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Delivering green social prescribing: An ethnographic exploration of the place of walking and gardening groups in a social prescribing intervention

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ABSTRACT

Green social prescribing involves link workers referring people from healthcare systems into nature-based activities, expected to offer holistic therapeutic experiences. Using ethnographic methods, we examined the use of referrals and creation of pathways into walking and gardening groups as well as community gyms within a broader social prescribing intervention. We conducted participant observation and interviews with social prescribing clients, link workers and green activity groups. We found that utilising a more disciplinary gym pathway, supporting clients to work on their health, was straightforward for link workers. However, integrating clients into green activity groups that offered a more therapeutic and caring experience depended on attentive coordination efforts from both link workers and activity leaders, and on the conviviality of group members. The reliance of walking and gardening groups on the work of leaders and members, as well as on seasonally changing green spaces, also created instability in groups, in turn making more work for link workers, who had to keep track of an ever-shifting landscape of provision. Finally, green activity groups varied in character and purpose, offering variable fit with individuals and with social prescribing itself. We conclude that the therapeutic and caring promise of walking and gardening groups is challenging to incorporate into social prescribing, while more disciplinary pathways, which work well for some but carry potential to create shame and stigma, may be more accessible.

1. Introduction

There is increasing interest in 'prescribing' nature for health and wellbeing (Bell et al., 2019; Ivers and Astell-Burt, 2023), which has now been formalised in the UK as green social prescribing. Social prescribing involves patients being referred to a link worker or community navigator who meets with them to identify their health and wellbeing needs, aiming to link them into community-based activities (Morse et al., 2022). In green social prescribing, sometimes known as nature-based social prescribing, referrals are to activities that involve connection with 'nature', usually as part of a group, for example group walking or community gardening (Garside et al., 2020, NHS England, n.d.). Green social prescribing referrals are considered to offer holistic therapeutic benefits for physical and mental health and wellbeing.

However, there are concerns that the implementation of green social prescribing has not proceeded at the pace or scale anticipated (de Bell et al., 2024). This has been attributed partly to capacity, since referrals into green activities rely not only on access to green spaces but on the availability of well-resourced green activity groups that can accommodate social prescribing clients (Grantham and Whaley, 2023). An austere and volatile funding environment for community groups limits such capacity (Grantham and Whaley, 2023; Power et al., 2021). Further, a lack of frameworks and networks to support links between social prescribing and green activities has been identified (de Bell et al., 2024; Grantham and Whaley, 2023). Beyond such structural constraints, Bell et al. (2019) demonstrate that nature prescriptions are unlikely to be a good 'fit' for all because their therapeutic potential for different individuals is shaped by personal understandings of 'nature', developed over a lifetime, and by embodied knowledge and skills relating to activities such as gardening.

In this context of interest in the potential of green social prescribing, but concern that realising that potential is not straightforward, we used

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a novel ethnographic approach to examine whether and how green social prescribing referrals were implemented within a broader social prescribing intervention. We undertook intensive and extended fieldwork with social prescribing service users and link workers, and with walking and gardening groups, to provide a unique understanding of unfolding, non-linear social prescribing pathways (Reynolds and Lewis, 2019). Our approach generated novel findings that go beyond existing insights to explore the place of green activity groups within social prescribing, drawing on Mol's (2008) notion of contrasting logics of choice and care. Here we first explore how Mol's logics, developed in relation to the provision of healthcare, can be applied to different social prescribing destinations. We then go on to use our ethnographic data to trace the pathways of clients through a social prescribing intervention, focusing especially on walking and gardening group referrals, but also considering how they contrast with community gym pathways. We suggest that our results can explain the very limited place of walking and gardening groups within the intervention we explored. Finally, we consider wider implications for green social prescribing.

1.1. Socially prescribed activities: disciplinary or/and caring

Discourses and practices of link workers' social prescribing practices vary from the motivational, aiming to empower individuals to work on their health, to the more attentive and holistic, focusing on tailoring support to align with individual needs/issues (Calderón-Larrañaga et al., 2022, 2024; Griffith et al., 2023). The former approach to social prescribing accords with a national and international context of neoliberal governance, reduced state provision and increased focus on the individual as responsible for their own health and behaviour (Baum and Fisher, 2014; Crawford, 1980; Petersen and Lupton, 2000). We have argued (Griffith et al., 2023) that this approach aligns with Mol's logic of choice, which treats those requiring healthcare as autonomous, and as "encouraged to 'choose to comply'" (Mol, 2008, p.82). In contrast, Mol suggests that applying a logic of care would mean that: "Instead of obliging us to exercise our will power, they [health professionals] would help us to take care of our bodies" (Mol, 2008, p.80), according with a "'care-based' framing of social prescribing" (Calderón-Larrañaga et al., 2022, p.863). We suggest that, beyond link workers' practices, some community activities used as destinations in social prescribing align with a disciplinary approach to health promotion, for example nutrition classes and referrals to gyms, both attempt to directly engineer healthier 'lifestyle' choices. In contrast, green activity groups are expected to enhance health more indirectly and holistically, offering a more caring approach, potentially challenging notions of personal responsibility (Lawson, 2007).

Gym pathways are evidently disciplinary, sitting easily alongside biomedical models of health and a broad understanding that the gym is a place to 'work' on one's health, often with the aim of losing weight (Allain and Marshall, 2017). Weight is a key concern for biomedicine, as a risk factor for conditions such as type 2 diabetes and as a target in the management of health conditions. Community gyms, which in the UK may be based at leisure centres owned by local authorities, or hosted by voluntary and community sector (VCS) organisations, often offer to social prescribing clients what was previously labelled as 'exercise on referral'. That is, an exercise specialist receives a referral directly from a health professional and oversees a programme of physical activity over a fixed number of weeks, often aiming towards a weight-based target (Fox et al., 1997).

Green social prescribing has been promoted partly because of a recognition that formal exercise in such settings can be unfamiliar or experienced by some as stigmatising (Pickett and Cunningham, 2016). Thus the National Academy of Social Prescribing in the UK suggests that "physical movement doesn't have to mean going to the gym, swimming pool, or anywhere else you may feel out of place". Instead, it suggests, it is possible to engage in activity that will "connect you" with other people and with nature, for example in walking and gardening groups (National Academy of Social Prescribing, n.d.). This emphasis on the potential for 'connection' in green activity groups resonates with research by health geographers and others showing that people can feel a sense of interdependence and 'mutual care' in walking and gardening groups, not only with humans but with gardens and landscapes (e.g. McSherry and Kearns, 2023; Milligan et al., 2004; Priest, 2007). Such experiences have been widely understood as therapeutic, and green activity groups have been theorised as therapeutic landscapes or landscapes of care (Bell et al., 2018; Doughty, 2013; Milligan and Wiles, 2010), or as therapeutic or enabling assemblages (Duff, 2012; Foley, 2023; Ireland et al., 2019).

Adopting the terminology of Milligan and Wiles (2010) and Williams (2020), we consider green activity assemblages as dependent on the 'care-full' work of their members and perhaps especially the work of their leaders (Buser et al., 2020; Duff, 2012), aligning them with Mol's logic of care and with a wider ethic of care (Tronto, 1993; Lawson, 2007). For example, Harrod et al. (2024) show how facilitators of nature-based interventions for young adults set the tone for the creation of therapeutic places through non-judgemental acceptance, empathic understanding, genuineness, and by demonstrating trust in participants. Similarly, the facilitating and nurturing role of leaders is vital in creating caring spaces in blue (i.e. water-based) activities (Buser et al., 2020), where leaders choreograph activities and also relations between group participants (Juster-Horsfield and Bell, 2022). Other members of activity groups also play a role in creating such spaces. For example, Neal et al. (2019) suggest that in diverse urban settings, to achieve a sense of connection to others and to place, members of social leisure groups must be oriented "to commune and to the precarious processes of conviviality" (p.83), involving an openness to engaging across difference. Green spaces and materialities are also actors, as Neal et al. (2015) show for urban parks, which act as sites of shared affection and can animate affinities and interactions between park users, while Ireland et al. (2019) observed that 'nature' provided a sense of escape from the concerns of everyday urban life for members of a walking group for breast cancer survivors. Green assemblages are understood then as enabling multidirectional flows, interdependence and reciprocity (Milligan and Wiles, 2010).

Having made this broad distinction, we also acknowledge that disciplinary and caring orientations can coexist in both gym and green social prescribing pathways. For example, in community gyms, machines are often adapted for different bodies, and group sessions may attend care-fully to different abilities and body sizes, as well as offering peer and professional support, and formal exercise classes can offer embodied and immersive pleasure (Allain and Marshall, 2017; Phoenix and Orr, 2014). Conversely, applying a Foucauldian reading, Brown and Bell (2007) suggest that public health discourse may use ideas around the pleasures of being active in nature to mask underlying messages about the importance of being active for health. Or community gardeners and walking group members may explicitly regard 'good' exercise as a healthy outcome of their activity (Hale et al., 2011; Pollard et al., 2020), albeit linked with a wider "healthy doing" (Hale et al., p.1860) that is more than just physical. Alignments with discipline and care may also vary *between* green activity groups. Pudup (2008) argued that some community gardens may act as sites of resistance to neoliberalisation, as places for building social capital and community organisation or cohesion, while others may be oriented to the pursuit of individual change and improvement. Walking groups may variously be badged using terms referencing health (such as 'health walks') or, alternatively, as nature or heritage walks, reflecting different priorities.

While there is no absolute dichotomy then, link workers' referrals to gyms align more strongly with a disciplinary understanding of working towards better health, and referrals to walking and gardening groups reflect an expectation of a wider therapeutic benefit associated with care. Here we consider how in one social prescribing intervention, the more care-full onward referral experiences envisaged in green social prescribing were challenging to implement precisely because of the care

required to support transitions into groups, to hold therapeutic assemblages together, and due to varied orientations within green activity groups in relation to emphases on individual improvement versus broader connection and care. We show how these effects mitigated against the delivery of green social prescribing, whereas a gym pathway was well-used.

2. Methods

We set out to explore completed and potential/curtailed pathways into green activity groups within the wider 'journeys' of social prescribing clients (in the social prescribing intervention we explored the term 'client' was used and we follow this usage) and, by contrast, pathways into community gyms. Inspired by previous ethnographies examining people's pathways through healthcare and how their relationships and interactions with other people and technologies shape their experiences (Vernooij et al., 2022; Whyte, 2014), we considered such transitions within the wider context of clients' lives, and explored the roles of link workers, activity leaders and their groups in these pathways.

2.1. Context

Green social prescribing may be undertaken separately from more general social prescribing, as in the Test and Learn green social prescribing sites funded by the UK government in 2020 (NHS England, n. d.). However, most social prescribing is delivered by link workers attached to primary care practices who aim to refer to a variety of services and groups, usually including green activity groups, and here we explore the use of green social prescribing pathways in an intervention of this kind. We note that the intervention had convened a walking group before our study began, but it had proved unsustainable so that during the three years over which we collected data, available green activity groups were run by the local authority and voluntary and community organisations.

The social prescribing intervention was delivered in an ethnically and socially mixed urban area of the North of England, and served 16 GP practices. Patients were referred into the intervention from primary care, were aged between 40 and 74, and had at least one of six qualifying long-term physical health conditions, although many had more than one diagnosis, often including a mental health diagnosis. On referral from one of the participating GP practices, patients were assigned a link worker. At their first meeting, the link worker and client agreed a personalised action plan, following which the link worker was expected to support patients to access relevant community services, or in some cases to support clients to develop self-directed programmes. Three community gyms, four gardening groups and three walking groups operated within the geographical area served by the social prescribing intervention during the period of data collection. Two gyms and one walking group were provided by the local authority, while other activities were offered by a variety of voluntary and community sector organisations, some well-established, some more ad-hoc (for example, a heritage-based group tended a graveyard and organised local walks, relying on one primary convenor).

2.2. Base study

This paper draws on and adds to an evaluation of the impact of a social prescribing intervention on people with type 2 diabetes for which we conducted ethnographic fieldwork with clients and link workers (Pollard et al., 2023). For this 'base study' we purposively recruited 19 client participants with type 2 diabetes (since type 2 diabetes was the focus of the evaluation), although 16 of them had at least one other long-term condition, including mental health diagnoses. The sample captured variation in terms of ages, genders, ethnicities, employment status, and duration with the intervention. KG undertook a first (N = 19) and a final (N = 15) interview with these participants, as well as photo-elicitation interviews (N = 9) and over 200 h of participant observation, visiting participants' homes, meeting in coffee shops, joining in activities, including gardening and walking, and accompanying them to meetings with link workers (see (Gibson et al., 2021) for further details of the sample and methods used). In addition, 20 link workers participated in three focus groups and JJ undertook additional interviews and shadowing with them (for further details see Griffith et al., 2023) (considering their whole roles, not just their work with clients with diabetes). This fieldwork was conducted in 2019 and 2020. Final interviews with client participants in 2020 were conducted over the phone or by video-call because of Covid-related restrictions.

2.3. Additional green social prescribing data

Given a policy context in which green social prescribing was gaining traction, we undertook further ethnographic fieldwork to specifically examine the place of walking and gardening groups in social prescribing pathways. We conducted additional in-person interviews and participant observation between 2019 and 2021 (data collection paused between March 2020 and April 2021 due to Covid). For this additional data collection we were not restricted to considering social prescribing for people with type 2 diabetes. We conducted an additional 12 interviews specifically focusing on social prescribing into walking and gardening groups with link workers (n = 3), and with organisers of walking groups (n = 4) and gardening groups (n = 4). We also conducted participant observation during 8 group walks and a walk leader training day. We aimed to recruit further clients from walking and gardening groups who had joined via the social prescribing intervention. However, there was almost no history of such referrals within groups and we were only able to contact only one group member who had joined via social prescribing, with whom we conducted an extended interview. Finally, in light of the lack of referrals identified into local gardening and walk groups, together with the high number of gym referrals identified in the base study, we subsequently interviewed a leader of one community gym to help us consider gym pathways as a point of comparison.

Detailed field notes were written after all fieldwork encounters and recordings of interviews and focus groups were transcribed. All participants gave informed consent and were assigned pseudonyms, as were walking and gardening groups. Durham University Research Ethics and Data Protection Committee provided ethical approval for the research.

2.4. Data analysis

Data collection and analysis was an iterative process beginning with reflexive field notes written after each research encounter. On completion of the additional fieldwork on green social prescribing, the first author undertook a process of immersion, descriptive coding and recording analytical memos, focusing on understanding how clients encountered (or did not encounter) and interacted with walking and gardening groups and gyms on their social prescribing pathways, and on how these pathways were shaped by the key people, especially link workers and activity group leaders, and groups involved (or potentially involved). Analytical memos identified salient themes and situated such themes in relation to social prescribing literature. Interpretations were discussed with the wider team. We identified three case studies which highlight the contrasting experiences of those referred into gardening and walking groups, as well as the complexities of the relationships between social prescribing and the various individuals and groups involved. This case study approach has been effectively employed in other studies to allow for detailed analysis of the contextual dynamics underpinning patient pathways (Vernooij et al., 2022; Whyte, 2014).

3. Findings

Below we first examine the relatively well-used referral pathway into

community gyms and explore why link workers were confident in making such referrals. We then go on to explore green social prescribing pathways, both successful and curtailed. We draw particularly on the experiences of three social prescribing clients as case studies (Table 1); Geetha and Tracy, both participants in the base study, and Derek, recruited during green social prescribing-focused data collection. We analyse their experiences drawing on the wider dataset.

3.1. The well-trodden route to the community gym: a formal referral pathway to disciplinary work

The pathway into the three local community gyms was well used in the social prescribing intervention, and, in turn, social prescribing referrals made up a large proportion of these gyms' users. To make a referral to the local authority gym, link workers completed an electronic form referring clients either for weight management or for support to become more active, and the leader of the programme, Dawn, then invited clients to attend an induction session. She met with them for an hour, to "*talk about their hopes and dreams and goals and all those sorts of things, and we have a few lifestyle questionnaires that are NICE*[1] *guidelines to fill out*". She also weighed clients referred in for weight management, and agreed targets with them, very explicitly locating the gym pathway within the logic of choice, as a technology understood as a means to an end (Mol, 2008, p.57). At the end of their 12 weeks on the gym programme, attending sessions that she normally oversaw, Dawn met with clients again and discussed what they might continue to do to keep physically active. She described herself laughingly as "*Big Brother*".

We found that the gym worked well for some of our client participants. For example, Andy's diagnosis of type 2 diabetes served as a biographical disruption (Bury, 1982), kick-starting his re-engagement with physical activity (he had been a keen footballer and gym-goer previously). Andy told us appreciatively how Dawn would "*come over and just go 'well, you're looking really good*'", giving him supportive feedback on his progress. Brenda was referred to the same gym, but in addition to diabetes has arthritis that causes pain in her knees and hips. She had a *"really lovely"* link worker who referred her into the same gym. She found that one gym leader ignored her pain, causing Brenda to leave for a while, but she rejoined with Dawn, who was tactful and supportive, noticing subtle indications when Brenda found an exercise painful and tweaking it for her. Tracy, whose experiences in relation to a community garden we discuss in detail below, was directly referred by her hospital consultant to a different community gym. She also enjoyed her sessions and developed a close relationship with the leader there. At the gyms there was also a sense of camaraderie with others attending the group sessions, although most interaction tended to be with the activity leaders. Others have also observed care in community organisation fitness classes with trusted leaders and camaraderie with other members (Henwood et al., 2011). Nevertheless, this care is clearly nested within an overarching disciplinary aim.

For other clients the gym pathway was associated with shame and stigma, as seen elsewhere (Pickett and Cunningham, 2016). After discussing a referral to the gym with her link worker, Shirley was worried that she would not fit in at the gym. Although she was pleased to find at her induction that there were "*no skinny people*", she had not started her course there when we lost touch with her. After attending for a while, and finding Dawn very supportive, Christine subsequently felt she had "*put on too much weight to go back*". Here, despite Dawn's tact, her role as Big Brother and concern about more general surveillance in the gym setting meant that Christine did not continue her engagement.

Link workers were confident in referring to the gyms. Coordination work was minimised for them, as they plugged into the same exercise referral mechanisms available to other health professionals. Referrals were always open, partly because the duration of the programme was limited. The work done by gym leaders aligned well with the logic of choice that had become dominant in the intervention, while also offering care. However, while gym referrals were straightforward for link workers to make, and worked well for some clients, other clients experienced shame there. It is partly an acknowledgement of these kinds of concerns that have led to increased attention to green social prescribing.

Table 1
Summary information for the three study participants whose experiences in relation to green activities are explored in detail, with key link workers and group leaders involved with them. All names are pseudonyms.

Client Name (approximate age)	Personal characteristics	Link worker	Group(s) joined	Group leader
Derek (60s)[a]	White retired and divorced man living with disability, had lived in the local area all his life	Susanna	Hartwell Garden	Kirsty
Geetha (60s)[b]	Moved to the UK from India, widowed and retired, living with well-controlled diabetes	NA	Burham Walking Group	Rosemarie
Tracy (40s)[b]	White woman who moved to the area from elsewhere in the UK, living with her ex-partner on benefits, with multiple illnesses	Lucy	Southfields Garden	Yasmin (garden leader) and Vic (community centre leader)

[a] Recruited from a gardening group during green social prescribing fieldwork.
[b] Client participants from the original study, with additional data on their pathways, including on their walking and gardening groups, collected during fieldwork focused on green social prescribing.

3.2. Successful transitions: coordination work and enabling assemblages

We explore the work of activity leaders and link workers in facilitating green social prescribing, and ways in which green activity groups can enable engagement, through the experiences of Derek and Geetha (Table 1). At a community garden we met Derek, who had previously been referred there via the social prescribing intervention. Geetha was also a social prescribing client, but joined a walking group independently of the intervention. Both experienced the therapeutic and caring promise of green activity groups, facilitated by care-full support from activity leaders and by the wider assemblage, and, in Derek's case, by attentive care from a link worker.

3.2.1. Derek and Hartwell Garden

Kirsty is the coordinator of the group of older gardeners at well-established Hartwell Garden, working as part of a team of part-time staff, and convening every weekday with the older gardeners. The large garden is compartmentalised into separate carefully tended areas, as well as some 'wild' sections. There are vegetable plots and a couple of ponds, with some rare aquatic species. There is a covered area for bad weather where members do woodwork and mending, and where the staff run workshops, and a small building with a kitchen where the older gardeners cook and eat a weekly meal together.

Kirsty feels gardening is valuable for older gardeners partly because *"it's tangible and productive and meaningful work that they can see what they've done is really making a difference to the garden, and also to other people who use the garden"*. She identifies tasks she thinks will suit gardeners, sometimes pairing more and less experienced gardeners

[1] National Institute for Clinical Excellence.

together. Kirsty described the gardeners as "*a really strong knit group of people*". Only two arrived via the social prescribing intervention, one of whom was Derek.

Derek was introduced to Hartwell Garden by his link worker. He grew up in the local area and then worked as an engineer but had to leave his job due to ill health and associated disability. At around the same time his marriage broke up. At his local GP surgery, he was referred into social prescribing in the early years of the local scheme. Derek visited Susanna, his link worker, at the surgery, and she visited him at his home. He spoke to her regularly, describing her as "*a good listener, like, and a good talker as well*". He recounts how Susanna:

> "actually drove me up here to get me out of the flat. Because there's like a big metal door, I just couldn't get past the metal door. She said "Derek, you're going to have to get out … You've got so much to offer, and there's a lovely spot at [Hartwell Garden]"

Kirsty felt Susanna "*understood what we did here and how much of a team and a family it is really",* identifying that what Derek needed was "*the atmosphere that the garden creates*". Not only did Susanna persuade Derek to leave his house, she accompanied him to the garden, helped him complete the paperwork he needed to join, and then came with him for his first gardening session as well.

While, like Dawn at the community gym, Kirsty runs an induction session which creates a formal entry point for referrals from a number of different organisations, there is no established formal referral route for social prescribing. Derek's successful referral relied on coordination work performed by both Susanna and Kirsty. Susanna's care-full link working involved improvising (Mol, 2008): understanding Derek's needs, repeatedly visiting him, and physically transporting him out of his house and to the garden. Crucially, she worked with Kirsty, and together they made it possible for Derek to join the garden.

Derek found being at the garden difficult for the first few sessions because of the new people around, but then he began to feel that he could be useful, particularly in making things. He enthusiastically described his construction projects in the garden and, echoing Kirsty's comments, said how useful they make him feel, how he loves working with his hands: "*there are a lot of women couldn't nail, they haven't nailed a nail, and I used to show them. But absolutely mint* [fantastic]*, and I just got so much pleasure out of that*". Derek repaired a table for the garden and said: *"It looked so sad, I said "It needs to be sorted." So I sorted it. And everybody uses it now, it's used every day. A bit like me."* Kirsty was warm and encouraging with Derek, joking but supporting him and helping him communicate with others, which was sometimes difficult because of his disability. Kirsty described Derek as "*different now, completely different*".

While Derek found the transition into the garden challenging, the 'sad table' attracted his attention and drew him in, along with the women who 'couldn't nail', supported by the care offered by Kirsty. The group was welcoming, in the way that Carroll et al. (2021) found that 'enabling' sporting assemblages welcomed young disabled people. In both cases, though in different ways, material components (basketball chairs or adapted sailing boats for young disabled people, and the 'sad table' for Derek) facilitated self-esteem by allowing members to demonstrate their skills to themselves and to others. In line with the ethos of the garden to support older people to flourish, for Derek we see the therapeutic effects of community gardening realised, as envisaged for green social prescribing.

3.2.2. Geetha and Burham Walking Group

Burham Walking Group was mentioned to us as a possible destination for clients by several link workers. It convened each week a few metres from one of the GP practices participating in the social prescribing intervention. It was run for the local authority's public health team by their staff member Rosemarie. We walked with the group over a period of several months, often with social prescribing client Geetha, who had become a dedicated member. We did not hear of, or meet, anyone who had joined the group via social prescribing.

Geetha went to university in India before coming to the UK and settling in the local area. When we met her, she was widowed and recently retired from her job in community support work and wanted to avoid just *"sitting in the house"*. She was referred into social prescribing shortly after being diagnosed with type 2 diabetes, and her diagnosis prompted her to take action to manage her illness. Having seen it advertised, she told some friends about the walking group, and they went along together. Here we see Geetha using her classed capital, tactically managing her diabetes, following recommendations to increase her physical activity to work towards improvied future health in a way that worked within her own social world (Gibson et al., 2021). Nevertheless, her successful entry into the walking group was also facilitated by the care-full work of its leader, Rosemarie, and the features of the wider assemblage that made it enabling for Geetha.

Each week Rosemarie greeted the walkers as they arrived in the community building which acted as their meeting place. She knew everybody by name and asked after their families, creating a friendly and comfortable atmosphere that encouraged people to chat as they waited. When everyone was assembled, she would briefly welcome the whole group and describe the route she had planned, asking for volunteers to act as front, middle and rear markers. Each walk took the group of usually 8–15 walkers through local parks, along residential streets and past a supermarket or two. Most members were retired and in their 60s and 70s, and most were women. Many, like Geetha, had joined the group after seeing a poster at the GP surgery near the meeting point, and some had joined via friends who were already members. Two retired men walked regularly, generally sticking together, having recognised each other from previous encounters in the neighbourhood.

Geetha and her friends chatted as they walked, speaking in a mixture of Punjabi and English, pointing out meaningful local places, Geetha showing where she used to bring her children for a picnic in the park, and sharing stories about her now-grown daughter and her grandchildren. For Geetha and her friends, as for other members of the group, the park and its immediate locality were places of belonging for which they felt shared affection and which they enjoyed as they moved together, reliving familiar sensory connections (Neal et al., 2015), for example in kicking up autumn leaves. Geetha took her phone on the walk because it told her how many steps she has taken, signifying that part of her aim in walking is to be active, but she has found more in the group than steps; she was 'welcomed' to the walking group by the opportunity to connect with her own past and with her friends.

Rosemarie, as walk leader, made quiet and sensitive efforts to offer inclusivity, embracing the participation of Geetha and her friends of South Asian origin in an otherwise predominantly White group. As with Kirsty at Hartwell Garden, Rosemarie's skilful attentiveness was vital to Geetha's successful accommodation within the group. Where social prescribing was successfully involved, at Hartwell Garden, this was because Susanna knew the garden well and responded sensitively and actively to Derek, coordinating carefully with Kirsty.

3.3. The instability of green activity groups

Green activity groups are fragile assemblages, relying, as we have seen, particularly on the work of care-full leaders, but also on the conviviality of group members and the work of more than human elements. As a result, the green activity landscape in the area of the intervention was unstable and constantly shifting.

In Burham Walking Group there were, each week, signs of fragility. As the group left the meeting point, the front, middle and rear markers soon moved apart, with two or three women quickly speeding ahead, while medium-paced walkers like Geetha strolled along chatting, pointing out significant sites. Rosemarie tended to stay towards the middle of the group, reminding walkers about the route and encouraging people to wait for one another at turning points. Sometimes Geetha and her friends would strike up a brief conversation with other people, who also shared histories related to the park, and to buildings on

the route, but mostly the friends stayed together and separated out from others, and we see here limits to conviviality in the group. The two retired men, Stephen and his friend, would usually bring up the rear, walking more slowly, and discussing the local area more intensely, once taking TP on a diversion to see a grand old building. Despite Rosemarie's efforts, often the different parts of the group had completely lost sight of each other by the end, but she would wait to see everybody off and to obtain promises that she would see the walkers the following week. The fractured nature of the group echoes findings of other studies of walking groups, which have raised concerns about differences in pace and that cliques often develop (Pollard et al., 2020). As Neal et al. (2019) suggest, conviviality cannot be assumed.

At this time, the local authority was planning to withdraw Rosemarie from the group due to funding constraints. The plan was that the group should be led by volunteers from amongst the members, and to that end Rosemarie and colleagues led a walk-leader training day that several members of the group joined, including Geetha and Stephen. However, several months after the training, Rosemarie was still leading the group most weeks, and was worried about its prospects of continuing without her because the volunteers had struggled to take over. Walks had also been disrupted by the winter weather, another source of instability for green activity groups, because ice made it difficult to walk safely. One walk in the city centre planned and led by Stephen dissolved in acrimony as some members of the group lingered too long at a heritage site. It seemed that nobody with Rosemarie's skills and commitment to care-full attunement and choreography (Harrod et al., 2024; Juster-Horsfield and Bell, 2022) was available to take over, and the group, which partially fractured each week under her leadership, could not hold together without her. While within social prescribing policy, group settings are imagined as connective and tension-free (Pot, 2024), they are better understood as inherently unstable and requiring active maintenance.

Skilled leadership was particularly difficult to guarantee at a time of increasingly restricted government funding. The local authority had already cut a post dedicated to leading walking groups, and Rosemarie's role was stretched. Even a well-established organisation like Hartwell Garden was reliant on constantly seeking short-term funding, previously recognised as limiting opportunities for green social prescribing (Grantham and Whaley, 2023). Groups that relied on volunteers were even more vulnerable, as also observed by Carroll et al. (2021). As noted above, the intervention had itself hosted a walking group for a while, having been approached by a volunteer leader, but that had disbanded when the leader regained paid employment.

Not surprisingly then, link workers were often unsure about whether groups they knew of were still operating. Furthermore, turnover amongst link workers was high (Griffith et al., 2023), and knowledge about local groups was thus frequently lost. At the end of our data collection, link workers described pointing clients to external website listings to find out about local gardening and walking activities, relying on clients to identify their own activities and join them independently.

3.4. Discordance between social prescribing and green activity groups

While Derek and Geetha successfully integrated into their groups, for other social prescribing clients walking and gardening groups were inappropriate for a variety of reasons. Link workers recognised that the health-promoting effects of green activities are shaped by clients' prior experiences and understandings, as previously observed (Bell et al., 2018; Milligan and Bingley, 2015). Even for keen gardeners, gardening groups were not necessarily considered a good fit because of existing commitments to domestic gardens or allotments. Conversely, we encountered mixed responses from green activity groups about social prescribing, ranging from interest, although often cautious, to outright hostility. Here we examine Tracy's ultimately thwarted pathway into a local gardening group, showing how discordance between the group and social prescribing contributed to making it difficult for her to join. Tracy (Table 1) was supported by her link worker, but did not ultimately become a member because of a sense that she did not belong there.

Tracy had been living in the area for five years when we met her. She had worked in a variety of manual jobs but had stopped work because of poor health, and used a walking aid. Throughout the ten months we knew Tracy she was working hard to improve her health to allow a planned major operation to go ahead. She had stopped smoking, was losing weight and attended and enjoyed "cardio rehab" at a community gym, as mentioned above. She got to know the leader of the session, a community health trainer, well, and she made Tracy feel comfortable, and Tracy also got to know other gym-goers. Like Geetha, Tracy wanted to "*keep myself occupied, to get myself out*". She is a cheerful person, told by the nurse at the GP practice that she's 'always smiling', but also often in pain and exhausted.

When KG met Tracy one day after spending time with another study participant at his allotment, Tracy told her that she would love an allotment too – that she'd "*be there all the time, it'd be peaceful*". Then, after some time in social prescribing, she found out about a gardening group at nearby Southfields Hub. The garden had developed around ten years previously, after the Hub reached out to women mostly of South Asian origin who lived in the neighbouring streets, knocking on doors and asking what would encourage them to come in, and found that the answer was a space to grow things. The local terraced houses mostly have no back gardens and women had been restricted to growing plants in containers. The group was led by Yasmin, who came to the area as an asylum seeker from the Middle East. Vic, an organiser at the Hub, described the garden as a "*little oasis*" for women who "*need a bit of space, a bit of time*". Some of the gardeners were referred in by local voluntary agencies, but many joined with friends and family, in some cases with several generations of the same family involved. Tracy attended gardening sessions twice, but did not go back to the garden after a couple of sessions there, as we now explore.

Tracy first went to a gardening session after which the gardeners cooked with vegetables from the garden and ate a meal together. She was grateful that a retired woman, who had come to the area as a refugee, sat with her at the meal to chat. The following month on a bright autumnal day KG met Tracy at the Hub after a second gardening session, where she was told by Yasmin, while Tracy smiled, how brilliantly Tracy had worked. But Tracy added that it was difficult because she didn't know which plants were weeds, and she was frightened to pull the wrong things up. Over the following weeks and months KG arranged to meet Tracy at the gardening session several times, but each time Tracy cancelled gardening and chose to meet up elsewhere. When KG asked why, Tracy said she liked Yasmin, who made her feel welcome, and that she would like to go; she said the same a few weeks later in a meeting with Lucy, her link worker. Lucy urged Tracy to keep going, responding to Tracy's concerns about fitting in, saying that eventually she will meet people, and that gardening is *"good for mindfulness"*. However, Tracy continued to cancel arrangements to go to the garden. By the end of our study Tracy had not gone back to gardening or cooking at the Hub.

When we talked to hub organiser Vic about social prescribing in relation to the Southfields Hub she said:

> "to tell you the truth the people who come through social prescribing, they don't tend to stay long. Because ….we are very much a community here."

adding

> "this isn't for you [people referred in through social prescribing] this is for the women of our local community" and suggesting "it's about using gardening as a tool for community cohesion"

In contrast to Derek's experience, we suggest that Tracy felt excluded from the garden at Southfields Centre even though she expressed an interest in gardening, and despite the efforts of Lucy her link worker, Yasmin the garden leader, and another member of the group, to welcome her. For Vic, as a leader of the Southfields Centre, the creation

and support of a 'family' there was important, but Tracy felt that she did not belong in this family, and she was uncertain about how to interact with the other women, as well as with the plants. Despite both Tracy and her link worker feeling that a garden would offer peace, and Vic considering it an "*oasis*", Tracy felt self-conscious and anxious at the gardening session where, unlike the members for whom it was created, she did not feel a connection.

Southfields Hub garden's focus on supporting its local community meant that it was not ultimately enabling for a social prescribing client from outside its existing 'family', who did not fit in for a variety of reasons. We suggest that one reason for this was that the garden was not aligned with a focus on improving individual health or wellbeing. The variety of community gardens operating in the area reflected the diversity/bricolage of logics underpinning community gardens generally, with varying aims, including varying orientations to individual health and being (McGuire et al., 2022; Pudup, 2008). Hartwell Garden, in contrast, offered a better fit with social prescribing, emphasising individual development within a caring assemblage.

4. Conclusion

Our analysis suggests that the challenges involved with facilitating green social prescribing pathways are partly a result of the very properties of walking and gardening groups which make them attractive as a possible locus of care in social prescribing. The therapeutic properties of these groups derive from attentive, attuned work by skilled and empathic leaders, along with conviviality from other members, including newcomers, as part of the wider green assemblage. We found that incorporating new members required work within the group to allow a care-full reconfiguration. For social prescribing clients, this work might require support from link workers, including liaising with group leaders. In the absence of recognition of the need for such work, or if group leaders, members and/or link workers lack capacity or willingness to undertake it, green social prescribing pathways may be curtailed. We also found that partly due to their reliance on the work of group members, along with the seasonality and unpredictability of 'natural' components of green assemblages, particularly the weather, green activity groups could be fragile. Together with a challenging funding environment, this led to an ever-shifting landscape of provision. We suggest that this fragility makes it particularly difficult for link workers to keep abreast of changes and to establish relationships with green activity groups that social prescribing may wish to harness. Beyond this, green activity groups varied in their receptivity to social prescribing, with some resisting being harnessed for health purposes, instead being committed to other goals related to wider community connection and care. Thus while others have noted structural constraints limiting the roll out of green social prescribing, and that not all social prescribing clients will feel an affinity with green activities such as gardening (Bell et al., 2019; Grantham and Whaley, 2023), we go further, using a concern with Mol's logics of care and choice to suggest that, more fundamentally, the orientation of green activity groups to care makes them challenging for social prescribing to access. Thus care and connection are not easily or simply harnessed by social prescribing.

In contrast, gym pathways had formal and streamlined referral processes that allowed link workers to pass clients on, confident that they would receive the attention of gym leaders. Gyms could work well as a destination for social prescribing clients, as gym leaders acted as 'Big Brother', encouraging clients to undertake disciplinary work towards better health, while also often offering tactful care and support. Gyms were relatively well-resourced and convened by paid staff and offered stable and predictable spaces. In these ways, the local community gyms were a good fit with the social prescribing intervention. In both social prescribing and community gyms we found that the dominant logic was of motivating clients to work on their health, encouraged by care and support beyond that typically available within primary care. However, while some social prescribing clients flourished on the gym pathway, others were vulnerable to experiences of shame, stigma and exclusion. These findings resonate with those of other studies which show how health interventions may drift towards approaches that hold individuals responsible for improving their own health, creating potential for stigma (Powell et al., 2017; Williams and Fullagar, 2019).

We also raise concerns about possible effects of green social prescribing on local walking and gardening groups. Following Rose (1996), Pot (2024) argues that social prescribing builds on an increasing tendency to imagine 'communities' and community organisations as resources that can be harnessed to address a diverse range of problems. Such approaches have been invigorated as part of the austerity-driven restructuring of the welfare state, which seeks to devolve responsibility for health. However, walking and gardening groups may find the approaches of social prescribing disruptive, and be concerned that social prescribing would change the character of existing groups. Dedicated green social prescribing interventions also exist within which there may be funding available to work more closely with green activity groups or to set up groups solely for people referred through social prescribing, which is likely to ease the concerns we identify here. Indeed a walking group established in close collaboration with the social prescribing intervention explored here was successful for a couple of years. However, even in these schemes fewer green social prescribing referrals than anticipated have been made (Grantham and Whaley, 2023).

We conclude that creating green social prescribing pathways into walking and gardening groups and delivering the therapeutic and caring promise of green social prescribing requires correspondingly care-full work within and between social prescribing and green activity groups (which in turn requires funding). It also requires attention to the needs and preferences of pre-existing green activity groups. Further ethnographic research on interventions dedicated to green social prescribing that create and run their own green activity groups would be valuable.

CRediT authorship contribution statement

Tessa M. Pollard: Writing – original draft, Supervision, Project administration, Methodology, Investigation, Funding acquisition, Formal analysis, Data curation, Conceptualization. **Kate Gibson:** Writing – review & editing, Methodology, Investigation, Formal analysis, Data curation. **Emily Tupper:** Writing – review & editing, Investigation. **Laura McGuire:** Writing – review & editing, Investigation. **Bethan Griffith:** Writing – review & editing, Formal analysis. **Jayne Jeffries:** Writing – review & editing, Investigation.

Ethics

Durham University Department of Anthropology Research Ethics and Data Protection Committee provided ethical approval for the research.

Declaration of competing interest

The authors have nothing to declare.

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Data availability

The data that has been used is confidential.

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