Shifting Sands: A Scoping Review of Health Models for the Treatment of Chronic Illness in the Middle East for the Proposed Inclusion of Social Prescribing

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The authors propose that social prescribing should be reviewed as a health and social care strategy to assist patients diagnosed with chronic illness in order to support existing traditional bio-medical treatments so that individuals receive a holistic care package that will create improvements in their health and well-being. Whilst, social prescribing strategies have been developed within western healthcare systems for over twenty years and are again, receiving renewed interest, there has been little evidence of its use within the MENA region. This Middle East region has pre-dominantly continued to utilize pharmaceutical interventions for patients with chronic illness. Post-COVID-19 healthcare providers continue to look for innovative strategies within a global economic downturn crisis whilst also looking to address the detrimental effects on the treatments of chronic illnesses. The use of social prescribing utilizes psychological and social factors rather than an overreliance on the bio-medical model which relies on biological interventions to chronic illnesses. Firstly, the authors recommend for the of social prescribing in order to create a holistic approach to combating the health and social care determinants of those diagnosed with chronic illness within the Middle Eastern region. This paper will conduct a scoping review of health models and present three models that demonstrate how the use of social prescribing could be used encourage a self-management approach as a means of aiding patients to become more independent of in-patient care and current medically led interventions. Secondly, the authors will highlight three health models to demonstrate the theoretical evidence base of how social prescribing could be aligned with a health strategy to treat chronic illness in the Middle East.

Keywords: Chronic Illness, Health Models, Social Prescribing, Self-Management, Middle East

INTRODUCTION

Once a person has a chronic disease such as asthma, cancer, diabetes, arthritis or a heart condition, their life and that of their families are changed, and it becomes extremely important for them to adopt new routines. These routines or behaviors support people in their daily activities or stabilize their conditions to prevent further detrimental effects. However, the effects of chronic illnesses are not only limited to patients and their families; they also impact society due to the use of resources to combat them and overload the healthcare system. Therefore, a National Chronic Diseases Strategy (NCDS) has been implemented to prevent and care for chronic diseases in many countries around the world.

Key research questions to be answered in this paper include: Why is the healthcare system concerned about chronic illness? Why is most of this interest focused on the area of self-management? Is it the cost of implementation and management of chronic illnesses that makes self-management programs a priority? Although such innovation is a broad topic, the focus of this paper is limited to a review of the academic literature in the form of journals and textbooks on self-management. The paper aims to review of three self-managements programs from different countries as found in the literature with correlation to the best practice will be investigated. The authors highlight social prescribing as an alternative treatment strategy to traditional biomedical models. Social prescribing is advised to assist individuals to connect and thrive within their communities and to support individual's health and well-being within the Middle East region. The authors will discuss some limitations of these programs before concluding the paper.

Background

Before discussing any issues associated with self-management, it is important to have an overview of chronic illnesses and their effects. Chronic disease is becoming a serious concern as it is responsible for almost 60% to 73% of all deaths worldwide (Catford, 2007, Martin

& Peterson, 2008). Nevertheless, there has been a huge transition over the years in what can be done for individuals with physically illness. The advances in the medical field enable more people to live longer; yet, many of these people experience difficulties within their advanced years of declining health and well-being. Statistics have shown that 70% of patients who present to general practice do so due to chronic diseases (Armstrong et al. 2007). Therefore, collectively chronic diseases put great pressure on health systems and there is a need to source the most effective and increasingly, economically efficient models of care.

There are a multitude of effects of chronic diseases on patients, their families and the society that they belong to. It is necessary to underline that patients are the ones who suffer the most from such diseases, which directly influences their health and may consistently deteriorate their physiological state or, what is more, even result in their death. Healthcare organizations are affected as well by a serious financial burden, especially if these organizations are public and have to rely on national budgets with finite financial resources. Patients can also be said to suffer from serious financial losses as a result of chronic illness, particularly if their treatment is not covered by health insurance. Within Saudi Arabia the national strategy entitled, Vision 2030 seeks to support and acceleration of the nations' ability to achieve health targets (2021). Within the United Arab Emirates (UAE) Vision 2021 (2018) and Vision 2071 (2018) have set out ambitious goals around healthcare provision that will look to meet the needs of the nation. Both of these strategies demonstrate a mindfulness to seek new cost-effective solutions to real-world challenges and encourage innovation and leadership within the healthcare sector.

In the past, healthcare professionals have attempted to minimize these effects in different ways. Within the United States (US) the government, has for example, established the Physicians Assistants (PA) scheme in the 1960s, but this occurs mainly in the primary care setting (Rosemann, 2006). In other countries, Nurse Practitioners (NP) have been created, which has increased that status of nurses and allowed them to take on procedures that were traditionally only performed by doctors (Rosemann, 2006). Despite all these trials that have been made in the past to reduce the work overload for General Practitioners (GPs) in particular and healthcare systems, the increase in costs and the incidences of chronic disease is creating a challenging quagmire that means that healthcare practitioners are toggling through models of care. Therefore, a shift has occurred in order to cope with increasing numbers of patients. This transition was clearly identified and widely discussed in the literature; nonetheless, healthcare providers should realize that most models of care used in the acute care setting are inappropriate for chronic illness and costly (Martin & Peterson, 2008). Therefore, it can be suggested that a universal agreement of health strategies outside of the

traditional biomedical model may induce self-care and socially focused solutions essential for the treatment of chronic illnesses (Armstrong, 2008; Wilson, 2007; Williams, 2007). A definition of self-management will be provided in the following sections and models of care that the authors have identified to be foundation on which social prescribing could be based upon as a national strategy to combat chronic illnesses.

Social Prescribing and the Treatment of Chronic Illness

As highlighted previously by the authors (Mottershead and Ghisoni, 2021) social prescribing can be an effective strategy in supporting health and social care needs as a bespoke addition or an alternative to pharmacological treatment plans. Social prescribing within the UK is used for the effective management of chronic illnesses but as yet has not been disseminated within the MENA region. The author, Mottershead (2022) previously extrapolated that social prescribing can be an effective management strategy for the treatment of addiction and related issues, and can be successfully used as an independent treatment method as well as adjuncts to pharmacological treatment plans for those suffering with addiction and substance misuse issues within the UK. This strategy was then explored by Mottershead and Alonaizi (2023) within the Middle East to utilize as an empowering intervention that could be adopted through peer-support to improve health and well-being. This study was supported by earlier findings undertaken by Mottershead (2019) which indicated that there was evidence that if empowered by systems that could identify disenfranchised sub-groups, then a system of peer support could create positive outcomes in terms of therapeutic interaction.

That same study by Mottershead (2019) identified that a peer-support relationship could be a powerful cohesive bond that had clear supporting benefits if mentors felt that they were empowered to support those in their care. In a later study Mottershead and Alonaizi (2021) demonstrated the potential of peer support within the Middle East, peer support with individuals with shared lived experiences.

Mottershead (2019) noted it was possible to treat psychological trauma through the use of peer support as sub-groups with shared experience were more willing to share their feelings and concerns with a peer who had similar experiences and background. Shared identity was an empowering feature within that previous study due to enhanced trust, fairness and consistency. It has been evidenced by Mottershead and Alonaizi (2021) that trust was an integral building block to establishing credibility and assisting in forming therapeutic relationships as well as creating positive peer-to-peer engagement. This paper suggests adapted models attesting to the beneficial interaction between the two sub-groups which concurs with the findings by Eisen et al., (2012); Mottershead and Alonaizi (2021) who illustrates how peer support between sub-groups can provide a wide-range of benefits by

creating an environment conducive to credibility and trust.

Scoping Review

Scoping Review will outline the significance to undertake this study. This chapter undertakes a systematic review of the literature on the relevant models that can adopted to support the use of social prescribing within healthcare systems within the MENA region.

Arksey and O'Malley (2005) advocate the use of a scoping review if there is a need to address broader topics where many different study designs might be applicable and there is a challenge in establishing a well- defined question. Arskey and O'Malley (2005, p.20) explain that literature reviews/systematic reviews are predominantly concerned with aiming to provide answers to questions from a relatively narrow range of quality assessed studies, whereby a scoping review is 'less inclined to seek to address a specific research question nor, consequently, to assess the quality of included studies. This was of particular interest for this research as previous studies appear to have become entrenched within the statistical approximation of the presence of

Arksey and O'Malley (2005) provide a framework which was adopted to undertake this scoping review as it provides a systematic approach to the literature searching and also helps to establish a comprehensive foundation to guide a review. There was a need by the researcher to determine the extent of research previously conducted but also identify any grey literature, theory or perspectives that may have relevance to the understanding of the selected topic. Table I provides a tabular format for the chapter's adherence to this framework. Colquhoun et al. (2014) emphasise that a scoping review is not a linear process but rather describes a cyclical process of the researcher going back-and-forth between early finds and new insights, and changes in the search terms and even the questions. Hence, the sections not being sequential with the six stages.

Table I: Scoping Review Framework - Six Step Approach

1. Identify the Research Questions
2. Identify the Relevant Studies
3. Study Selection
4. Charting the Data
5. Collating, Summarising and Reporting
6. Consult Stakeholders and Policy Makers – Aim:
To obtain more references, provide insights on what the literature fails to highlight.
Arksey and O'Malley (2005)

Search Strategy

This scoping review explores the question: What evidence is there of appropriate models of care that can be engaged to use social prescribing to treat chronic illnesses. The renewed interest in this particular topic area

has meant that there has been a wide ranging source of research and literature on social prescribing but less so with reviewing models of care to implement the strategy. This has meant that the authors undertook a broad focus and flexible hierarchy of evidence was adopted when sourcing for relevant studies. Long, Godfrey, Randall, Brettle, and Grant (2002) advocate that an inclusive approach should be adopted by ensuring that qualitative and quantitative (inclusive of randomised control trials) are reviewed within the scoping review. This scoping review extrapolated the evidence from published literature and identified the profile and key themes that related to the evidence base of the selected models of care. Models were analysed and identified in conjunction with the relevance of and success of their implementation on total populations targeted, alongside information gained from randomised controls trials and analysis found in both quantitative and qualitative studies.

Key databases searched were: CINAHL, MEDLINE, Cochrane Library, ASSIA, Web of Science and Scopus. The database search was also supplemented by hand searches of British and American publications/policy documents that were considered key to underpinning this study, although they may not have been comprehensively covered by databases as such. No time restriction was set initially, as the authors wanted to seek relevant literature. However, for specific studies relating to models of acre and social prescribing a literature search was undertaken from the time periods 2000 to 2023 to capture the most current research. A wide range of studies were sought that focused on policy objectives and initiatives influenced by Government health agenda, through to independent and statutory studies exploring relevant models of care and social prescribing. Also the cited journal articles of the main article found were explored. A wide variety of search terms were used independently or in different combinations which were directly pertinent to the research questions or were slightly tangential to the research questions in order to fully explore any areas that may be linked to them and evolved as new material was found.

Self-management and its effectiveness

Self-management is about people being actively involved in their own care. Jordan (2007) noted that a patient's self-management is considered to be central to the design of any care system. This quote confirms that self-management needs to exist in any healthcare system, the details of which will be considered and discussed later on. Chronic disease self-management (CDSM) programs have been found to be effective in improving clinical, behavioural, and self-efficacy outcomes associated with a range of chronic illnesses, and evidence suggests that CDSM is also effective in reducing healthcare costs and health service utilisation (Williams, 2007). Self-management education programs are significant for helping patients learn new skills in order to enhance the self-care of their conditions (Williams, 2007). The concept

behind self-management as mentioned previously is self-efficacy. It is well known that chronically ill people may have different symptoms, such as lack of energy, sleep difficulty and loss of appetite. Therefore, managing these symptoms is extremely important. In coping with such diseases, healthcare providers must empower patients and let patients them be positively involved in addressing not only their physical well-being, but also their emotional struggles.

Self-management programs, self-determination theory and the identification of models of care

Self-management programs assist people in finding strategies to deal with their illness with the support of health professionals. Most programs are run in groups so that people with chronic illnesses are able to share their experiences and learn from each other. This approach is of importance if the expansion of social prescribing is to be achieved within the MENA region. The benefits of social prescribing for this region have been identified previously by Mottershead and Alonaizi (2023) and can be understood as a self-perpetuating strategy for chronic illness through the Self-Determination Theory (SDT). This theory was originally proposed by Deci and Ryan (2000) who advocates that individuals are active and growth-orientated agents, inclined to organise and initiate their actions with reference to their values and interests, with the tendency to integrate social norms and practices. This can be transferred over to the use of social prescribing which allows patients to engage within a plan of care that facilitates healthy activities aligned to their interests and social needs. This paper advocates also add that the individual is intrinsically motivated to pursue personal goals and will strive to master the environments they find themselves in, however this ability is dependent upon the kind of support that they receive from the socialising environments, which may promote or undermine their intrinsic motivation and internalisation. The researchers remonstrate that SDT provides an evidence base for how patients in the MENA region who engage with social prescribing for the treatment of chronic illness could become self-aware of their health and social care needs. Moreover, self-management is about taking an active role in managing any long-term health condition in partnership with health professionals, family and friends. Indeed, the author (Mottershead, 2021) identified that health professionals demonstrated evidence of SDT when initiating resilience building strategies to maintain positive physical and mental health within the National Health Service (NHS) in the United Kingdom.

Three main noteworthy types of self-managements programs identified by the authors are the US based Wagner model, which emphasizes service integration, the American Stanford model based on Lorig's work, which emphasizes the patient's journey (Lorig, & Holman, 2003). Finally, the Expert patient model that emerged from the UK healthcare system. All three of these empowering models can be utilised with minimal involvement of the traditional bio-medical model practices entrenched within the MENA region. These suggested models of care align with social prescribing frameworks and could be applied to health policy directives within the region.

The Flinders model

Malcolm Battersby, the senior lecturer in psychiatry at Flinders University, Australia, has worked extensively with general practitioners and other international healthcare professionals to develop what is known as the Flinders model, which consists of generic assessment and care for chronically ill people (Battersby, 2008). The model is a patient-centered care model for the management of chronic illness where the patient is the decision maker, while the caregiver is an advisor. This approach can be applied to a variety of chronic conditions and has six basic principles of self-management where the patient: 1) has knowledge of the condition, 2) follows a care plan agreed on by the healthcare providers, 3) actively shares in the decision making, 4) monitors signs and symptoms of the condition, 5) manages the impact of the condition on physical, emotional, and social life, and 6) adapts a lifestyle that promotes health (Zwar, 2006).

The philosophy underpinning the Flinders model was based on the cognitive behavioural theory of Bandura (Battersby, 2003). It comprises a clinical assessment of self-management with goal setting which results in a 12-month care plan agreed on by the patient. In the Flinders model, the healthcare providers and the patient work together in sharing decisions and taking responsibility. This differs from the Stanford model (discussed below) which can be delivered without the use of healthcare professionals.

The Stanford model

The American Stanford model is based on the work of Holmen and Lorig at Stanford University, who in 1979 started by teaching arthritis patients about self-care through using lay tutors (Griffiths et al, 2007). Many countries around the world including Australia and the U.K. have adapted this program, because it delivers cost-effective and successful results. The Stanford model contains six sessions led by a trained pair of lay peer leaders and is based on the self-efficacy theory, mainly with regards to setting goals, obtaining feedback, changing lifestyles, coping, controlling anger, problem solving, managing pain depression, and improving communication with friends, family and healthcare providers (Wellington, 2001). Nordner and Ahlberg (2006) conducted a study on the importance of group therapy for patients with chronic illness and found that it helped them to share experiences and emotions, exchanging informational support, and exchanging of emotional support. Consequently, such therapy enables people to work in a group setting, to understand the components of self-management, and to learn skills and strategies that

will help to enhance their ability to manage their lives.

The Expert patient model

In 1999, the British national health system adopted the Expert Patient Programme (EPP), which is a lay-led self-care support workshop for people with various long-term conditions based on the Chronic Disease Self-Management Programme (CDSMP) (Sobel, Lorig, Hobbs, 2002). The EPP is particularly cost-effective as it is carried out by volunteer personnel. Therefore, the U.K. Department of Health set up a specialized team to develop the EPP to be applied within the U.K. over the next few years (Wilson, 2007). The EPP is a 6-week small-group program attended by people with different chronic illnesses, with the sessions lasting 2.5 hours. The participants self-define their chronic conditions based on an underpinning of empowerment. The setting of weekly goals and action plans are essential for the success of the course. A randomised control trial by Richardson, et al. (2008) found that the EPP could reduce the cost by £27 per patient. If the goals are successfully achieved, it is subsequently more likely to enhance confidence and assist the participants in achieving more health-related behaviour changes (Wilson, 2007).

Limitations

Some drawbacks of the above mentioned models are found in the following three categories: 1) the healthcare system and provider, 2) the patients, and 3) the disease. Firstly, the nature of the primary healthcare system in those countries and its services are very complicated, as they combine both national and regional responsibilities with public and private providers (Zwar et al, 2006), and some GPs have insufficient information of the self-management programs concerning each chronic condition (Lorig & Holman, 2003). As for the patients, some pass through a denial stage when first diagnosed with a chronic disease, which may affect their engagement and involvement with social prescribing through a lack of awareness of the system because of their denial (Telford, Kralik, Koch, 2006). This can be seen, for example, with patients who have mental health problems such as dementia. Conversely, when dealing with pediatric patients, nurses may have different and more difficult experiences. For instance, children's perceptions and understanding of hospitals, illness and treatment are different from those of the adults (Hart & Chesson, 1998). Unlike adults who have already developed self-discipline and a grasp of illnesses and treatments, children's emotional and psychological capabilities as well as their behaviours are not yet fully developed for them to understand clearly the intervention processes associated with hospital care, hence affecting their engagement in self-management. Finally, some specific types of chronic diseases need to be treated in acute contexts, such as quadriplegic patients who need to be connected and monitored, not only in an acute context, but in an intensive care unit as well.

CONCLUSION

Chronic diseases have become a serious concern for modern healthcare systems. The numbers of chronically ill people are increasing; therefore, a transition in care is taking place, particularly in the area of self-management. The paper has discussed three self-management programs established to date in order to prevent and care for the chronic sufferers of disease within the MENA region. The author's propose that the use of social prescribing in its entirety is demonstrates a potential of to support the treatment of chronic illness of patients within this region. As yet social prescribing has not been widely applied to healthcare sectors in the Middle East. This strategy would not only allow patients greater autonomy within their care but is also cost effective which, is a theme within the 2021 Vision (2018) and subsequently within the UAE Centennial 2071 (2018). An evaluation of these three programs has been highlighted; with the Flinders model linked to healthcare providers and the Stanford model or the Expert Patient Programme being run and carried out by non-medical professionals. Added to that, some limitations have been presented, namely physicians having insufficient information, patient denial, and children or people with mental incapacity having difficulties in fully engaging with the suggested health and social care strategy. Despite these limitations the authors suggest that if there is to be a shift in these proverbial sands of healthcare strategies, then a new swell of innovative practice must be created to direct positive change and fill the sails of a self-management ethos. The inclusion of social prescribing for the treatment of chronic illness within the Middle East is a paradigm shift necessitated by the need of patients as well as healthcare providers.

CONFLICT OF INTEREST

The authors declared that the study was undertaken in the absence of any conflict of interest.

AUTHOR CONTRIBUTIONS

The authors conceptualised, wrote and then read the approved final version.

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