local PC
- to return transcribed material to the research team when completed by the agreed deadline and do so in password protected files
- to destroy any audio and electronic files held by you and relevant to the above study immediately after transcripts have been provided to the research team, or to return said audio files.
- to assist the University where a research participant has invoked one of their rights under data protection legislation
- to report any loss, unscheduled deletion, or unauthorised disclosure of the audio material to any third parties, to the University immediately
- only act on the written instructions of the University/researcher
- to, upon reasonable request, allow the researcher, or other University representative, to inspect the location and devices where the audio material is stored to ensure compliance with this agreement
- to inform the University's Data Protection Officer if you believe you believe you have been asked to do something with the audio material which contravenes applicable data protection legislation
- to not employ any other person to carry out the work on your behalf.

Your name (block capitals) _____

Address at which transcription will take place

_____

Your signature _____

Date _____

12.9 Appendix I: Indicative Line of Questioning for Semi-Structured Interviews

The following research questions relate to how men have experienced social prescribing as an intervention, asking questions that encourage reflections on the negotiations of gender, and what it means to "be a man" and if this intersects with social prescribing as an intervention.

The questions will especially probe the political or power/structural determinants pertaining to the delivery of social prescribing and how these play out in the experience of relationships embedded within social prescribing. The project will look to take seriously the claim made by the Social Prescribing network, that SP is built upon a relationship of "coproduction", giving patients the "power" to choose their preferred pathway through the intervention. Questions concerned with this will look to elicit if the experience of social prescribing is consistent with language used to market social prescribing.

Life history/context

1) *Initial explanation by the researcher on process of the interview, explaining the ethical guidelines, especially stressing the role of anonymity and the ability to opt out of the process at any time.*

2) *Begin the process by giving an account of interviewers aims, with one or two personal disclosures used to remove the feeling of "doer and done to".*

3) **How did you first come across social prescribing?** *If the response contains elements of life history, use this as a possible connection into the relationship between "identity" and social prescribing.*

4) For example, if the interviewer discusses his consultation with a GP led him into "tool workshop" in Sefton, then **why did this appeal to him?**

5) *If the interviewee is very forthcoming and responds quite freely to the intersection of his life history, allow the response to flow unimpeded, unless the conversation drifts too far off topic as to warrant minor interjections that guide the focus back.*

6) Again, depending on the emotional tone of the interview, this could be used as a direction again into the patient's history, including employment etc. To continue with the tool example, **did you use tools in you previous or current employment.**

7) *Responses, when appropriate, should be met with mirroring affirmations that confirm to the interviewee that he is being understood.*

8) *Again, depending on the nature of employment, the use of associations from the researcher can help generate rapport.*

Moving into the experience of social prescribing

1) How long were you involved in [social prescribing intervention]?

2) What did attending [social prescribing intervention] entail?

3) Who were the people involved in delivering [the intervention]?

4) Can you elaborate any on your relationship with [name of intervention], the staff there or the other people attending? (If any material related pertains to the phenomenological qualities of the relationship, ask the interviewee to describe more. Trying to evoke if he felt listened to, empathically and not alienated or passed over?

5) Did you feel in control of the process and did the intervention help you in the way you had expected at the outset of joining [social prescribing intervention]? What about how they felt it helped them? And whether that has changed over time?

12.10 Appendix J: Model Social Media

Message one:
With target audience being programme deliverers and link workers on Twitter, LinkedIn and Facebook.

I'm looking for participants for my study on men's lived experience of social prescribing or community health interventions. If you are a link worker, GP or programme deliverer who could refer valuable voices to be heard, then please get in touch!

@socialprescribingnetwork

Message two:
Have you recently been referred to a community health resource sometimes referred to as Social Prescribing? This often takes place in leisure centres, venues that run cultural activities or similar places. I am currently looking for participants to have their voices heard on their experiences of social prescribing, with the data helping to design better health outcomes for social prescribing across the UK. If you would be interested in taking part in an interview online, or over the phone, then please get in touch.

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