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How to improve support for people with (complex) multiple-problems through social prescribing in a vulnerable neighborhood; professionals', experts-by-experience' and clients' perspectives

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Abstract

Background Comparative analysis of literature on social prescribing implementation suggests that strategies for implementing social prescribing for people with (complex) multiple-problems may differ significantly from those for people with mild-psychosocial issues. Similar findings have been observed in the Netherlands, where a SP program has been developed in 2018. This study examines the perspectives of health and care professionals, experts-by-experience, and clients regarding the design and implementation of social prescribing in vulnerable neighborhoods in order to better support people with (complex) multiple-problems.

Methods This study includes the first steps of the participatory action research methodology. During the research, 26 semi-structured interviews and observations were applied to gain insight among professionals, experts-by-experience and clients.

Results The findings indicate that support for people with (complex) multiple-problems requires more than a referral to already existing activities and services. Experts-by-experience and clients highlighted the necessity for a tailored based approach that considers clients' unique circumstances, e.g. the clients' living environment, particularly for those with (complex) multiple-problems and having a multicultural backgrounds. While all participants recognized the importance of addressing wider health needs, they also identified several challenges in doing so. Key themes for improving the support for individuals with (complex)multiple-problems are related to fragmentation due to insufficient collaboration, and to how wider health needs can best be addressed and by whom.

Conclusion While there is a clear willingness to enhance support for people with multiple-problems, findings reveal significant challenges faced by all parties involved. A key issue identified is the mismatch between what clients need and what professionals are able to provide. Ultimately, a tailored approach is essential for effectively addressing the complex and wider health needs of both individuals and populations, in order to improve their overall health and

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well-being outcomes. This approach may be feasible by providing clients with (complex) multiple-problem with a single case manager as first point of entry.

Keywords Social prescribing, implementation, multiple (complex) problems, Participatory action research, Integrated care, Person-centred care, Addressing wider health needs

Introduction

Universally, it is increasingly recognized that people's health can be influenced by factors from different living domains. For example housing, finance, (un)employment status, daily functioning, social network, meaningfulness and mental health [1–3]. Some people experience difficulties that are interwoven, complex and exist in different living domains, often characterized as vulnerable people with complex needs and referred as people with (complex) multiple-problems [4]. People who experience physical complaints amongst difficulties related to their (complex) multiple-problems are using healthcare and social care services frequently, creating an enormous pressure on healthcare system while solutions often lay outside of medical care. Supporting people with (complex) multiple-problems requires help from different sectors, e.g. medical, social, community, or voluntary at the same time [5, 6]. Therefore, organizations in healthcare, social care, voluntary sector providers, insurance companies, and municipalities are collaborating to implement new and more holistic models of care, such as Social Prescribing.

The Social Prescribing (SP) approach originated in primary care, where general practitioners searched for ways to support clients with unmet non-medical needs [7]. Various models of SP have since emerged, aiming to address clients' wider health needs and facilitate collaboration across different sectors. These models differ in term of referral pathways, target groups (e.g. clients with psychosocial problems, (complex) multiple-problems, chronic illness), and the services and activities offered (e.g. gym referrals, community classes, housing advice, gardening clubs, green health interventions) [8, 9]. However, this approach primarily relies on linkworkers, who support primary care clients in access to social, community and voluntary services to improve their health and wellbeing. Link workers address clients' personalized needs and, together with the clients, decide which services and activities are most appropriate [10, 11]. Linkworkers have different backgrounds (e.g. psychotherapy, psychology and coaching, but mostly they do not have (professional) specific backgrounds, or work as volunteer [10, 12–14]. Implementing SP has been found complex, with several challenges identified. For example, both professionals and clients usually do not utilize SP services [15–17], and there is limited awareness among both groups regarding opportunities to address issues related to wider health determinants [18]. Additionally, barriers include a lack of shared understanding regarding working methods between professionals across sectors, as well as insufficient shared resources and structural funding [10, 14, 19, 20].

Comparative analysis of the literature on SP implementation suggests that strategies for implementing SP for people with (complex) multiple-problems may differ significantly from those used for people with mild-psychosocial issues (9, 20, 21). Mild psychosocial problems refer to early-stage social or societal issues that cause complaints such as poor sleep, fatigue, shoulder and neck pain, and headaches, as well as feelings of sombreness or fear. These problems typically arise from significant life events such as relationship difficulties, caregiving for a sick partners, or job loss. The key characteristic of mild psychosocial problems is that they involve a single issue and are addressed early on, before situation the becomes chronic or leads to multiple interconnected problems [21]. For example, SP for people with mild psychosocial issues focuses on engaging clients through brief conversation with the linkworker, with the aim of enhancing their participation in activities for social activation and are for a feeling of meaningfulness within the social, community, or voluntary sectors (e.g. gardening, painting or walking groups) [12, 14, 15, 18, 22–25]. In contrast, (complex) multiple problems involve the simultaneous presence of several deeply intertwined issues across different domains, such as social (e.g., domestic violence), economic (e.g., unemployment, debt, housing problems), and psychosocial (e.g., addiction) problems. These problems have often persisted for a long time, reinforcing and exacerbating each other, making intervention and resolution more challenging [4]. Examples of SP for people with (complex) multiple problems require a different scope and duration of the role of the linkworker. SP for this group would include long-term solving strategies involving multiple sessions with a link worker, as well as integration of mental, social and financial services (e.g. housing, financial, or serious mental health problems), which require a multi-professional approach [10, 13, 24, 26]. Investing in a safe living environment is crucial for individuals with (complex) multiple- problems, as it fosters their confidence to engage in community activities and reduces their dependence on various health and professionals [9, 27]. Although the literature shows that Social Prescribing (SP) for individuals with (complex) multiple problems may require different strategies, little is known about how SP can be better aligned with the

needs of this group. Therefore, it is important to understand how SP can be tailored to people with (complex) multiple problems.

Similar findings have been observed in the Netherlands, where an SP program has been developed in 2018 and has increasingly been implemented since [28]. This program is named "Well-being on Prescription", and is grounded in concepts from "positive health" [3], "positive psychology," [29] and "social identity theory" [30, 31], emphasizing a holistic approach to physical complaints rather than relying solely on medical treatments [28]. Well-being on Prescription focuses on addressing mild psychosocial issues of people by connecting individuals with a wellbeing coach who guides them towards wellbeing activities (e.g., yoga, or walking groups) in the social, community, and voluntary sectors. This form of wellbeing on prescription is a short-term intervention which aims to increase social activation, early detection, and preventing the escalation of issues, without focusing on treatment. "Wellbeing on prescription" is at this moment not intended for individuals with long-term care trajectories, chronic psychiatric conditions, intellectual disabilities, severe substance abuse, or serious personality disorders [21].

This program has been, amongst others, implemented in one vulnerable neighborhood of the city The Hague. However, as stated in the literature and experienced by professionals in practice, this approach is not fully compatible with people with (complex) multiple-problems [21]. Well-being on Prescription was offered as a form of informal support and social activation to this group as well. However, people with complex multi-problems appeared to need much more intensive, additional, and different types of support to adequately address their needs [9, 21, 32]. In addition to participating in social activities, people required support in addressing problems related to livelihood security, such as finances, housing, and employment. When people experience significant stress related to these issues, participation in social activities only appears insufficient to provide adequate support [4]. This study builds on these experiences, in a cases where the use of "wellbeing on prescription" is found not fully compatible with clients with (complex) multiple-problems, living in a vulnerable neighborhood. Professionals of primary healthcare centers, involved in implementation of SP in this vulnerable neighborhood of The Hague, opted an action research approach to learn how SP could meet the needs of people with (complex) multiple-problems. This study outlines the first steps (orientation and system exploration) of this action research approach, examining the perspectives of health and care professionals, experts-by-experience, and clients regarding the design and implementation of SP in vulnerable neighborhoods in order to better support people with (complex) multiple-problems. This led to the following research question:

> *How can we improve the support for people with (complex) multiple-problems through Social Prescribing in a vulnerable neighborhood, according to professionals', experts-by-experience' and clients' perspectives, their experiences in the current situation, and the desired situation?*

Methods

Setting

This study is part of the reflexive evaluation of a large national transformation process from healthcare systems to integrated health and well-being systems - 'Right Care at the Right Place', implemented in ten Dutch regions and performed by the Dutch National Institute of Public Health and the Environment [33]. The study is set in a neighborhood in The Haque (capital in province of South Holland), one of the involved regions in the evaluation. The inhabitants of this neighborhood have 149 different nationalities, 91% has a migration background, 19% is unemployed, are mostly uneducated: 55% has no starting qualification for the labor market, 65% has a minimal income and 23% has debts. Compared to other neighborhoods, people in this neighborhood exhibit significantly poorer health outcomes with 37% having a long-term illness or condition, 66% feeling lonely and 22% experiencing severe loneliness [34]. Professionals of one primary healthcare center in this neighborhood have been searching for ways to better address the (health) needs of many people with (complex) multiple-problems in their neighborhood. Therefore, they started a network of professionals from different sectors (health care domain and wellbeing domain) to discuss client cases with (complex) multiple-problems in multidisciplinary consultations. These multidisciplinary consultations took place every six weeks online and lasted 1.5 h. This network was based on collaboration agreement, serving more than 10.000 clients and involved general practitioners, social workers, elderly advisors, advisor financial helpdesk, and a neighborhood sport coach. Another primary healthcare center got involved as well, bringing involvement of general practitioners, physiotherapists, dieticians, various support staff, and nurses.

In the Netherlands, primary health care providers are financed by health care insurers. Whereas the professionals from the wellbeing domain like, social workers, wellbeing coach (linkworkers), elderly advisor, advisor financial helpdesk and neighborhood support, home support worker, ambulatory counselor are all financed through the municipality (local government). The experts-by-experience work as volunteers at a municipal organization. An important difference

between professionals and volunteers is that volunteers are not bound by formal regulations regarding registration. Professionals, on the other hand, must adhere to protocols and regulations, such as record-keeping and privacy laws, which can sometimes limit their flexibility in practice.

Design

This study includes the first steps of the participatory action research (PAR) methodology. PAR is an approach that enables people to solve complex problems in practice together [35]. By jointly investigating the situation with involved stakeholders and being open to their different perspectives, a shared base of knowledge can be created for all involved parties. This can enable conversation of, insights from different perspectives into appropriate action plans [35]. This PAR methodology consists of seven different stages: 1 Orientation research focus; 2 System exploration; 3 Insights sharing and solution identification, 4 Action plan cocreation, 5 Formalization and transferal, 6 Monitoring and 7 Evaluation [35]. This paper focuses on stage 1 and 2, orientation research focus and the system exploration. In the orientation stage, professionals from the primary healthcare centers collaboratively determined the research scope. The system exploration consists of different elements: 1. Context of the problem; 2 Desired situation, 3 Requirements to achieve the desired situation, 4 Possible solution directions, 5 Motivation to change the situation [35]. During the system exploration, semi-structured interviews and observations were applied to gain insight into the different elements from the diverse perspectives of the involved stakeholders.

Recruitment strategy

The study received ethics approval from the Ethical Review Board of Tilburg University (PR252). Participants of this research consist of three groups: professionals, experts-by-experience and clients. To recruit participants for this research purposive sampling and snowball sampling was used [36]. The involved primary healthcare centers used their multidisciplinary network to contact professionals to participate in this research. Director of one primary healthcare center provided a list with the involved professionals within the of the multidisciplinary network and who also regularly join the multidisciplinary consultations to discuss cases of clients with (complex) multiple-problems. The researchers CB and SV approached these selected professionals. A total of thirteen executive professionals were willing to participate in the research.

Experts-by-experience are people who have faced (complex) multiple-problems in the past and still encounter minor difficulties. Recruitment occurred through the supervisor of a volunteer organization, where these experts assisted clients with (complex) multiple problems. This supervisor invited experts-by-experience to participate in the research, and interested experts were then approached by researchers CB and SV. Additionally, snowball sampling was employed, asking participating experts if they knew others who might want to join. Ultimately, seven experts-by-experience agreed to participate in the study and received financial compensation for their time.

Clients are people who visit primary healthcare centers and voluntary organizations for their currently (complex) multiple-problems. With help from professionals and experts by experience, clients were recruited through leaflets about the research. Interested clients informed their health and care professionals, who then referred them to researchers CB and SV. Recognizing that client recruitment requires significant time and effort, the researchers opted not to impose specific timeframes, instead prioritizing data saturation and accommodating participants' individual needs. Ultimately, six clients agreed to participate in the study. Reasons for declining included feeling overwhelmed by their problems or discomfort discussing their problems.

Data collection

Data were collected between April and October 2023. All study participants received an information letter and provided their informed consent (RP252). A semi-structured interview guide and observation format were used for data collection. The semi-structured guide, informed by elements of the system exploration, was used to anchor the interview process. The interview questions were designed to explore the current situation, the desired situation along with the associated motivation, and potential improvements (possible solutions) (see appendix 1). Although the structure of each interview was the same, the type of questions was adapted to the type of participant (professionals, experts-by-experience and clients) (see appendix 1). CB first conducted a pilot interview with two professionals from the primary healthcare centers for missing parts and whether they could adequately tell their stories. No adjustments were necessary. CB and SV conducted the remaining interviews which each lasted 45–60 min. Interviews with professionals took place at the primary healthcare center, with experts-by-experience at the volunteer organization and with clients one of these locations or at home or over the phone, depending on their preferences. To aid data analysis, all interviews were recorded and transcribed ad verbatim. In addition to the semi-structured interviews, the researchers also joined multiple multidisciplinary consultations with health and care professionals for observations. Observations during the multidisciplinary consultations

Table 1 Professionals participating in this study

Number	Profession/Function	Workplace	Sector (as categorized in Dutch financing system)
3	General Practitioner	Primary health care center	Medical sector
2	General practitioner assistant	Primary healthcare center	Medical sector
2	General practitioner assistant mental health	Primary healthcare center	Medical sector
1	Social worker/Linkworker	Primary healthcare center	Social sector
1	Social worker	Municipality	Social sector
1	Supervisor Experts-by experience	Volunteer organization	Volunteer sector
1	Home support worker	neighborhood and residential care	Social sector
1	Ambulatory counselor specialist	Social organizations for people with disability	Social Sector
1	Elderly advisor	Social organizations	Social Sector

were written in notes by CB and SV. Fieldnotes included the discussion during the meeting and the observed reactions. The fieldnotes were used for cross validation of data collected by the semi-structured interviews.

Data analysis

This study consist of a thematic content analysis, which consist of an inductive and deductive approach for analyzing the data. The deductive codes were based on the elements of the system exploration (second stage of PAR): (a) current situation, (b) de desired situation, (c) solutions, (d) motivation (i.e., what drives it) [35]. The inductive codes consisted of themes that where directly retrieved from the data (i.e., what the data are about) and included, for example *health and care professionals' attitude and commitment towards clients*, *clients attitude towards receiving support* or *regular services and activities not aligned with wider health needs.* All transcripts were coded by two researchers (CB and SV). The first three interviews were checked for intercoder reliability. All interviews were coded in MaXQDA according to the following steps:

- Each transcript was coded simultaneously using both deductive codes (what is it: elements of the system exploration for example current situation or desired situation) and inductive codes (what is this segment about; these codes later formed the themes).
- A summary was created for each perspective and clustered by thematic content.
- For each thematic content, an overview was made of deductive codes (i.e. current situation, desired situation, solutions or motivation).
- All data were then organized. Comparisons and similarities could be identified per perspective, theme, and deductive code.

Results

The following section presents the perspectives of three groups of participants on improving the support for people with (complex) multiple-problems through designing SP in an vulnerable neighborhood: (1) Health and care professionals, (2) Experts-by-experience, and (3) Clients. For each group, first an overview of experiences about the current situation will be provided. Secondly the perspectives on the desired situation and, if mentioned, possible solutions will be described.

Interview participants

In total 26 interviews were conducted; 13 with executive professionals, 7 with experts-by-experience and 6 with clients. Professionals worked in different functions and sectors (see Table 1).

Both clients and experts-by-experience have or had a wide range of problems on different living domains, which varied from unemployment, physical health issues, dept or housing problems, mental health issues (ADHD), drugs addiction or alcohol abuse, language issues, no social network, sleeping problems, traumatic history, and criminal history. Both experts-by-experience and clients were struggling with a combination of these issues.

Perspectives of health and care professionals

The main themes that were identified by health and care professionals with regard to SP for people with (complex) multiple-problems are (1) the importance of addressing the wider health issues and needs of clients with (complex) multiple- problems; (2) inadequate organizational structures and (3) unclarity in interprofessional collaboration.

The importance of addressing the wider health issues and needs is recognized, but it is difficult to address these sufficiently

According to health and care professionals, addressing clients' wider health needs is crucial for providing comprehensive support and improving their overall health and wellbeing. However, they observe that clients do not always realize that physical complaints may stem from other life circumstances, (e.g. stress, financial or social problems) and these different aspects interconnect. This lack of awareness makes it difficult for health and care professionals to address the root causes of their clients' health problems. The complexity of (complex) multiple-problems results in clients tendency to discuss their physical complaints primarily from the perspective of their illness. Consequently, general practitioners encounter difficulties in referring and motivating clients to other services and activities outside the regular healthcare. Clients might be hesitating or lacking the motivation to engage with non-medical support services, which in turn results in clients not using the holistic support they need hindering their overall health and wellbeing.

> *"We are searching how to you motivate patients who don't come to you with that question. We are searching how to explain the concept of SP to patients. We need to learn, what works or not in explaining and motivating clients." General Practitioner.*

Some general practitioners perceive their role as to ensure that clients are referred to the appropriate professional rather than addressing the wider health issues and needs without a medical cause themselves. They state that in a desired situation, clients are capable to seek the appropriate help for their non-medical needs themselves instead of going to a general practitioner for help.

> *"it would be helpful if clients start to realize that other factors influence their health experiences and that GPs can help them find the right place but that we cannot solve those problems, because it is not my expertise" General Practitioner.*

Inadequate organizational structures to support the wider health needs of clients

According to health and care professionals, adequate organizational structures across healthcare, social and voluntary sectors are crucial for addressing the wider health issues and needs of their clients. However, currently professionals experience significant difficulties in organizing care and support for people with wider health needs due to fragmented coordination between different sectors and not finding each other. For example there is no comprehensive overview of all available services, activities and initiatives. Especially professionals from the primary healthcare center experience several obstacles when working with professionals outside the primary healthcare center. For example frequent staff changes and shortages in the social domain, coupled with changing policies and limited financial resources, hinder effective collaboration between professionals from medical and social sector.

> *"What remains difficult in working with professionals in the social domain are the changes in personnel. It also depends on who sits in the city council and how the wind blows and how budgets are deployed. By the time you know each other well a new person is sitting there. That remains a challenge and brings risks to the collaboration" General Practitioner.*

Professionals outside the primary healthcare center acknowledge these difficulties. They in turn feel frustrated because their tasks often exceed the allocated time, and because there is insufficient stimulation for collaboration. Additionally, financial resources for collaboration are frequently lacking.

Professionals from both sectors advocate for a desired situation of structural collaboration, where a permanent team of professionals from different sectors work together to help clients with (complex) multiple-problems and address public health issues and local population needs. They emphasize the municipality's responsibility in committing to this structural collaboration with professionals from the social sector (e.g. invest long-term focus). To find each other more and know about the collective initiatives some professionals suggest reorganizing their division of tasks. To include more time for networking and visiting local initiatives, in addition to client contact and registering.

> *"Professionals in salaried positions are under pressure due to the requirement to register. You must have contact with individual clients 75% of the time, and the rest of the time you are registering. There should be more flexibility or a different division of tasks, as being able to spend some time each week to networking is important for clients." Supervisor experts-by-experience.*

Furthermore, professionals desire whether it would be possible to bring in client cases through different professionals instead of only by professionals of the primary healthcare center. They doubt however if current financial structures sufficiently support this construction; a collaborative environment where all professionals can

bring client cases to joint consultations, not just those from primary health care centers.

> *"Ideally, we would all like to bring in client cases so that we can jointly assess what is needed and how to address this together", professional social domain.*
> *"A client case should only be brought in from the linkworker who is paid by the health insurance company. The other way around would be possible but then the focus is moved from the primary healthcare center to outside. Then the question is whether the health insurer wants to paid that because now the approach is from the medical side", General Practitioner.*

Unclarity in interprofessional collaboration for clients' wider health needs

According to health and care professionals, fostering a shared understanding of expectations, roles, tasks, and functions, as well as investing in mutual knowledge and trust, is essential to stimulate interprofessional collaboration. However, in the current situation professionals experience numerous roles with overlapping tasks and responsibilities, funded by various sources such as health insurance and municipalities. The lack of clarity and overlap makes it difficult for general practitioners to decide where to refer a client to, particularly given the limited time they have for each client.

> *There are many unclear roles with a lot of overlap between different roles. There are many different practice support workers with different backgrounds, so some could address (complex) multiple-problems, for example (when a) general practitioner assistant mental health care also has a background as a social worker.*

Furthermore, in the current situation each problem of a client is treated separately by different professionals, without a central point of contact for non-medical needs. This causes a lack of overview of the involved professionals, and the actions already taken to support the client. This fragmentation is experienced to lead to wasted resources and funds due to inefficiencies and duplicated efforts. Additionally, professionals often prefer to keep clients within their own care, partly due to difficulties in transferring responsibility and partly out of concern that involving others may encroach on their role. This dynamic affects interprofessional collaboration and can hinder to take clients' health and well-being outcomes collectively as a starting point.

Health and care professionals propose the creation of an overarching function, such as a case manager for addressing clients' non-medical wider health needs. According to professionals this overarching function must be able to (1) perform conversations; engage in comprehensive discussion with clients to address their wider health needs; (2) multidisciplinary leadership; lead and connect a multidisciplinary network and consultations to ensure coordinated care; (3) service overview; create and maintain an overview of locally available services and activities (4) customized support: provide tailored support to clients with (complex) multiple-problems. Linkworkers mentioned that a solution can be for them to operate as independent professionals, serving several general practices to help clients with (complex) multiple-problems instead of linked with one GP practice. Several health and care professionals also suggest that this role can be filled by a social worker, funded jointly by health insurance and municipalities. This social worker would work as an equal partner with general practitioners, addressing both medical and non-medical issues simultaneously.

Perspectives of experts-by-experience

The perspectives of experts-by-experience are described based on two different types of experiences namely, experiences from their own personal life or past when they had (complex) multiple-problems and experiences as volunteers through helping other people with (complex) multiple-problems. The main themes that were identified by experts-by-experience as of importance for designing SP for people with (complex) multiple-problems are (1) lack of communication and alignment between health and care professionals; (2) health and care professionals 'lack of committed attitude towards clients; and (3) Clients' attitude and mindset crucial towards receiving support.

Lack of communication and alignment between health and care professionals

In line with professionals, experts-by-experience mentioned the importance of alignment between professionals when helping clients with (complex) multiple-problems. However, currently they highlight significant issues in the communication and coordination among health and care professionals when they are involved with the same client. This results in the clients' wider health needs being addressed separately, which caused clients often have to repeatedly tell their stories to different professionals, leading to frustration and inefficiency. Additionally, clients are frequently moved back and forth between professionals, causing fragmented and uncoordinated care.

> *"Visitors often experience that they are sent everywhere. Sometimes these organizations don't take*

responsibility either. Communication between organizations should be better", experts-by-experience.

Besides professionals, experts-by-experience also suggest that in the desired situation professionals communicate with each other and have a complete overview of the problems experienced by clients. Additionally, they suggest having one central professionals (e.g. case manager) who serves as the central point of contact for clients ' non-medical needs. This person should be responsible for maintaining overview, coordinating, and communicating with other involved health and care professionals. Experts-by-experience mentioned that this central professional must have enough flexibility to arrange necessary services for clients and overcoming rigid rule-bound constraints (laws and regulations or financial).

"Better communication is needed between healthcare professionals. Everyone needs a complete picture of the problems of clients that is essential to help someone. Too many healthcare professionals with their own view of the problem doesn't help either," expert-by-experience.
"If a client has difficulty asking for help, it is very important that there is a central person who initiates everything and keeps direction with other parties everything coordinated because now there are too many islands", expert- by-experience.

Health and care professionals' lack of committed attitude towards clients

To effectively address clients' wider health needs and win their trust, experts-by-experience highlight the importance of professionals demonstrating a committed attitude, genuine interest in clients' stories, and supportive behavior. However, they experience that many professionals currently lack this level of commitment and responsibility towards clients due to demanding of their jobs. Professionals are often perceived as not being fully committed or feeling as responsible for their clients as experts-by-experience do. This perception may arise because experts-by-experience have personal knowledge of how challenging the situation can be and understand more deeply what the client needs. This firsthand experience enables them to relate more empathetically and provide more personalized support, which may not always be apparent in the professional's approach.

"As expert-by-experience, I still experience too often that healthcare professionals do not really commit to clients who need help badly, that conversations are not recorded or documented……. as experts-by-experience, we really go through fire and water for people to get things done and that is also necessary to really help people move forward", expert-by-experience.

Furthermore, experts-by-experience mentioned that it is importance that professionals have substantial work or life experience, sufficient time for in-dept conversations, and an understanding of their living environment. Experts-by-experience express a desire that professionals want to work with them structurally, recognizing the unique contributions that experts-by-experience can bring. Potential benefits include that experts-by-experience can act as a temporary support system for clients when there are long waiting lists for treatments, and they often have valuable ideas for initiatives that can support clients with (complex) multiple-problems.

"As volunteers, we are not bothered by requirements around registration and have more freedom to shape the work ourselves.", expert-by-experience.

Clients' attitude and mindset are crucial towards receiving support and making changes

Experts-by-experience emphasize the critical role of clients' attitudes in receiving support and mindset in making changes. According to experts-by- experience clients are often not fully transparent about their problems due to feelings of shame and guilt, which can hinder their motivation to seek and accept support. For example, cultural factors can cause these feelings and make clients reluctant to admit that they cannot solve their problems themselves. Additionally, they mentioned the importance to make distinction between clients' attitude and self-reliance to ensure they receive appropriate care. Some clients requiring targeted support, particularly those with mental vulnerabilities, may struggle with daily activities and problem-solving due to their condition.

Expert-by-experience mentioned that, in a desired situation, fostering an open attitude and mindset among clients is crucial. They mentioned that clients should feel free from resistance to fully benefit from available the support, because only when clients have an open attitude and do not have longer feelings of resistance they can receive all the support they need. It is important to create a supportive and non-judgmental environment where clients feel safe to express their issues without fear, shame or guilt. Furthermore, it is important to be aware of and sensitive to cultural factors that may influence clients' feelings of shame and reluctance to seek help.

"Many clients experience a lack of self-reliance. Clients cannot do things themselves because of mental problems. It often has to do with mental vulnerability", experts-by-experience.

Perspectives of clients

The main themes that were identified by clients as of importance for designing SP for people with (complex) multiple-problems are (1) a lack of attention for underlying problems by physical complaints; (2) regular services and activities not always aligned with the wider health needs and (3) too often not taken seriously and seen as a person.

Lack of attention for underlying problems by physical complaints

In line with the perspectives of professionals and experts-by-experience also several clients indicate the importance of addressing clients' wider health needs. However, in contrast to the perspectives of health and care professionals, clients experience that professionals in the medical sector have limited time to investigate the underlying problems behind physical symptoms. As a result of time constraints, medication is often prescribed quickly as a solution for physical complaints. This approach leads to underlying problems remaining unaddressed, resulting in ongoing or recurring health issues. Besides experts-by-experience, also clients suggest that in a desired situation, professionals should have enough time to delve into the client's entire life situation. By thoroughly understanding a client's wider health needs, professionals can provide more appropriate and comprehensive support.

> *" When things are really not going well, you need a coach who delves into the living environment and helps from there, who stands beside you daily, helps you plan, takes you seriously and interested in how you are doing", a client.*

Regular services and activities not always aligned with the wider health needs

Most clients experience that existing services and activities do not always align with their health needs. Specific issues include for example the involvement of multiple professionals for each problem, to be referred anywhere instead of being heard, and the lack of cultural sensitivity in services. Currently, in line with professionals as well experts-by-experience also clients experience a lack of cohesive care due to the involvement of different professionals for each single problem, leading to a fragmented care experience and a lack of comprehensive overview. Furthermore, services often do not meet the needs of clients from diverse cultural backgrounds, particularly in neighborhoods with significant cultural diversity.

To work towards a desired situation clients suggest a client-centered approach, which means that services and activities need to be tailored to the specific needs of each clients, considering their unique circumstances and cultural background. Furthermore, in line with expert-by-experience they also suggest more collaboration between professionals and experts-by-experience, because of their personal approach, having more time, the (practical) support and the low threshold for clients to contact and experts-by-experience instead of a professional.

Too often not taken seriously and seen as a person

In the current healthcare environment, many clients feel that they are not always taken seriously by professionals and are often treated based on a stigma associated with their problems. Therefore, Clients experiences feelings of shame and powerlessness. In line with the perspectives of experts-by-experience this created a situation where the route problems are not shared and they do not receive appropriate support. To move towards a desired situation, clients mention that it is essential that they are treated with respect regardless of their current or past issues.

Discussion

This study represents the first phases of a participatory action research aiming to explore how to improve the support for people with (complex) multiple-problems through SP in a vulnerable neighborhood, according to health and care professionals, experts-by-experience and clients. To our knowledge, this study is one of the few with a multi-perspective approach to improving Social Prescribing (SP) for people with (complex) multiple problems in the first line healthcare. The findings indicate that support for people with (complex) multiple-problems requires more than a referral to already existing activities and services. Experts-by-experience and clients highlighted the necessity for a tailored based approach that considers clients' unique circumstances, e.g. the clients' living environment, particularly for those with (complex) multiple-problems and having a multicultural backgrounds. While all participants recognized the importance of addressing wider health needs, they also identified several challenges in doing so. Key themes for improving the support for individuals with (complex) multiple-problems are related to fragmentation due to insufficient collaboration, and to how wider health needs can best be addressed and by whom. The findings of this study are comparable to a previous study [26]. However, this research provides additional and more in-depth insights beyond the findings of the comparable study. Shared themes include the importance of a non-stigmatising environment, attention to the wider determinants of health, and poor communication between professionals. This research adds further depth by highlighting issues such as inadequate organisational structures (e.g., fragmented coordination, lack of oversight of available services, activities, or initiatives), unclear roles, tasks,

and functions, a lack of professional commitment, and the critical role of clients' own attitudes. Additionally, it underscores that current services and activities are often not aligned with the wider health needs of clients.

Addressing fragmentation due to insufficient interprofessional collaboration

Collaboration among professionals from different sectors is often hindered by inadequate organizational structures. Our study, identified that this results in fragmented care delivery, poor communication regarding clients among professionals, and unclear responsibilities between various health and care professionals. Most participants highlighted the necessity for structured interprofessional collaboration among professionals from diverse sectors to ensure that clients and the local population receive coherent support rather than fragmented services. Professionals elaborated on the importance of team work across sectors, aligning with the wider literature that underscores this necessity [37–40]. Improving this collaboration requires addressing systems barriers related to time, finances, role and tasks division. This is consistent with the literature on integrated care, which describes different levels —macro (system integration), meso (organizations and professionals), and micro (citizens and clients)—interact with one another [41]. For example to improve collaboration across sectors (e.g. alignment and communication), some preconditions (e.g. space to collaborate and knowing each other) work through all levels (system, organizational, professionals and clients) and depend on each other.

Addressing wider health needs – tailored care – and single point of contact

Another key theme identified is the necessity of understanding the root causes of clients' problems, as participants noted a lack of awareness by clients regarding wider health needs. Also, clients' attitude towards receiving help (are they open to talk about support for wider health needs) and their feeling of not being seen as a person (but only as their symptoms) is not helpful in addressing roote problems. This study revealed that regular structures, interventions, and services often do not align with the needs of clients facing (complex) multiple-problems. Clients frequently have to visit multiple professionals separately for each single problem. There is a mismatch between clients' needs and the services that professionals are able to provide, often due system barriers. According to our participants, a tailored based approach would be more appropriate for clients with multiple-(complex) problems. To enhance professionals' understanding of clients' situations, Knox (2022) found in a study on the success of case management in health and social care programs that regular home visits increased professionals' awareness of and ability to address challenging circumstances (e.g. status home situation) [42]. Difficulty on addressing wider health needs is however, not only related to health professionals, but also to the perspective of clients themselves. We found that some clients were prone to discuss their physical problems instead of wider problems. And need to feel safe enough and free from resistance in order to change their mindset towards receiving help. Moreover, the case study by Knox (2022) again showed the interdependence of addressing these key themes on micro, meso and macro level, as professionals had limited time and unsuitable task division [42]. This resulted in not having enough time, capacity and commitment, e.g. expressing empathy, demonstrating respect, keeping appointments or calling to check in and 'being there', to build a trustful relationship with clients.

To establish a trustful relationship with clients, the participants suggested that having a first single point of contact could be beneficial. This is consistent with the international literature where Bertotti (2018) emphasized that for people with (complex) multiple-problems, having a single contact person who is knowledgeable about the local social support infrastructure fosters a sense of agency and provides non-imposing support [12]. Besides, having a central first point of contact for people with (complex) multiple-problems might help to alleviate the fragmentation for professionals as well as clients. Additionally, participants in our study mentioned that professionals can collaborate more closely with experts-by-experience who serve as volunteers to enhance support for clients. They were found to offer practical, empathetic support and help bridge the gaps between clients and professionals. This aligns with the findings of Stathi et al. (2021), which emphasize the value of peer volunteers [43]. However, our study indicates that, in implementing these points of contact, it is essential for clients to understand that they do not always need to consult their general practitioners for physical complaints that may stem from other life circumstances.

Shifting the focus of individuals to communities

Finally, the collaboration among professionals in our study was primarily initiated from general practice settings, focusing on individual clients who actively seek out their GP. Literature suggests a different approach which includes engaging with clients within their neighborhoods to gain a deeper understanding of their living environments. To achieve this, Chen et al. (2024) suggest a "communities of care" approach, which emphasizes smaller, place-based partnerships between professionals to create multi-provider teams and deliver personalized support that is tailored to the specific needs of the community at neighborhood level. One key element of

this approach is a community needs assessment, where networks of partnerships engage in collaborative efforts to reach out to citizens within the local community [44]. This engagement helps to better understand the clients or citizens' needs and to provide upstream interventions or recommendations that improve health and wellbeing [45–47].

Practical implication

The PAR methodology actively engages stakeholders in a collective learning process and the co-designing of solutions tailored to a specific context. Unlike more traditional research methods, the PAR methodology is designed to ensure that the insights from the exploration phase lead to concrete follow-up actions. This study also incorporated the perspectives of experts-by-experience and clients, further enriching the data. The benefit of including experts-by-experience, compared to only clients, is that they can retrospectively reflect on the situations they were in, providing valuable insights. For example, their critical reflection highlighted that the attitude and mindset of clients are crucial in receiving support and making changes. This perspective emphasizes that challenges are not always solely due to the availability or actions of professionals but also depend on the clients' readiness and willingness to engage.

By analyzing the data from the system exploration phase – examining different elements such as the current situation and the desired situation - and sharing these insights with involved stakeholders, they gained a clearer understanding of the overall system and the diverse perspectives embedded within it, including those of clients. The insights and discussion points of this study were shared with the involved stakeholders and participants in this PAR research. By reflecting on these findings together, the included stakeholders and participants can take informed next steps in the process to co-create an action plan for improving the local Wellbeing on Prescription program for people with complex multiple-problems.

Strengths and limitations

A strength of this study is its multi-perspective approach, which provided a comprehensive understanding of the challenges and potential solutions for improving care for individuals with (complex) multiple-problems. However, whereas this study focused on including people with (complex) multiple problems, we should consider the possibility of selection bias. Our study population consists of individuals (including experts-by-experience and clients) who were approached through professionals and were therefore already within the scope of professional care. While we also spoke with clients who were critical towards current care programs, we should consider that this population might represent only a subset of people with (complex) multiple problems. For example, we did not include people who are not in contact with professionals or do not access the current support services. This may have led to missing information about the reasons why some people choose not to use the existing services and about what people might need for better support. Understanding these reasons is crucial for improving the accessibility and effectiveness of SP for individuals with (complex) multiple problems. Another strength of this study is that it was initiated by professionals from or working together with the primary healthcare practices to better address the support needs of clients with (complex) multiple-problems, which fostered strong commitment and collaboration throughout the research process and is expected to aid adaptation based of the recommendations of this study. Despite the research being initiated by professionals, a possible limitation is that the focus remained largely on the healthcare systems and its services, leaving little room to approach the issue from a community perspective. This may have missed valuable opportunities to explore how community-driven solutions and local resources could contribute to more effective support for individuals with (complex) multiple-problems.

Future research

Recommendations include utilizing the insights gathered from these perspectives to inform regional stakeholders – such as municipalities, healthcare insures, and regulatory bodies – in their collaboration with professionals, experts-by-experience, and clients to co-create solutions and develop an action plan as the next step in the action research. After co-creating and designing a regional action plan with key themes to enhance support for people with (complex) multiple-problems through SP in vulnerable neighborhood, it is recommended that future research focuses on evaluating the implementation of these key themes. Furthermore, future research can explore the benefit of having an alternative point of contact, other than the general practitioner (GP), as a first point of contact for people with (complex) multiple-problems. Additionally, future research could further investigate how a team or professionals can contribute effectively to deliver tailored support.

Conclusion

While there is a clear willingness to enhance this support, findings reveal significant challenges faced by all parties involved. A key issue identified is the mismatch between what clients need and what professionals are able to provide, often due to systemic barriers, such as flexibility to adjust role divisions and tasks or shared financial resources. Ultimately, the findings suggest that a tailored

approach is essential for effectively addressing the complex and wider health needs of both individuals and populations, in order to improve their overall health and well-being outcomes. This approach may be feasible by providing clients with (complex) multiple-problem with a single case manager as first point of entry.

Abbreviations

RIVM	National Institute for Public Health and the Environment (Dutch: Rijkstinstituut voor Volksgezondheid en Milieu)
HU	University of Applied Science Utrecht
ACTA	Academic Centre for Dentistry Amsterdam
SP	Social Prescribing
GPs	General Practitioners
PAR	Participatory Action Research

Supplementary Information

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Supplementary Material 1

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Author contributions

The research design was developed by CB and subsequently reviewed and refined by SV, NvV, and BK. Recruitment was conducted by CB and SV in collaboration with the involved organizations. Data analysis and interpretation were carried out by CB and SV, with feedback and input from NvV, BK, and KJ. CB drafted the manuscript, which was reviewed by SV, NvV, BK, and KJ. All authors made significant contributions to the study's concept and design and have approved the final manuscript.

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Data availability

"Templates used for data extraction and analysis are available upon request. Data request can be made by the authors".

Declarations

Ethics approval and consent to participate

This study received ethics approval from Tilburg University (PR252). All participants were provided with detailed information letters about the study and given sufficient time to ask any questions. Participation was clearly explained to be entirely voluntary. Subsequently, participants signed informed consent forms, agreeing to their involvement in the study and its design, and approved the final manuscript. This is in compliance with Dutch national guidelines: https://www.tilburguniversity.edu/upload/ddc3ce11-1e82-4bf7-ac6d-e813999e5037_CODE%20OF%20ETHICS%20FOR%20RESEARCH%20IN%20THE%20SOCIAL%20AND%20BEHAVIOURAL%20SCIENCES%20DSW%20J%20%20%20.pdf and http://ec.europa.eu/research/participants/data/ref/fp7/89867/social-sciences-humanities_en.pdf.

Consent for publication

Not applicable.

Competing interests

The authors declare no competing interests.

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