Social prescribing for suicide prevention

Policy Evidence Brief

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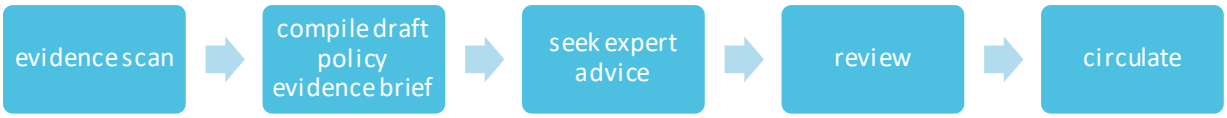

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Social prescribing: a brief overview

Social prescribing involves the referral of patients to non-clinical care to address or prevent adverse effects of the social, environmental and economic factors that are inextricably linked with health and wellbeing. These are commonly referred to as the social determinants of health.

Social prescribing recognises that improving health or managing health conditions for individuals can require more than clinical care and that health professionals do not necessarily have the expertise, resources or time to address these needs [1]–[5]. This additional form of prescribing enables health professionals to refer patients with social or practical needs that contribute or potentially will contribute to poor health, to a local community provider of non-clinical services [1], [3]–[6]. This enables a wider range of options for care and management to be provided at the primary care level.

Social prescribing models have been developed internationally in the UK, Europe, USA, Canada, New Zealand, Scandinavia, Asia and Australia. In Australia, there are currently a small and growing number of practice or area-based programs in several states and a trial of social prescribing to support mental health, particularly for older people, has been initiated in Victoria following recommendations by the Royal Commission into Victoria's Mental Health System [7].

Most recently, the Commonwealth and the state of Queensland have announced a new trial of Distress Brief Support, a two-week program to support people experiencing psychological distress, offer practical solutions to manage that distress, and identify additional services to aid longer term recovery [8]. The trial will be undertaken in two sites in Queensland and is to provide access to non-clinical support for people who are experiencing distress and who may be at heightened risk of suicide.

A 2019 roundtable on social prescribing, hosted by the Consumers Health Forum together with the Royal Australian College of General Practitioners (RACGP), made recommendations for incorporating social prescribing into future health system planning and service delivery strategies [9].

Broadly, social prescribing programs in Australia have included physical activity, allied health or community group referral, community group and programs addressing the social determinants of health [10]–[14].

Social determinants of health, chronic illness, loneliness, mental health and wellbeing are all inextricably linked to suicide risk[15]. However, suicide prevention or management of suicidal distress is not explicitly targeted by existing social prescribing models in Australia. Despite this, the current trials and particularly the recently announced Queensland trials, of social prescribing directly inform suicide prevention given the shared underpinnings between chronic disease, social isolation, and suicide risk (e.g., social determinants of health, social capital, etc.).

The scope of this report

This report summarises the current academic and grey literature on social prescribing for suicide prevention. The report then identifies and discusses key themes drawn from expert

consultations with expert advisers to the project who have lived experience and those who are involved in the design, implementation and evaluation of social prescribing programs in Australia. The report then proposes an evidence-informed model for social prescribing for suicide prevention in Australia. This model considers what can be readily implemented within existing health and social care infrastructure, and what could be implemented alongside other systemic changes.

There has been substantial discussion of social prescribing internationally and, increasingly, within Australia [12]. An in-depth summary of the purpose, definitions and broader evidence supporting the efficacy of social prescribing is beyond the scope of this report.

Language and key definitions of social prescribing

Various terms are used to describe aspects and components of social prescribing.

Provision of a social prescription to an individual is by one of two methods: direct referral and indirect referral. **Direct referral** is also referred to as 'sign-posting' and is a recommendation to a patient, provided by a clinical referrer, either a medical practitioner or other clinical health professional or other service (e.g. on discharge from hospital), to connect with a community service [6], [16]. The second model is **indirect referral**. A clinical referrer engages a community worker generally referred to as a l**ink worke**r, **patient navigator** or **case manager** to act as a bridge between the individual and the community service [6].

The scope and responsibilities of the central linking role in an indirect referral social prescribing model, the link worker, patient navigator or case manager [16]–[18], have similarities and key differences. For example, a link worker may include motivational interviewing and needs assessment to identify non-medical needs, facilitating access to non-medical sources of support, providing ongoing support and data collection [16]. A patient navigator shares many responsibilities of a link worker and the terms may be used interchangeably, however the term patient navigator is more commonly used in the navigation of clinical health care services [19]. Case management typically refers to a role that is the broadest in scope and may include management of both health care and social services [20]. Case managers may conduct clinical assessment and/or discharge tasks that are typically out of scope for link worker or patient navigator roles. For the purposes of this report, the term link worker is used and is viewed as most relevant to the social prescribing models proposed.

In the primary care setting, referral to the link worker or other connecting role is usually made by a general practitioner (GP), practice nurse or other practice staff member, with some programs accepting self-referral [3], [6], [21], [22].

The evidence for social prescribing in prevention

The broader social prescribing literature supports the benefits of social prescribing for health and wellbeing, as well as general acceptability of social prescribing for both patients and clinicians.

Suicide risk is understood to be a complex combination of biological, psychological, clinical, environmental and social factors [23]. Although broader social prescribing literature has not been developed through an explicit suicide prevention lens, it is important and this paper

makes it evident, that the social and health benefits of social prescribing more widely are also relevant and applicable in suicide risk.

Health, wellbeing and social outcomes

Reviews of social prescribing programs, particularly from a qualitative perspective, suggest it improves health and wellbeing [3], [6], [24]–[26]. The results from quantitative data approaches to health and wellbeing effectiveness are mixed [16]. Reported benefits of social prescribing include improved self-reported health and wellbeing, self-management skills, physical activity, ability to carry out activities of daily living and enhanced quality of life as well as reduced anxiety, social exclusion, demand for health professionals to address non-medical needs [3], [6], [24]–[26].

Client experience

Evidence also supports the acceptability of social prescribing from a client or patient perspective. For clients, outcomes including reductions in social isolation and loneliness, increase in social contacts, leisure activities, social support, self-esteem, companionship, motivation, awareness of local services and acquisition of new skills, learning, new interests have been reported [16], [25]–[28].

Practitioner experience

Practitioners have reported that social prescribing outcomes for them include reduced demand for General Practitioner (GP) services, fewer consultations focused on social issues and greater focus on medical problems [3], [21], [24]–[26]. Practitioners have also identified challenges for successfully implementing and utilising social prescribing. These include: lack of central coordination of referrals; insufficient resources and training; a need for good communication and trust between the health professionals and the Link Worker; quality of the partnership and cooperation between primary care staff and the social prescribing provider; the quality and professionalism of services referred to including quality control and safeguarding; and, confidentiality; expertise and the limited data on costing and whether social prescribing interventions save money [1], [4].

Relevance to suicide prevention

There is significant overlap between risk factors for suicide and broader health concerns [23]. Social prescribing has been found to be effective in reducing depression and anxiety [29].

Social prescribing can also play a role in suicide prevention by providing patients with access to community-based support services that can help address the underlying social determinants of health that contribute to suicide risk[29]. Social prescribing can help address social isolation and loneliness, which are known risk factors for suicide[30].

Additionally, social prescribing models for broader health and wellbeing are likely to share many characteristics with models for suicide prevention. Though this literature is not focused explicitly on suicide prevention, this evidence is relevant in considering the efficacy and feasibility of suicide prevention models.

Social prescribing for suicide prevention: a rapid review

To build on the broader social prescribing literature and to examine the evidence specific to social prescribing for suicide prevention, a rapid review of the literature was conducted.

Methods

A search of databases Medline EBSCOhost, PsychInfo, Wiley and Sage was conducted. Search terms included social prescribing, suicide and efficacy search terminology. Details on the search strategy are included in Appendix 1.

A total of 3063 publications were identified from all databases, of which 683 were duplicates. Publications were evaluated for eligibility against inclusion and exclusion criteria. To be eligible for inclusion, publications must have been in English, have been about social prescribing, have focused on suicide or suicide risk factors and included a component of evaluation. Publications were excluded if they were a stand-alone intervention without referrals or linkages. After review of 2380 titles and abstracts, 89 publications were selected for full text review. Of this, 8 publications were included in this rapid review. An additional 6 publications were identified from the authors' libraries and were also included in the review. A full summary of the review process is outlined in Appendix 1.

Summary of social prescribing for suicide prevention literature

Social prescribing addressing risk factors of suicide

The majority of the included literature examined social prescribing models relevant to suicide prevention through suicide risk factors, such as loneliness, social isolation or mental health concerns. Two recent systematic reviews evaluated the literature for the impact of social prescribing on social risk factors for suicide. Reinhardt et al (2022) [25] assessed the impact of social prescribing programs on loneliness. A total of nine studies met inclusion criteria, all of which reported by Reinhardt et al. described overall positive impacts of social prescribing programs. Three of the studies reported reduction in service use (e.g., GPs, social worker) and one demonstrated that belongingness reduces both loneliness and healthcare used.

Similarly, Vivodic et al. (2021) [26] conducted a systematic review of the impact of social prescribing on loneliness, social isolation, connectedness and wellbeing. They examined a total of 51 studies of adults aged 18 or older. When looking at individual outcomes, the authors identified that findings were clearer in relation to loneliness and wellbeing compared to social isolation and connectedness. System-level findings of this review include reductions in health care usage (e.g., emergency department visits, healthcare appointments). Importantly, Vivodic et al. identify that few studies made clear causal links between positive outcomes and the social prescribing model. Authors identified barriers to effective program delivery (e.g., patient accessibility, funding). However, there are few descriptions of key components of social prescribing models. Both systematic reviews identify significant variation in measuring outcomes and identifying pathways of impact and call for improved evidence on how social prescribing works and how best to define its impact.

One study tested a model of collaborative care for referred patients with unmet mental health needs. Wolk et al. (2021) [31] developed and implemented the US-based Penn Integrated

Care program; a new model of collaborative care that includes a triage and referral management system based on a resource centre that also provided support for individuals to be referred to appropriate community health services and resources. The program was trialled by primary care clinicians in 8 practices. Patients with specific conditions, ranging from mild to moderate depression, serious mental illnesses, to acute suicidal ideation, were referred to community programs based on clinical assessment, their preferences, insurance coverage and information from the primary care clinician. The centre then assisted with scheduling an appointment and followed up to ensure the individuals attended and engaged with care. If not, the centre linked them to other services. Mental health professionals were available for 'warm' referrals when patients were in crisis, however most referrals were conducted electronically. Where appropriate, patients were referred to community-based program, psychiatrists or specialists. In 12 months, over 6000 patients were referred, primarily to collaborative care (26%) or specialty mental health care with active referral management (70%). Of the over 6000 referred to the program, approximately 3500 were provided with resources and referrals, the majority of whom (approx. 2500) were provided community referrals. Patients enrolled in collaborative care had an average of 7 encounters over an average of 78 days. Remission of symptoms was obtained in approximately a third of participants and the program was viewed favourably by stakeholders. Although this model does not examine all types of community referral (e.g., addressing social determinants of health), it demonstrates efficacy of community referral in addressing suicide risk factors and active suicidal ideation.

More specifically, four studies describe qualitative findings of social prescribing models for suicide risk factors. Farr et al (2022**)** [32] described the Hope service, a program developed for men at risk of suicide (aged 30-64) to provide psychosocial and practical advice in relation to money, employment and housing a psychosocial support program based in Bristol, England. A previous pilot randomised trial found it to be feasible and acceptable [33]. This study aimed to evaluate the acceptability from a service user, staff and referrer perspective and to understand which factors of the program influence its impact. The program used a project team member who functioned in a 'link worker' role (although not named as such) who delivered up to 8 face to face sessions within this intervention to connect each user to other agencies. Researchers conducted 26 interviews and identified key elements of the program included creating a safe space, building trust and specialist advice on psychosocial problems. They also found that suicide ideation in men was closely linked to life crises. Addressing social factors improved a sense of control, which supported mental health. Men may also have felt less threatened by Hope project workers than those in mainstream health services. The authors noted limitations of interviewing those that were well engaged with the program but reported that the service overall was considered useful and important.

Scott et al. (2020) [34] published a qualitative study exploring the potential for a social prescribing model within pre-hospital emergency and urgent care in England. They specifically examined groups who might benefit from this model, including those with suicidal risk factors. They conducted interviews (n=15) and a focus group (n=3) with clinical and non-clinical staff from an English Ambulance Service covering emergency and non-emergency calls. They wanted to determine awareness of social prescribing, identify patient cohorts that would benefit from social prescribing and explore barriers and enablers. Participants had varying levels of awareness of social prescribing. Key groups identified as suitable cohorts were patients with mental health conditions, lonely and/or socially isolated groups and older people and frequent callers. They identified key criteria for implementing a social prescribing model, including patient and staff acceptability of the model, knowledge of services, available triage

pathways, funding and commissioning and equitable access across areas. At a micro level, they identified the importance of the acceptability of social prescribing; at a meso level, the importance of triage and referral pathways and at a macro level, that social and health infrastructure is essential.

Dayson et al. (2020) [35] described a social prescribing model within the NHS in England, which currently operates in primary but not secondary care. This existing primary-care based model was unable to handle referrals from community mental health services, so a second model was needed. The service helps patients tailor packages of support and enables them to participate in peer-led community events. Community mental health centres and link workers work together for ten weeks to ensure patients are engaged with community-based activities and community mental health centres remain involved for up to six months. The authors conducted 20 semi structured interviews with a mix of commissioners, service providers and patients accessing social prescribing. Patients reported improvements in quality of life and identified that social prescribing activities brought a sense of purpose, particularly that they enabled integration for previously isolated patients. The supportive transition model was very important. Not all participants engaged and/or could be discharged, so social prescribing may not be effective for everyone.

Lastly, Rhodes & Bell (2021) [36] conducted semi-structured interviews with nine social prescribing link workers across five organisations in London, exploring the role of link workers and examine training and support needs. While these link workers were not operating in an explicit suicide prevention model, they encountered suicide risk within their role. Key support needs included defining and promoting their link worker role, coping with the emotional challenges of the role and managing clients with complex needs. Most link workers felt their training was not adequate for the most challenging parts of their role, which often included suicide risk.

Social prescribing addressing risk factors of suicide – summary findings

Overall, the literature on social prescribing for suicide risk factors indicates some positive impacts on suicide risk factors such as loneliness, belonging, social connectedness and sense of purpose. However, there are limitations to drawing causal links between social prescribing models and these outcomes, and further research is warranted. Although these models were generally considered acceptable by patients and staff, several authors outline infrastructure-associated barriers to implementing or scaling up these programs.

Social prescribing for suicide bereavement and prevention

Three studies included in the rapid review examined social prescribing models that included suicide. Importantly, two of these studies focused on suicide bereavement and one included those with reduced social support, an important suicide risk factor.

Studies by Galway et al. (2019) [37] and Hill et al. (2022) [38] both tested social prescribing for suicide bereavement support. Galway et al. (2019) tested the acceptability of adapting digital social prescribing for suicide bereavement support based in North Ireland. There was a consensus that digital social prescribing could potentially improve access, reach and monitoring of care and support. However, the stigma of care, reluctance to access support,

matching types of support to needs and some limitations of digital resources (e.g., rural areas, limited internet) were noted.

Exploring a more traditional social prescribing model, Hill et al. (2022) examined a Primary Care Navigator model for people bereaved by suicide. This took place in Western Australia, and bereaved individuals were referred by police into the model. The Primary Care Navigator assessed the needs of the person(s) referred and connected them with other community services (e.g., meals, housing, sporting clubs) as needed. Over a 15-month period there were 90 suspected suicides and this model reached 347 bereaved individuals, just under half of whom accepted further support. While bereavement information and clinical support were the most prevalent, individuals also accessed financial assistance, meals, housing assistance, and referral to community services (11-16%). This model was perceived to be effective by police, stakeholders and people with lived experience of a suspected suicide.

Lastly, Petrakis & Joubert (2013) [39] evaluated an intervention that, among other objectives, focused on facilitated community linkage responding to impaired social support. This was monitored through the number of referrals and subsequent engagement with existing community resources. Although the details of linkage pathways are not clearly outlined, the authors make practice recommendations about improving the interface between acute care and community care. Without monitoring, patients often do not follow up on referrals as advised. Particularly among patients with depression, monitoring and support is required for referral uptake and retention.

Social prescribing for suicide bereavement and prevention - Summary

These studies highlight that literature explicitly taking a prevention-based approach to suicide prevention through social prescribing is limited. Importantly, engagement and effectiveness data of suicide bereavement may not readily translate to suicide prevention (e.g., people may be more likely to engage with social prescribing as early intervention, rather than amidst a crisis). Given the unique needs and challenges of a suicide prevention social prescribing service, additional research is required.

Social prescribing pilots in Australia

There are several social prescribing programs targeting risk factors associated with suicide that have been trialed and evaluated in Australia. Although other programs may be ongoing, just three programs were retrieved during rapid review and met inclusion criteria.

In 2021, Aggar et al. (2021) [40] published *Social Prescribing for Individuals Living with Mental Illness in an Australian Community Setting: A Pilot Study*. The authors describe this as Australia's first social prescribing pilot program (Plus Social) for individuals with mental illness (mood and psychotic spectrum disorders), and the program was implemented in Sydney in 2016/2017. This study provides an evaluation of that program.

A total of 13 individuals participated and were assessed at baseline and six months follow up; results indicate significant improvements in quality of life and health status. Participants were referred by a GP into the program and were assessed by a mental health social worker (link worker) who referred onwards (e.g., NSW Health House and Accommodation Support Initiative) as needed. All participants also attended weekly arts and craft class. The results

indicate that participants who completed the program experienced significant improvements in psychological and physical quality of life, health satisfaction, and self-perceived health status. Importantly, the results show no significant differences in social participation and self-rated loneliness, although scores suggest participants experienced less loneliness through the duration of the study.

Results of an Australian-based workplace suicide prevention and early intervention program called MATES in Construction were also published in 2021 [41]. The paper evaluates service demand, demographic and occupational profile of users, reasons for access, referral pathways and perceived benefits.

MATES in Construction was developed by the Building Employees Redundancy Trust in 2008 to prevent suicide in the construction industry. The program offers mental health training, non-clinical case management, an outreach service and a 24-hour support service to employees. Previous evaluation of the program demonstrated its validity, effectiveness in shifting beliefs around suicide, improved suicide prevention literacy and increased intentions to seek help for themselves, as well as significant economic return on investment.

The program uses a case management approach, though MATES case managers do not provide mental health care to clients. They use a brokerage model where case managers endeavour to help clients identify services and broker supportive services over a short contact period. This model assumes the individual will voluntarily access services when they know what is available and how to access them. The focus is less on direct service to the client, and a focus on assessing needs, planning a service strategy, connecting and following up with clients. Clients are most commonly referred to Employee Assistance Programs, followed by mental health, counselling or wellbeing services and a small proportion were referred to medical services. Findings of this evaluation indicate that clients felt their needs were addressed. Results also confirm that presenting issues include a range of psychosocial concerns.

Recently, Gullstrup et al. (2023) [42] conducted a systematic review on the effectiveness of the MATES in Construction program. The review included 12 peer-reviewed articles published between 2010 and 2023. The review identified evidence to support the effectiveness of the MATES program in improving mental health and suicide literacy among participants, helping intentions, and reducing stigma surrounding mental health. These results were positive in relation to reduced suicide risk in the construction industry, but few studies were well controlled and there were no experimental studies. Therefore, more research is required to understand the causal relationship between MATES and suicide risk.

Lastly, a pre-print of a paper published by Dingle et al (2023) [43] provides a controlled evaluation of 8-week outcomes of a social prescribing project addressing loneliness in adults in Queensland. The trial compared 1) treatment as usual only with 2) treatment as usual plus social prescribing among adults experiencing loneliness. A total of 114 participants were assigned to the two groups and were tested at baseline and at 8-weeks on a range of wellbeing metrics including loneliness and wellbeing. The findings showed a time with condition interaction with only the social prescribing group showing improvements over 8 weeks. Although there were small-moderate improvements on other measures (e.g., psychological distress, loneliness, wellbeing, social anxiety) among the social prescribing group, these weren't significant.

Participants were recruited from five GP clinics and/or community centres and allocation to treatment group was not randomised. Participants who were allocated to treatment as usual either declined the social prescribing group or referral wasn't feasible, or their GP didn't consider referral necessary. Importantly, there were some baseline differences between participants who opted to participate in social prescribing – e.g., the social prescribing group reported being more challenged. Over the first 8 weeks, loneliness decreased in social prescribing patients but increased in treatment as usual patients. Overall, compared to treatment as usual, there were significant effects on loneliness and trust among the social prescribing group.

Social prescribing pilots in Australia - Summary

These findings suggest that social prescribing models that address suicide prevention and/or suicide risk factors are only just beginning to emerge in the literature. In alignment with broader social prescribing evidence, these studies demonstrate that social prescribing models were generally effective at addressing needs and reducing risk factors such as loneliness. Generally, these studies did not provide substantial detail on the development of their models or the logistics of referral, indicating the importance of consulting with experts imbedded in this work.

Summary of key evidence-based elements of a suicide prevention social prescribing model

There are several key considerations that emerged from the literature that should be considered in developing a social prescribing model for suicide prevention, including:

- **Additional monitoring and support of referrals** may be required among those at suicide risk to support follow through [39]
- Given lower levels of social capital and social trust among those at risk for suicide [44], [45], warm referrals and **ongoing connection/relationships** are important in social prescribing models for suicide prevention
- Scott et al. (2020) [34] note the three key levels of intervention:
    - at a micro level, acceptability of social prescribing is needed.
    - at a meso level, triage and referral pathways are necessary.
    - at a macro level, social and health infrastructure is required.
- Those at risk of suicide were considered particularly complex and challenging for link workers [36] and **additional training and resourcing may be required**
- Digital services are being explored for suicide bereavement support but their application is currently limited to digital outcomes-based reporting to improve the capacity for measuring the effectiveness of interventions

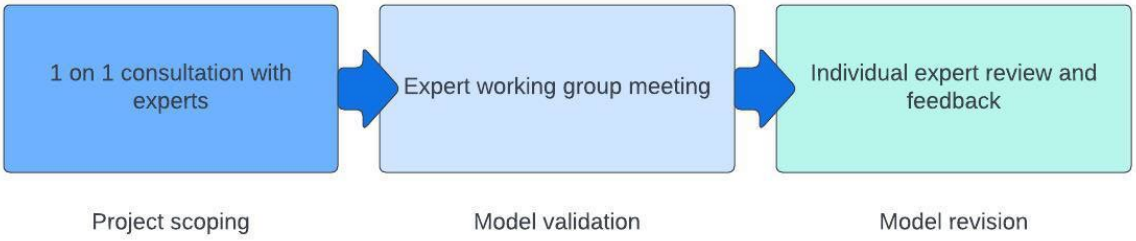
Additional evidence regarding social prescribing models ongoing in Australia are included in Appendix 2.

Expert working group consultation

Methods

In order to build upon the literature-derived evidence, we consulted several social prescribing experts with experience in implementing and evaluating social prescribing models.

The expert consultation included three phases as follows:



We held semi-structured conversations with experts based on the following questions:

Question 1: What do you know of social prescribing for suicide prevention?
Question 2: Are there any approaches that you regard as more effective and why?
Question 3: In your experience/knowledge, what would be the criteria/characteristics of an optional implementation of a social prescribing approach to suicide prevention in Australia?

These discussions are summarised in key themes below.

Summary of themes and feedback

What is meant by "community"?

Social prescribing is defined by the community in which the individual receiving the prescription is located or with which the individual identifies, culturally or socially. Communities form a critical component of health and social systems. They form the social context for individuals and relationships that underpin many aspects of health and social welfare, and they create social boundaries and networks for groups of people [46]. Terminology around community care varies widely across jurisdictions in Australia [47], and defining 'community' for the purposes of social prescribing remains a challenge. From a pragmatic perspective, communities are often defined by suburbs or geographic regions, or PHN regions in Commonwealth programs. Sometimes, the needs of a community may extend beyond these borders. For example, individuals belonging to under presented groups (e.g., those who identify as LGBTQIA+, young people or Indigenous peoples) may require support and a sense of 'community' from outside of pre-defined communities. Social prescribing models for suicide prevention must take a flexible approach, allowing for adaptability in sourcing support for individuals based on their needs which may extend beyond PHN or particular regions or catchment areas used by other levels of government. Link workers may need to consider some supports beyond specified boundaries of communities, and this may need to be considered when co-designing social prescribing models for suicide prevention with communities.

A warm referral is critical for success in suicide prevention

Experts re-iterated the importance of a warm referral in ensuring the person seeking support, particularly those at risk of suicide who may be likely to withdraw or socially disconnect, are supported to take up referrals to community services. Warm referrals may be incorrectly understood as providing a friendly referral to a service for the person to follow up on or following up with a patient at a later time following receipt of their information. However, warm referrals as required by a suicide prevention model of social prescribing must be highly personal and involved. Warm referrals include the handoff of a patient between members of a care team that takes place in front of and with the person [48]. Inclusion of warm referrals supports engagement and continuity of care.

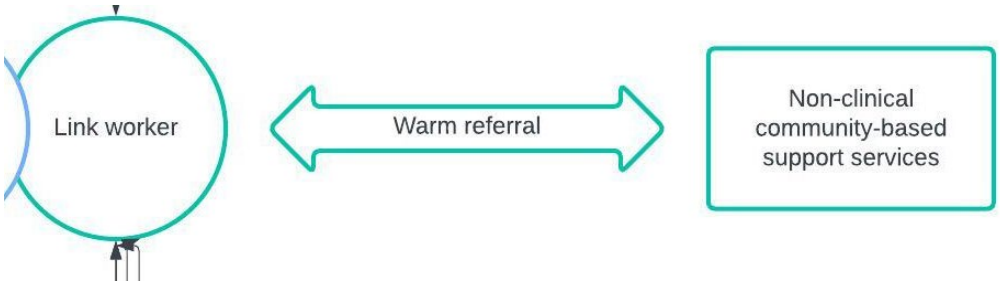


Figure 1: Component of the proposed social prescribing for suicide prevention model that demonstrates a warm referral as a key transition between the link worker and community-based support

Link worker must be very visible to clinicians and community services

Link worker role must:
- be located in a defined cachment
- be co-designed with community to meet needs
- map the service system within their area
- be adequately funded
- be trained for suicide prevention, including place-based, trauma informed and culturally inclusive approaches
- have appropriate funding for salary/salaries as well as service support

Note that a 'link worker' may include a small team (e.g., peer worker) based on the needs of the community and co-design outcomes

A link worker's base (e.g., GP office, community organisation, etc.) should be determined by the needs and dynamics of the community

Experts agreed that the link worker is central to a social prescribing model for suicide prevention and that the link worker must be well known both to clinicians and community. The success of social prescribing relies on the availability and accessibility of a link worker, otherwise links between clinical and community care are likely to remain disjointed. There must be an adequate communication and network strategy to supplement the trail and or scaling up of social prescribing for suicide prevention model.

Figure 2: Component of the proposed social prescribing for suicide prevention model that outlines the key functions/scope of responsibilities of a link worker

GPs are a logical host of social prescribing, but there are key caveats

Given existing health infrastructure, experts largely agreed that GPs are a logical 'host' for social prescribing. GPs are familiar, knowledgeable, and many are already practicing various forms of social prescribing. Evidence indicates that there is increased contact with primary care prior to suicide [49], [50] suggesting that GPs are well placed to intervene in suicide risk. However, this recommendation is not without caveats. Firstly, current business models deter GPs from engaging in social prescribing. To support the success of this model, provision of a Medicare item would support long consultation and referral to a link worker. The Medicare item and its implementation should be co-designed with GPs. Additionally, some individuals at risk of suicide are likely to be deterred by gap payments to see a GP; and this is likely to impact long term sustainability of a social prescribing model and must be addressed in scale up. Social prescribing models and implementation could explore voluntary patient enrolment with GPs in order to access social prescribing.

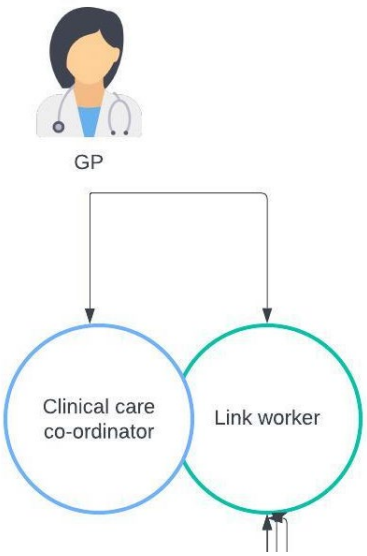


Figure 3: Component of the proposed social prescribing for suicide prevention model that demonstrates how a GP can support referral of patients to both clinical care and a link worker/social prescription.

There must be a way to capture those who do not have a usual GP

Social prescribing experts noted that a suicide prevention model has the unique challenge of seeking to reach people who may be less likely to be engaged with a GP or clinical services than those with physical health concerns or chronic disease. Experts highlighted the importance of additional mechanisms in a social prescribing model for suicide prevention (e.g., self-referral, key stakeholders (such as employers and teachers), emergency services and others working in high-risk environments) to support those at risk of suicide in a social prescribing model.

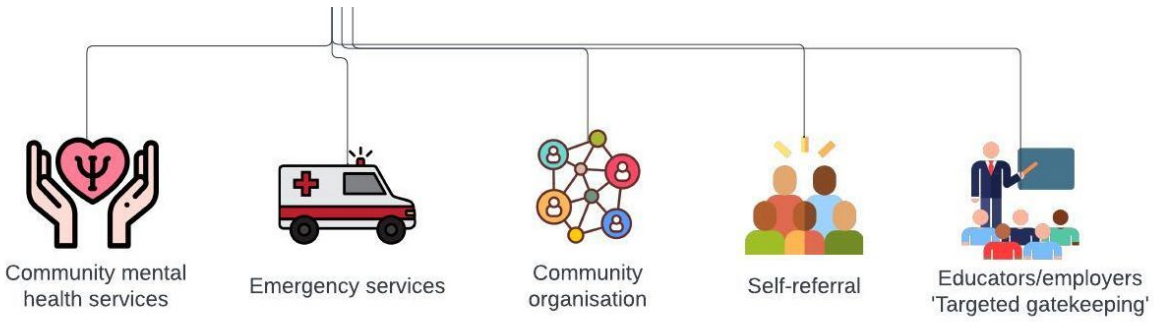


Figure 4: Component of the proposed social prescribing for suicide prevention model that demonstrates how members of the community can be referred or connected to a link worker

Commissioning by PHNs of social prescribing support

PHNs are currently funded by the Commonwealth to initiate preventive health strategies. This infrastructure provides a logical platform for social prescribing and PHNs could serve as commissioners of a social prescribing model for suicide prevention. One or more partner organisations, potentially community agencies, Local Government Authorities (LGAs) or GP practices, would be commissioned to provide the service. Commissioning requirements would include performance measures and evaluation with accountability to a community governance structure comprising stakeholder community organisations, the commissioning organisation and relevant service providers in the catchment.

Figure 5: Components of the proposed social prescribing for suicide prevention model that illustrates the model should be funded by a commissioner, delivered by a partner and must be evaluated and well governed.

Suicide prevention could be trialled within existing social prescribing models

From a pragmatic, implementation perspective, a social prescribing model for suicide prevention should be embedded within an existing or broader (e.g., inclusive of other health and wellbeing concerns) social prescribing model. A suicide prevention model would require additional supports such as a link worker with specific suicide-related training and additional mechanisms to engage at risk community members. These could be 'added in' to existing social prescribing models and evaluated against specific suicide-related risk factors and outcomes. The model should also be integrated with other existing suicide support, such as suicide aftercare programs (e.g., Way Back Support Service, Next Steps). This integration with existing models can reduce fragmentation in and promote holistic suicide prevention care.

A social prescribing model for suicide prevention

The purpose of this report is to consider and advise on the potential for social prescribing to be applied within suicide prevention initiatives and capacity in Australia. The report has identified and considered available and relevant academic and grey literature and has been informed by advice and guidance from professional experts and those with lived experience.

The following section outlines a potential model for establishment of social prescribing as a preventive and early intervention for suicide prevention. The model proposed is based on the evidence and on consideration of what can be readily implemented within existing health and social care infrastructure and what could be implemented alongside other systemic changes.

The proposed model can be implemented as a foundational service (Figure 6) that is readily established within existing health and social care service systems. A more comprehensive service (Figure 7) includes tailored support for engagement by GPs with coordinated clinical care for individuals as required. The latter option provides system infrastructure for sustainable, holistic care. The essential and structural service components identified in this report are presented in each service level and are discussed in further detail below.

In drafting this model, co-design principles were followed as co-design is an established way of improving health care services and policy-making by bringing together relevant stakeholders and consumers in partnership to design and develop preventive health policy programs and services that best satisfy the needs and preferences of consumers [51]. Thus, the new services or policies will be shaped in partnership with consumers "who use them and may be affected by them" [52]

There is little capacity in Australian health services to address unmet social and material needs that may impact on individuals at risk of and affected by suicide. Social prescribing, as it has developed internationally and, to some degree, within Australian health and support services, has potential to provide additional capacity to meet those needs.

Social prescribing, as an adjunct to clinical care and a resource for health professionals, particularly in primary health care, can form a bridge between the clinical care setting and the community sector to connect people to practical help to address suicide risk factors and influence wellbeing.

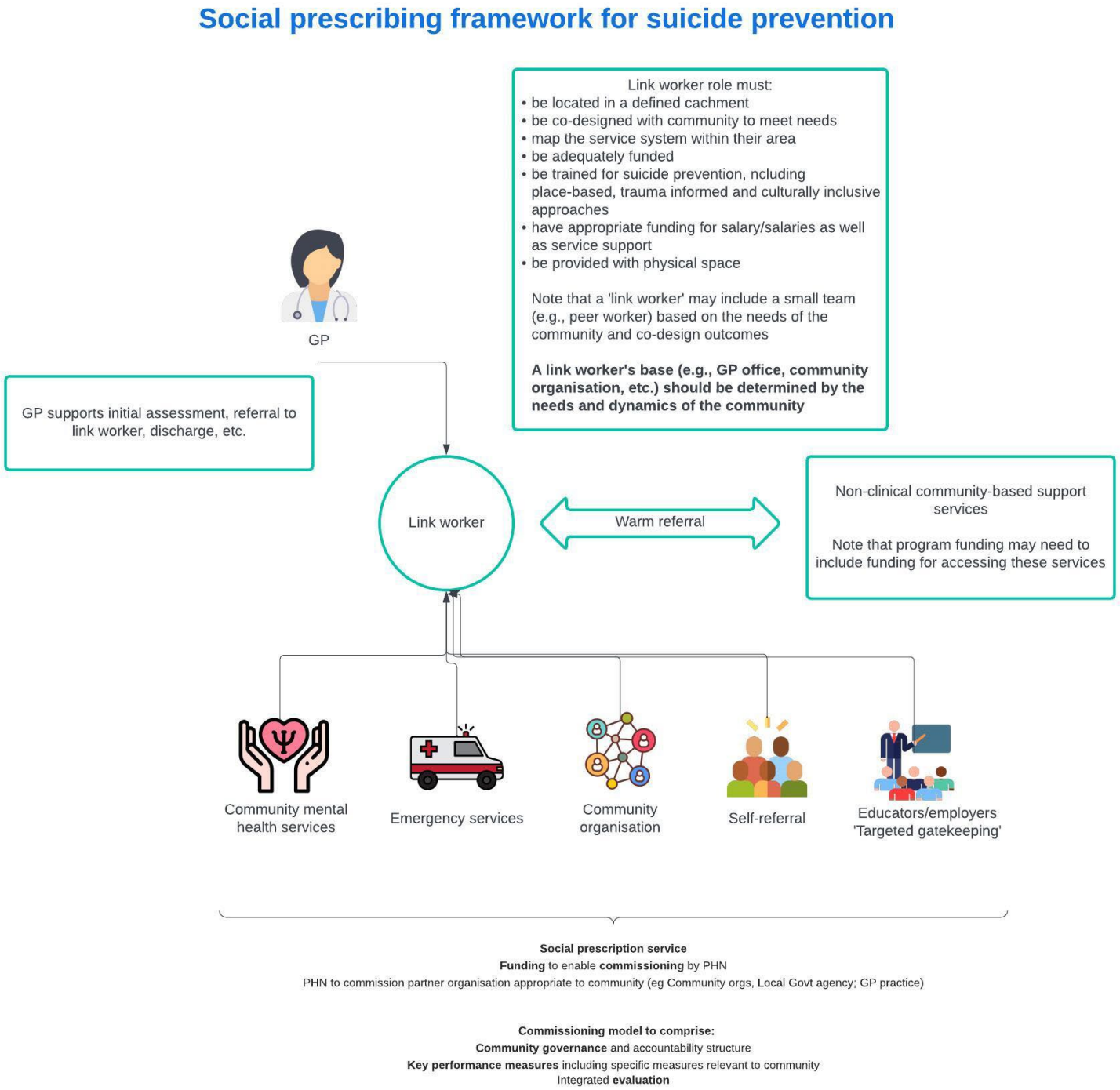


Figure 6: A ready-to-implement model of social prescribing for suicide prevention

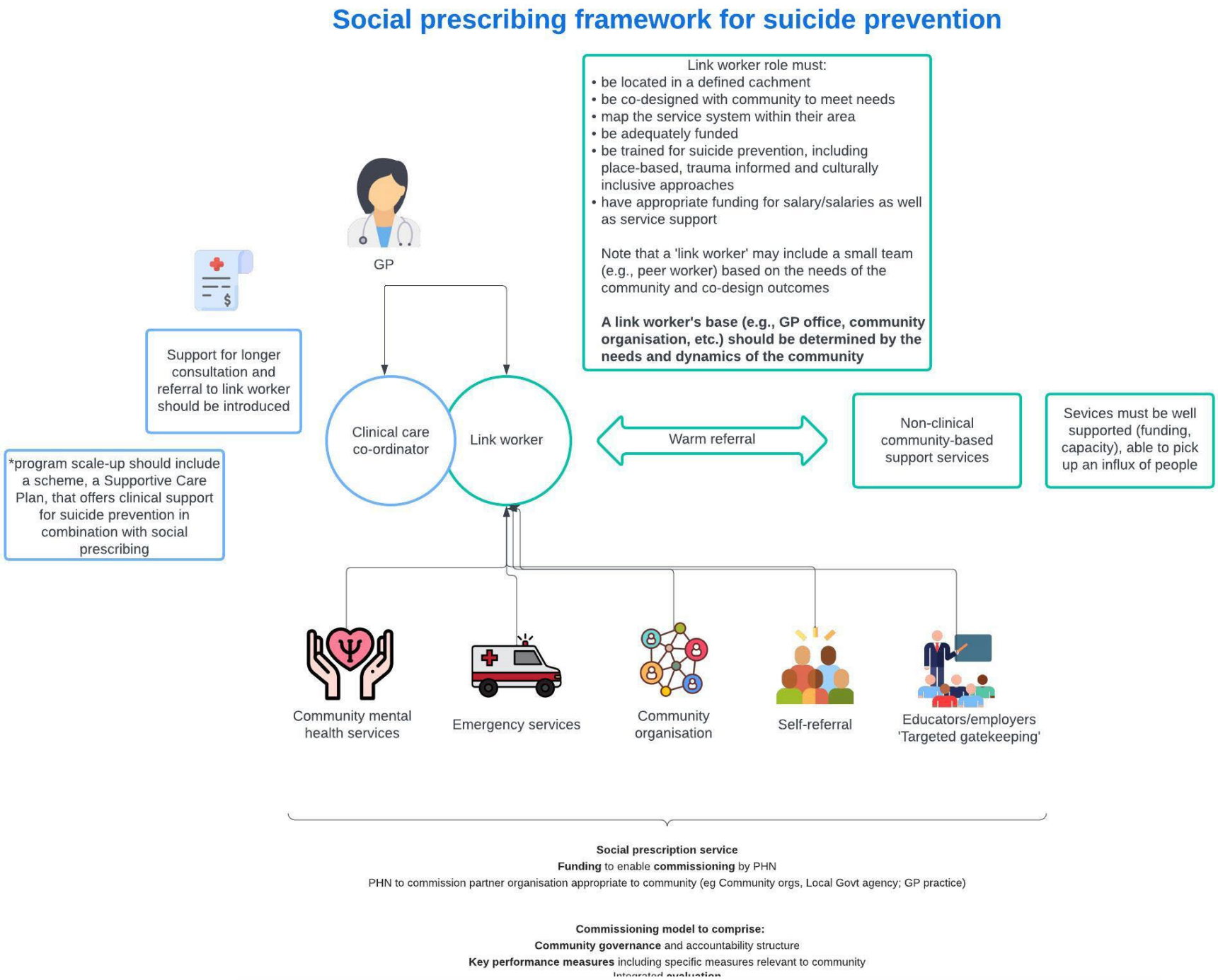


Figure 7: A comprehensive model of social prescribing for suicide prevention

Contextual considerations for social prescribing for suicide prevention

Following the development of social prescribing models in the UK, Canada and USA, interest in social prescribing trials has grown in Australia. In giving consideration to the development of social prescribing for suicide prevention, there are important contextual considerations in planning for a social prescribing model as well as for implementation of a model in an Australian context.

Firstly, suicidal distress is a result of complex factors and is often independent of mental health concerns. Social prescribing in suicide prevention would need to be accessible for those who are appropriately assessed as not in need of mental illness care. Such a model of care may need to also provide access for individuals who require mental health care together with tailored pathways to community supports outside of the mental health system. This also means that those experiencing suicidal distress may not already be in contact with either the physical health or mental health care systems, and therefore additional mechanisms of support and referral may be required to bring them into a preventive care system.

There are also key considerations related to public health infrastructure that will impact the delivery of a social prescribing model. Firstly, there is no existing specific Medical Benefits Schedule (MBS) item to subsidise a medical practitioner or general practice to address the unique clinical, social or community needs associated with suicide risk. A specific MBS item would support GP engagement in assessment of the potential for social prescribing referral in response to suicide risk or ideation. A specific MBS item for this purpose would also provide support for communication between GPs and community mental health services, who typically do not work together.

PHNs are currently already allocated funds for preventative health initiatives and offer a logical, pre-existing system for implementation of social prescribing. Importantly, the unique needs of populations in different PHNs must be considered and therefore, a social prescribing model must have flexibility to adjust to the needs of its community through consultation and co-design.

Health equity is also an important consideration in the implementation and governance of social prescription programs. The Alliance for Healthier Communities emphasizes that it is not enough to simply refer a client to a recreational program or encourage them to become involved in community activities or visit an art gallery. Successfully implementing a social prescribing program means removing the barriers (e.g., financial, emotional) that clients experience in accessing these services [53].

Lastly, it's important to note that several existing social prescribing trials or programs are underway currently in Australia, including a model led by COORDINARE and PCSS in the South-Eastern NSW PHN, the trial led by Dingle et al. [43] and the recently announced trial for people experiencing distress in Queensland [8]. Given that several relatively small social prescribing models have already been designed and implemented in Australia with evaluation indicating success and acceptability of the models [40], [41], [43] suicide prevention models could be tested within existing Australian social prescribing models. Inclusion of a suicide prevention capability within established or broadly focussed social prescribing programs would require the addition of specific, context appropriate elements and considerations to the

program's provision of referral support to range of community services or activities for other preventive health needs. Integrating suicide prevention models within existing programs would support a holistic approach to wellbeing and benefits from program infrastructure that has already been established and reduces fragmentation of suicide-related care from health and social care and support.

An overview of the proposed model and key differences

The proposed model is presented in two versions. Importantly, both models share being embedded within primary care, key principals of a centralised link worker, the necessity of a warm referral, multiple inbound referral pathways and connecting to existing infrastructure.

Key differences between these models include the level of infrastructure required to implement them. Figure 6 demonstrates a model that can be readily implemented within existing health and social care systems. Figure 7 outlines a more comprehensive model of social prescribing in conjunction with coordinated clinical care as required. The second version is the most appropriate to ensure the highest level of engagement of GPs in non-clinical support for suicide prevention (as appropriate). Differences also include the inclusion of support for longer consultation and referral to a link worker, and the concurrent, collaborative offering of clinical and social support. This permits a more comprehensive trial of complementary clinical and community care delivered simultaneously.

Funding and location

The proposed model is intended to complement existing health and social support infrastructure, while incorporating important modifications required to support scale-up. For example, in testing a suicide prevention model of social prescribing that is immediately accessible to all in the relevant community, a link worker is best located in a well-established community hub. In smaller catchments, this may be a GP's practice or it may be a particularly appropriate community organisation; in larger catchments the location may be a network of relevant locations within one or more organisations. In all catchments, the location of link workers should be determined through a careful co-design approach with key stakeholders.

It is also important to note that PHNs currently allocate funds to support preventive health initiatives, and a social prescribing for suicide prevention model would fit well within this capability. PHNs offer an existing pathway through which to fund this model, and PHN organisations could engage a partner/provider to deliver the model.

Importantly, link workers must be appropriately funded for their salary and infrastructure support and to cover the cost of establishing and maintaining a wide referral network and to provide follow up support for participating individuals. An essential component of funding support to be considered is ongoing link worker support to clients as determined by individual need and a budget to meet the cost of access by individual clients to community supports that require a financial membership, sessional fee or subscription.

In addition to supporting individuals to access community services where they may incur a gap fee, funding approaches must also consider the impact to community services who will receive increasing numbers of referrals. Having adequate resourcing (e.g., staff, space) for these community services to manage referrals from social prescribing is integral to the model's success. Although this funding sits outside the social prescribing model itself, community services that will form social prescribing referral networks must be appropriately funded to

support the success and sustainability of the model. Development of a funding framework for social prescribing needs to be co-designed with key stakeholders. This funding warrants consideration in both a ready-to-test implementable model, and a scaled-up version.

Link worker as the central piece

Evidence from the social prescribing literature and the advice of the project expert working group both support the role of the link worker as a central tenet of a social prescribing for suicide prevention model.

The link worker(s) are a central referral point for GPs, community organisations, community mental health services, first responders, key stakeholders working with high-risk groups (e.g., employers, teachers) and those who wish to self-refer. Though a link worker is a feature of broader social prescribing models, a link worker working within suicide prevention should have specific suicide-related training and understanding of relevant social supports within the community. A link worker must have specific knowledge of the needs of the catchment, a comprehensive understanding of the support services within that catchment (or beyond, as relevant) and strong, ongoing relationships with both referral and support services. In some cases (e.g., smaller communities), a link worker role may be taken on by an existing staff member (e.g., practice nurse). In these situations, role delineation between the scope of the link worker role and any other responsibilities (e.g., managing clinical care) must be established. Additionally, a link worker must also be connected to supports for link workers directly, including connection to or embedding within a network (e.g., a GP practice or community organisation in which they are located), for both oversight of their role and support services, as needed.

Peer worker as potential support

Inclusion of a **peer worker** within the link worker service, should be considered. Peer workers are recognized as important supports in both mental health and suicide prevention. The Australian Government Department of Health guidance on the role of the peer workforce in mental health and suicide prevention states that Primary Health Networks (PHNs) can support better outcomes by promoting and supporting the employment of peer workers as part of multi-disciplinary teams providing person centred support and recovery-oriented and trauma informed care. The peer workforce includes both consumer and carer peers [54]. Peer workers have been found to be effective in supporting access to physical health care for people with mental illness and a study of consumers and carers views of peer worker support found that individual peer worker roles were considered to have significant potential value in facilitating access to health information and in assisting with motivation, amongst other benefits [55].

A link worker is a bridge between clinical care and the community sector

Suicide prevention is complex. Many risk factors extend beyond the scope of clinical care, and a social prescription model and specifically, a link worker, adds significant value in linking community care to operate in conjunction with clinical care.

Warm referrals

As noted in the expert advice incorporated in this report, warm referrals must go above encouragement, provision of information or sharing contact information for support services.

Warm referral in a suicide prescribing model must involve the transfer of a patient from the care of one professional to another, with the person present. This is in line with evidence that identifies that trust, rapport and additional support is required for people at risk of suicide or experiencing suicidal distress. Specifically, evidence suggests that there are relationships between social capital and social trust and rates of suicide[44], [45]. Additionally, higher levels of social isolation are also associated with elevated suicide rates [56]. This evidence highlights the additional social and relational barriers that may exist for people at risk of suicide which must be addressed with additional supports. The absence or compromise of warm referral is likely to be a significant barrier to the success of a suicide prevention social prescribing model.

Referral pathways

Several inbound referral pathways to a link worker must be available for best coverage of those who need support. GPs offer a direct referral for patients who may visit a GP for a health or suicide-related reason. Various other inbound referral pathways must be in place to offer comprehensive community coverage to those who need support. There should be 'no wrong door' for referrals. Community mental health services, community organisations, first responders and members of the community themselves must all be able to directly refer to a link worker. Additionally, to account for the likely disconnect between individuals at risk and engagement with services, individuals in high-risk environments (e.g., employment, education) should be viewed as 'connectors' who have knowledge of their local link worker and the pathway available for referring someone at risk. Importantly, this model includes self-referrals which may include individuals at risk of suicide connecting directly with a link worker or being connected via friends and family. Given the urgency of some suicide prevention, self-referral to a link worker does not replace emergency services or urgent support (e.g., Lifeline). Self-referral to a link worker does also not preclude access to clinical services where relevant, and a link worker may also connect individuals with clinical health or mental health care. This emphasises the importance of appropriate skills and training for the Link Worker role. Lastly, referral pathways may differ between communities and should be co-designed based on the needs and infrastructure of each community.

Evaluation and governance

Evaluation of trials of social prescribing for suicide prevention must consider the complex nature of suicide risk factors and be cognizant that the benefit of social prescribing and community supports for individuals at risk of suicidal behaviour are unlikely to be evident in the short term. Testing of this model should be designed intentionally to develop an evaluation framework for social prescribing in suicide prevention that considers the:

- implementation process,
- effectiveness of engagement of key stakeholders and community supports,
- appropriateness and effectiveness of referral pathways within the community

and develops relevant measures of individual outcomes or benefit that are applicable to a time limited trial project.

Lessons from the National Suicide Prevention Trial – Final evaluation report should be taken into the design of an evaluation framework. These evaluation components should inform subsequent scale-up and an evaluation framework for scaled-up implementation.

Importantly, performance indicators for the link worker role should identity the role scope for stand-alone link worker positions and for the role when it is undertaken by a person with an additional clinical or other role related role. These indicators should also capture and provide guidance for instances in which the link worker becomes involved in clinical management or coordination and establish role delineation from a clinical case manager.

Overall, a comprehensive evaluation of a social prescription trial should include a combination of quantitative and qualitative methods to assess its effectiveness in improved health outcomes for individual and its cost-effectiveness. It is important to work with stakeholders, such as healthcare providers, community organizations and consumers, to ensure that evaluation is rigorous and relevant.

An appropriate governance structure for social prescription would involve collaboration between healthcare providers, community organizations and other relevant community stakeholders to ensure that the social prescription program is effectively implemented and meets the needs of the target population [54]. The World Health Organisation toolkit outlines the steps required to introduce a social prescribing scheme [57]. It can be used by implementing organizations, community healthcare and long-term care facilities, mental health and healthcare workers, among others.

A social prescribing model for suicide prevention must be accountable to a governance structure through regular reporting. This would include regular meetings with a community steering committee and regular collection of key metrics, including program uptake, case presentation, types of referrals, effectiveness of the link worker role scope relevant to community needs.

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Appendix 1: Rapid Review Method

MEDLINE

(("social prescri*" OR referral OR pathway OR linkage)) AND suicid* AND ((efficacy OR effectiveness OR impact OR benefits OR outcomes OR reduction))

English only

Results: 1691

PsychInfo

(("social prescri*" OR referral OR pathway OR linkage)) AND suicid* AND ((efficacy OR effectiveness OR impact OR benefits OR outcomes OR reduction))

(All Text)

English only

Results: 1217

WILEY
""social prescribing" OR "social prescription"" and "suicid*" and "efficacy OR effectiveness OR impact OR benefits OR outcomes OR reduction"

(Anywhere)

Results: 85

Sage
"social prescribing" OR "social prescription" AND suicid*
*Note that including 'outcome' search led to 0 results in this database
Results: 59

Inclusion/Exclusion Criteria:

Papers were included if they focused on social prescribing for suicide or suicide prevention risk factors, had some component of quantitative or qualitative evaluation, included referrals outside of the medical system. Papers were excluded if they were in a language other than English, focused only on a single intervention (e.g.,, gatekeeping trials) or did not include community referrals.

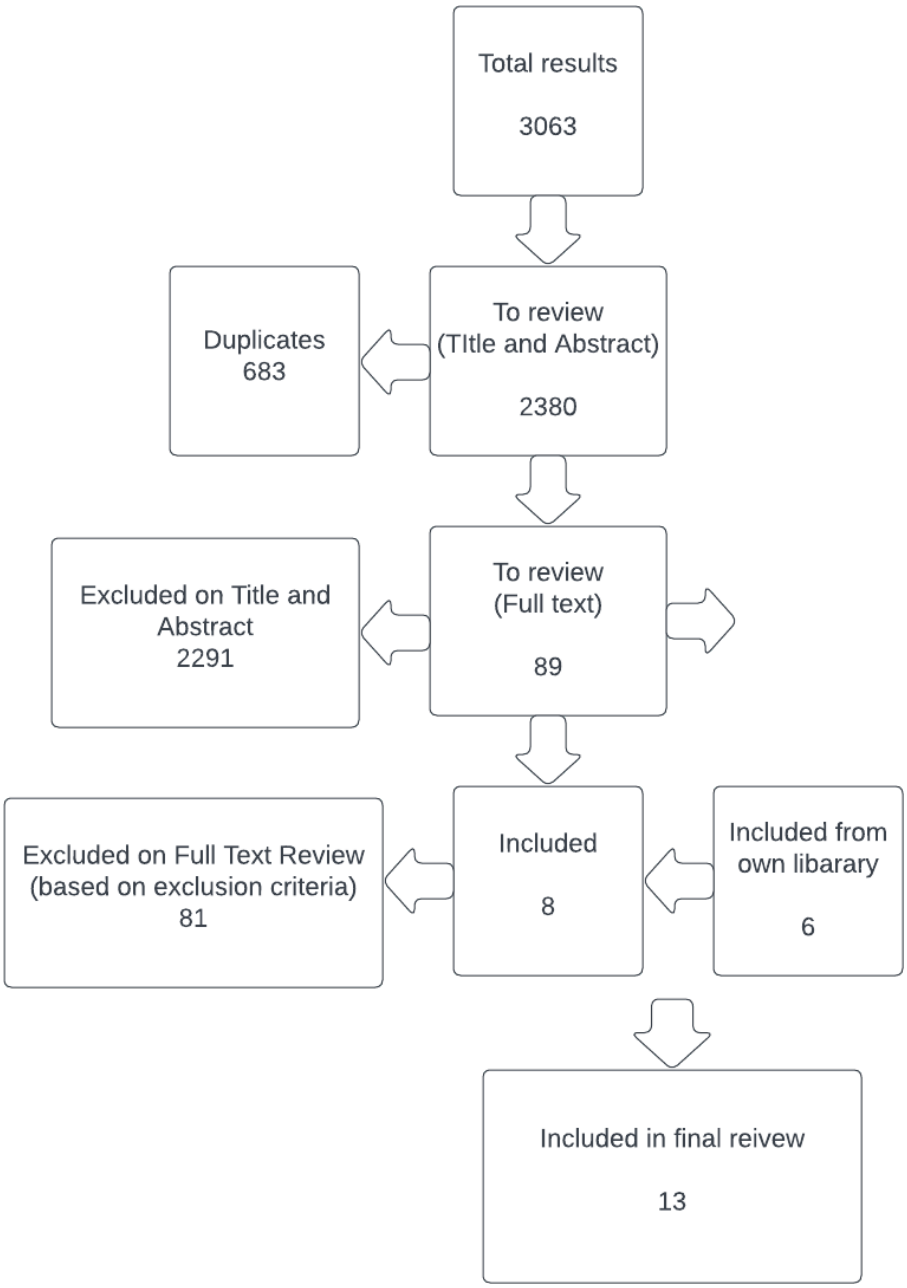

Figure 8: Summary of rapid review process

Appendix 2: Examples of current social prescribing initiatives

Name	Location	cohort	Program information
Access to Community (A2C)	City of Yarra, Vic City of Boroondara, Vic City of Manningham, Vic	Under 65, unpaid carers, people who are lonely or socially isolated	• Short-term (3-month) program connecting an individual with a volunteer Community Connector who is familiar with the local community. • Connects to free or low-cost activities. • Aim to improve social inclusion
Connect Local	Glen Eira, Vic	Over 65 who are lonely or social isolated	• Program works with GPs, clinicians, service providers and hospitals. • Community connector connects to services and activities in the area • Aim to promote wellbeing through social connection • Involvement from Bolton Clarke, South East Melbourne PHN
Digitally Enabled Social Prescribing (Kaleidoscope)	Gippsland, Vic	Patients who are at risk of mental illness, have mild mental illness and likely to become more complex without supports	• Practice nurse builds relationship of trust with individual the digital platform to support healthcare professionals develop a co-designed psychosocial care plan with a patient that tracks progress against agreed goals, referrals and patient outcomes
Footprint Care Coordination Service (CCS)	Brisbane North, Qld	Over 18, chronic health conditions and psychosocial challenges	• Referrals accepted from GPs, community health hubs, The Mater Refugee Complex Care Clinic, Ages Care Navigators, nurse navigators, pharmacies • Brisbane South PHN region
Footprints Social Health Connect	Kilcoy and Caboolture, Qld	Over 18, experiencing social isolation and loneliness	• Addresses barriers that may impact an individuals ability to improve their social health, community participation and connection. (e.g. finances, housing, physical health, mental health, language etc) • Supported by Brisbane North PHN

Inala Primary Care	Inala, Qld	People attending GP appointments with social needs, particularly social isolation	• Primary care practice- 6% of patients take up 24% of GP time
			• 3 models:
			  • PHN affiliated social worker
			  • Group programs for social isolation
			  • M-Choose for culturally and linguistically diverse (CALD) care coordination

IPC Community Health Service	Western Metropolitan Melbourne- Deer Park-VIC	Individuals who have social, physical or mental health needs that impact their daily lives and who want to improve their overall wellbeing	• A wellbeing coordinator works with clients to identify wellbeing goals and connects to free or low-cost community groups • GPs and health care workers can refer clients to the program • Program also accepts self-referral • Began as a collaboration between Brimbank City Council, North West Melbourne PHN, Victoria University and IPC
Southern Wellbeing Hub	Central and Southern Adelaide, SA	Children and families on low incomes; people needing different levels of intensity, and duration of mental health support.	• Can be referred to the hub by a GP issuing a Mental Health Treatment plan, a provisional referral to community services, self referral • Provide low-intensity mental health support including suicide prevention services • By Adelaide PHN and Neami National
La Trobe Health Assembly	Morwell, Churchill, Warragul, and Traralgon, Vic	Community members	• Pilot program • Community connectors in Latrobe Community Health Services (LCHS) • Any of the health services provided by LCHS to refer into the program • A continuation of the pilot program developed by Latrobe Health Assembly and run in Churchill 2021-2023
Living our best life project- Community Houses Association of	City of Knox, City of Maroondah, City of Manningham, City of	Over 60, living near in in the outer east of Melbourne, in need of support to find and	• GP, nurse or other healthcare professional refers to the program • A volunteer community connector then works with the individual to identify goals and connect to activities • Funded by Equity Trustees

the Outer-eastern Suburbs (CHAOS)	Whitehorse, City of Yarra Ranges, Vic	access community activities	
PCCS- Plus Social	Gold Coast, Qld	Over 18, Gold Coast area, people whose mental health significantly impacts their daily life	• Clinical care coordination between GPs, psychiatrists and allied health workers. • Connections to a range of local community services and social groups via a Service Specialist and • An after-hours community-based space (the Hub) • PCCS- not for profit charity • Supported by Gold Coast PHN
PCCS Social Rx	South East NSW	People with unmet needs	• Eligible consumers can be referred by GPs, practice teams, allied health providers, pharmacists and other health providers to a PCCS service specialist or social worker who links the consumer to the services from which they could benefit • Supported by Coordinare South East NSW PHN
Social connectedness for Older People in Hawksbury	Nepean and Blue Mountains PHN	Older people in the area	• Aims to reduce isolation and loneliness and improve mental health through community connections • Health connectors (practice nurses) and community connectors (members of the public) collaborate to connect older people to community assets using the My Health Connectors directory
Connecting Community in the Upper Hume Pilot project	Upper Hume, Vic	Social isolated community members	• Referral by a GP, social worker or self-referral • Delivered through five neighbourhood houses • Volunteer community connector connects to services and activities in the area • Includes Talking cafes, signposting • Funding through Department of Health Bushfire Recovery Mental Health package
Local Connections: Victorian Social Prescribing Trials- Mental Health	• Frankston (Wellways) • Latrobe (Neami)	Over 26, clients receiving support through the Local Service or their carers, family	• Integrated as part of the first six Mental Health and Wellbeing Locals (Frankston, Latrobe, Benalla-Wangaratta-Mansfield, Brimbank, Geelong-Queenscliffe and Whittlesea) • Link workers employed by services will support people to engage in local community-based activities.

	• Benalla, Wangaratta and Mansfield (Wellways) • Geelong Queenscliff (Barwon Health) • Brimbank (cohealth) • Whittlesea (Neami). Victoria	members or supporters.	
Ways to Wellness	Mt Gravatt, Qld	Over 16	• A community link worker is located in the Mt Gravatt Community Centre • Connects socially isolated community members to group programs and activities • Referrals accepted from GPs, OTs, primary health care providers, RAS assessors and self or community referral. • Funded by the Queensland Government, Department of Communities, Disability Services and Seniors

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