Social Prescribing in the Australian Context:

A National Feasibility Study

REPORT
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AUSTRALIAN HEALTH POLICY COLLABORATION

VICTORIA UNIVERSITY

Acknowledgement of Country

Victoria University acknowledges the Ancestors, Elders and families of the Kulin Nation (Melbourne campuses), the Eora Nation (Sydney campus) and the Yugara/YUgarapul and Turrbal Nation (Brisbane campus) who are the traditional owners of University land. We also acknowledge the ongoing contribution of Aboriginal and Torres Strait Islander people across the healthcare system and in the wider community. We pay our respects to the Ancestors, Elders and families of the traditional owners of this land.

About us

The Australian Health Policy Collaboration (AHPC), led by the Health Policy group in the Institute for Health and Sport (IHES) at Victoria University, is a national collaboration of Australia's leading stakeholders in health policy, population health and chronic disease. Established in 2014, AHPC brings together a broad range of organisations and topic-specific experts, including academics, health professionals and consumers, to translate contemporary evidence and expertise into consensus-based policy recommendations aimed at preventing and reducing the impact of chronic diseases on the population.

Project team

The project team who undertook the feasibility study and developed this report comprised:

- Professor Rosemary Calder, project lead (AHPC, Victoria University)
- Ms Stella McNamara, project manager (AHPC, Victoria University)
- Professor Maximilian de Courten, project research fellow (AHPC, Victoria University)
- Professor Mark Morgan, GP expert advisor (Bond University, Royal Australian College of General Practitioners Expert Committee for Quality Care)
- Ms Leanne Wells, sector expert advisor (consultant, former CEO, Consumers Health Forum of Australia)
- Mr Andrew Wade, project economist (CIRES, Victoria University)
- Mr Tyler Nichols, report co-author (AHPC, Victoria University)

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- Professor Yvonne Zurynski (Macquarie University)
- Dr Paresh Dawda (Prestantia Health)
- Ms Nicola Gitsham (NHS England)
- Dr Kate Mulligan (Canadian Institute of Social Prescribing)
- Dr JR Baker (Primary & Community Care Services)
- Dr Elizabeth Deveny (Consumers Health Forum of Australia)
- Ms Jayne Nelson (IPC Health)
- Ms Simone Jones (COORDINARE - South Eastern NSW PHN)
- Dr Sam Manger (James Cook University)
- Ms Tracey Johnson (Inala Primary Care)

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Glossary

Aboriginal Community Controlled Health Services (ACCHSs)

ACCHSs are non-government, not-for-profit organisations run by Aboriginal and Torres Strait Islander people, which provide an array of health and social care services to Aboriginal and Torres Strait Islander communities. ACCHSs emphasise the implementation of holistic, integrated and culturally safe models of care. Other terms such as Aboriginal Community Controlled Health Organisation (ACCHO) and Aboriginal Medical Service (AMS) are often used interchangeably with ACCHS[1]. In this report, ACCHSs is inclusive of the entire Aboriginal community-controlled health services sector.

Co-design

Co-design refers to an iterative and participatory engagement process in which members of the community work collaboratively with service providers, policymakers and/or other relevant stakeholders, to design new, or improve existing, services, programs and public policy. While existing definitions of co-design can vary, most emphasise a process of active (rather than passive) participation of consumers and the importance of shared decision-making in creating outcomes that are mutually acceptable to communities and service providers/program designers[2,3].

Community resources

In this report, 'community resources' is used to describe the broad range of community services, programs, activities and other supports that individuals can be referred to through social prescribing. The term also encompasses local infrastructure assets relevant to social prescription activities (e.g. parks, sports facilities, libraries, community centres etc.)[4].

Community sector

In this report, community sector is defined as the broad range of not-for-profit, non-government organisations that provide community services, programs and various other supports to individuals within the community. Community sector organisations will often undertake activities focused on community development, advocacy, addressing the wider determinants of health and/or reducing health and social inequities. They often work closely with people experiencing high levels of socioeconomic disadvantage and other priority population groups[5].

Feedback loop

In the context of social prescribing, a feedback loop is a system where referring clinicians are kept informed, generally by the link worker, about how the individual they referred is progressing[6].

Holistic care

Holistic care describes a comprehensive healthcare approach that goes beyond treating specific symptoms to address the entire person – including their physical, mental, emotional, social, and spiritual wellbeing. It recognises that these aspects are interconnected, and works to address both clinical and non-clinical factors that influence health and wellebing[7].

Link worker

The common title of the workforce role established in social prescribing programs that connects individuals to appropriate community resources, activities and other supports, to address the non-clinical factors which influence health and wellbeing. Individuals are most commonly referred to a link worker by a GP or other health professional, but in some social prescribing programs can also be referred by various community-based referrers.

Link worker services

In this report, link worker services refer to a service that provides the primary functions of the link worker role in social prescribing.

Mainstream primary care

Mainstream primary care encompasses all primary care services (e.g. general practice, allied health, community pharmacy etc.) other than Aboriginal Community-Controlled Health Services (ACCHSs). It differentiates ACCHSs from other primary care services due to the significant differences in how they are designed and operated.

Non-clinical needs

In this report, non-clinical needs are defined as the social, socioeconomic, cultural, practical, emotional and behavioural factors that influence health and wellbeing, but that are not directly related to the diagnosis or treatment of a medical condition. Examples of non-clinical needs include social isolation, loneliness and low health literacy, as well as behavioural factors related to the major risk factors for chronic disease (e.g. physical inactivity, unhealthy diets). Non-clinical needs also closely align with many of the factors commonly referred to as the wider determinants of health, such as socioeconomic status, housing and food insecurity, educational attainment and past experiences of trauma[8–10].

Postcode lottery

Describes a situation where the quality, availability or level of public services, such as healthcare or education, varies significantly across different geographic areas or postcodes. This disparity is often a consequence of local budgets, decision-making and resource allocation, meaning that access to essential services can be determined by one's residential location rather than individual need.

Priority population groups

There are a range of different population groups within society who experience a disproportionate burden of disease and disparities in health. The National Preventive Health Strategy 2021-2030 identifies these 'priority populations' as including, but not limited to[9,11]:

- Aboriginal and Torres Strait Islander people;
- culturally and linguistically diverse (CALD) populations;
- lesbian, gay, bisexual, transgender, intersex, queer, asexual and/or other sexuality and gender diverse people (LGBTIQA+);
- people with mental illness;
- people of low socioeconomic status;
- people with disability; and
- rural, regional and remote populations.

In this report, these groups, and others who may experience health disparities, are referred to collectively as 'priority population groups'.

Primary care nurses

Primary care nurses can be registered nurses, enrolled nurses or nurse practitioners who work outside of hospital settings. They provide a wide range of services to the community in various primary care settings, including in general practice[12].

Primary healthcare

Primary healthcare describes any health service that can be the first point of contact with the health system for treatment or management of non-emergency medical issues, typically outside of a hospital or specialist care setting. In the Australian context, the primary healthcare encompasses a broad range of services delivered in the community, including:

- general practice;
- allied health services;
- oral health and dental services;
- community pharmacy;
- sexual and reproductive health services;
- maternal and child health services;
- mental health and drug and alcohol treatment services;
- community health and community nursing services; and
- Aboriginal Community Controlled Health Services (ACCHS)[13].

Primary healthcare professionals

In the context of this report, primary healthcare professionals comprise health disciplines that work within Australia's primary care system, including general practitioners, primary care nurses, pharmacists, Aboriginal Health Workers and various allied health professionals (e.g. physiotherapists, occupational therapists, social workers, speech pathologists, psychologists, osteopaths, dietitians, podiatrists)[13].

Preventive health

Preventive health is any action taken to keep people healthy and well and prevent or avoid risk of poor health, illness, injury and early death. This includes both population-level policy interventions and individual-based actions which aim to minimise disease burden and associated risk factors. Preventive health is of fundamental importance to overall population health and wellbeing[9].

Signposting

Signposting refers to an informal referral process in which healthcare professionals provide patients with information to help them access non-clinical, community services and support that are relevant to their health and wellbeing needs[14].

Social capital

Social capital refers to the social connections, networks and relationships within a society or community that enable cooperation, coordination and collaboration for mutual benefit. The concept encompasses the available social resources, and shared values and social norms (e.g. reciprocity, social trust), that underpin effective cooperation and connection of individuals within a social network[15].

Social prescribing

Social prescribing is "a means for trusted individuals in clinical and community settings to identify that a person has non-medical, health-related social needs and to subsequently connect them to non-clinical supports and services within the community by co-producing a social prescription - a non-medical prescription - to improve health and well-being and to strengthen community connections"[16].

Social prescription

In this report, social prescription is defined as the non-clinical intervention/s (e.g. community program, service or social support) that an individual is referred to by the link worker (or other social prescriber) in a social prescribing program/service.

Social prescribing service

In this report, social prescribing service refers to any service or program that provides comprehensive link worker-supported social prescribing to individuals in the community. This mainly comprises the provision of link worker services but also includes working with communities and referrers to build local networks of social prescribing stakeholders.

Specialist link worker

A specialist link worker is a link worker with existing professional qualifications in a relevant health discipline (e.g. social worker, psychologist, occupational therapist) and appropriate skills and capability to work with individuals with the highest levels of psychosocial complexity and non-clinical needs.

Wider determinants of health

The wider determinants of health are the social, environmental, structural, economic, cultural, commercial and digital factors that significantly influence health and wellbeing, and are often outside the control of individuals. Health and wellbeing are inextricably linked to the environments and conditions in which people are born, grow, live, work and age, and the wider set of factors that shape those environments and conditions.[8–10].

'What matters to you' conversation

A 'what matters to you' conversation is a central part of the social prescribing process. It generally takes place between the referred person and a link worker and aims to ascertain what is important to the individual, identify the key areas where they require support, and then to inform the co-production of a personalised social prescription[4].

Acronyms and abbreviations

ACCHS	Aboriginal Community-Controlled Health Service
ADMA	Australian Disease Management Association
AI	Artificial intelligence
ASPIRE	Australian Social Prescribing Institute for Research and Education
CASCH	Canadian Alliance for Social Connection and Health
CHF	Consumers Health Forum of Australia
CISP	Canadian Institute for Social Prescribing
CLW	Community link worker (Scotland)
CoP	Community of practice
DSS	Australian Government Department of Social Services
GP	General practitioner
GSPA	Global Social Prescribing Alliance
ICS	Integrated care systems (UK)
LHN	Local Hospital/Health Network (or equivalent e.g. Local Health District)
MBS	Medicare Benefits Schedule
NACCHO	National Aboriginal Community-Controlled Health Organisation
NASP	National Academy for Social Prescribing (England)
NMDS	National Minimum Data Set
NGO	Non-government organisation
PCN	Primary care networks (UK)
PHN	Primary Health Network
PLACE	Partnerships for Local Action and Community Empowerment
RACGP	Royal Australian College of General Practitioners
RPB	Regional Partnership Board (Wales)
SROI	Social Return on Investment
SSPN	Scottish Social Prescribing Network
UK	United Kingdom
US	United States of America
WHO	World Health Organization
WSSPR	Wales School for Social Prescribing Research

Social Prescribing in the Australian Context: A National Feasibility Study Report

Executive summary

This report summarises the findings of a national feasibility study commissioned by the Australian Government Department of Health and Aged Care (now the Department of Health, Disability and Ageing) to assess the viability of implementing social prescribing in the Australian context. The aims of the feasibility study were to:

- collate and review the most up-to-date Australian and international social prescribing evidence, including peer-reviewed research, programmatic evaluations and other relevant literature;
- analyse the key features and shared characteristics of successful international and Australian social prescribing initiatives;
- determine which social prescribing models are most applicable and appropriate in the Australian context for connecting primary healthcare patients to non-clinical interventions and community supports; and
- identify barriers and enablers to the effective, systematic implementation of social prescribing as an adjunct to primary healthcare in Australia.

Social prescribing describes the practice of individuals being referred to one or more social supports, community-based programs and other non-medical interventions to improve health and wellbeing. It is developing across the world as an important adjunct to clinical care, particularly primary healthcare, and provides a pathway to address the non-clinical factors that significantly influence an individual's health and wellbeing. These factors disproportionately affect priority population groups and contribute to health inequities across the Australian population.

Social prescribing is associated with a wide range of benefits, at both the individual and broader community level, including improved health and wellbeing, increased community participation and enhanced social connectedness. By connecting individuals with community-based supports and resources, social prescribing addresses non-clinical needs such as loneliness and social isolation and can contribute to the prevention and improved management of chronic health conditions. It moves beyond treating established illness to proactively mitigating health risks associated with the wider determinants of health.

Social prescribing can also provide significant health system benefits as it relieves pressure on capacity-strained health services by providing appropriate referral pathways to address non-clinical needs and reducing overall demand for healthcare. This includes reduced demand for primary care services (e.g. general practice) and fewer emergency department presentations and hospital admissions. Economically, these outcomes translate into cost savings for the health system, while also enhancing productivity by supporting individuals to remain healthy, engaged in work or education and active in their local community.

More than 25 countries have started to implement social prescribing to address unmet non-clinical needs affecting population health and wellbeing and to contribute to systemic improvements in preventive health and service delivery models. Globally, the design and implementation of social prescribing programs vary significantly, with different models incorporating a diverse range of referral networks and pathways, workforce roles and funding arrangements. International examples of social prescribing range from small-scale local initiatives through to large, government-funded schemes implemented nationally.

In line with the rapid global expansion of social prescribing, various small-scale, local initiatives have also been implemented across Australia over the last decade. This includes social prescribing programs or services initiated by Primary Health Networks (PHNs), general practices, community health organisations, Neighbourhood Houses/Centres and other community organisations. Since 2021, multiple state-government supported pilot programs have also been established across different state jurisdictions.

Social prescribing provides a bridge between the health and community sectors to better integrate health and social care for individuals. The integration of health and social care is not a new concept in Australia, having been a foundational aspect of Aboriginal Community-Controlled Health Services (ACCHSs) since their inception in 1971. This report acknowledges and advocates for learning from and supporting the integrated models of care pioneered by ACCHSs.

The implementation of social prescribing as an adjunct to primary healthcare in Australia would complement various Australian policy initiatives, frameworks and national strategies that are currently being or soon to be implemented. It strongly aligns with recent increasing recognition of the benefits of coordinated health and social care, such as by recent national reports released subsequent to consultations for this report, such as the *Review of General Practice Incentives*, September 2024 and the *Unleashing the Potential of our Health Workforce - Scope of Practice Review*, October 2024. Each of these considers and makes recommendations about the role of general practice that are directly relevant to the content of this report, including aims to expand and enhance multidisciplinary team-based care within general practice.

This feasibility study, undertaken over a 12-month period, comprised a rapid evidence review of social prescribing literature and an extensive program of consultations with key experts and stakeholder groups relevant to the Australian context. The rapid evidence review and multi-stage consultation program guided the development of a series of 'implementation design principles' and 'operational components', to support the establishment of social prescribing as an adjunct to primary healthcare in Australia.

This report identifies four options for implementing social prescribing in the Australian context, headlined by an optimal model that would achieve comprehensive, systematic and equitable implementation across Australia. All four options were developed and refined through an extensive program of consultations, drawing on the expertise and experiences of key social prescribing stakeholders and leading international and Australian experts. Implementation of any of the options presented in this report would provide critical support for the expansion and advancement of social prescribing across Australia.

The optimal model outlines a blueprint for the nationally coordinated implementation of social prescribing across Australia, supported by long term government investment and stable, sufficient funding for service providers. The four central features of the optimal model are:

- development of a National Social Prescribing Framework;
- establishment of a National Centre for Social Prescribing;
- support and funding for PHNs to co-commission new localised social prescribing services with other relevant community stakeholders (or scale-up exisiting services where appropriate); and
- investment in implementation enablers and national infrastructure.

The implementation enablers and national infrastructure considered essential as to support the optimal model include:

- a social prescribing workforce strategy;
- support for referrer engagement;
- validated non-clinical needs screening and assessment tools for the Australian context;
- a national evaluation framework and minimum data set for social prescribing;
- community resource and asset development guidelines;
- a national community resource database; and
- digital transformation readiness planning.

The staged implementation proposed in the optimal model allows communities most affected by the wider determinants of health, particularly socioeconomic disadvantage, to be prioritised in a national rollout. The three other implementation options identified in the feasibility study are to:

- Establish a National Centre for Social Prescribing as a standalone initiative.
- Establish a grants program for PHNs and/or community consortia to implement localised link worker services, and a National Centre for Social Prescribing.
- Establish a grants program for general practices and other health service providers to embed link workers within existing primary care settings, and a National Centre for Social Prescribing.

While these options are less comprehensive than the optimal model, they are also likely to be more feasible in the short term, as they require fewer resources to implement and less structural change to existing systems. Any of the alternative options could potentially serve as a stepping stone to comprehensive implementation of the optimal model.

Establishment of a National Centre for Social Prescribing is considered an essential requirement of all four implementation options, as is appropriate funding and support for the ACCHS sector to ensure the ongoing delivery of high-quality, holistic care to Aboriginal and Torres Strait Islander communities.

The pervasive impact of social and other non-clinical factors on the health of individuals and the subsequent need to rely on increasing levels of clinical healthcare is evident at all levels of the health system. This report opens the opportunity for health policy and health services to implement effective preventive interventions to reduce and mitigate these impacts on individuals and on the broader health system.

As the Canadian Alliance for Social Connection and Health puts it, “social prescribing, while offering a pathway to better health and wellbeing, should also be seen as a catalyst for broader societal change. It brings the deficiencies of our social structures into sharp focus and emphasizes the need for systemic change. The vision of social prescribing is not just to link individuals to existing services but to contribute to a transformation that sees the rise of compassionate, interconnected communities”[17].

About this report and National Feasibility Study

This feasibility study report presents multiple options for the implementation of social prescribing as an adjunct to primary healthcare in Australia. It is accompanied and supported by a Technical Appendices document that includes additional technical detail and contextual information related to the contents of this report.

The 2022-23 Australian Government Budget provided funding for "a feasibility study of non-medical prescribing" to assess the viability of a national preventive health program aimed at connecting primary healthcare patients with community activities, resources and other social supports to improve health and wellbeing.

The aims of the feasibility study were to:

- collate and review the most up-to-date Australian and international social prescribing evidence, including peer-reviewed research, programmatic evaluations and other relevant literature;
- analyse the key features and shared characteristics of successful international and Australian social prescribing initiatives;
- determine which social prescribing models are most applicable and appropriate in the Australian context for connecting primary healthcare patients to non-clinical interventions and community supports; and
- identify barriers and enablers to the effective, systematic implementation of social prescribing as an adjunct to primary healthcare in Australia.

These aims were addressed through a rapid evidence review of Australian and international social prescribing literature and an extensive program of consultations with leading social prescribing experts and key stakeholder groups, including primary care service providers, community sector organisations, health professionals, social prescribing program providers, policymakers and consumers. The rapid evidence review and preliminary phase of consultations guided the development of a series of 'implementation design principles' and 'operational components', to support the integration of social prescribing as an adjunct to primary healthcare in Australia

The implementation options presented in this report, including the optimal model, were then developed, tested and refined through a secondary round of consultations and targeted semi-structured interviews with Australian and international social prescribing experts. Further detail on the project process and methodology can be found in Appendix 1 of the accompanying Technical Appendices.

This project builds on prior work undertaken in Australia, specifically a social prescribing roundtable, led by the Royal Australian College of General Practitioners (RACGP) and Consumers Health Forum of Australia (CHF) in 2019. The associated report, *Social Prescribing Roundtable, November 2019 Report*[18], recommended a strategic and systematic approach to incorporating social prescribing into the Australian health system, starting in primary care.

1

Background and context

1.1 What is social prescribing?

Social prescribing involves the practice of individuals being referred to a range of social supports, community-based programs and services, and other non-clinical interventions, to improve health and wellbeing[16,17,19]. Specific definitions of social prescribing vary across the world; however, one common, widely accepted definition, developed by an international collaboration of leading relevant experts, states that:

> *"Social prescribing is a means for trusted individuals in clinical and community settings to identify that a person has non-medical, health-related social needs and to subsequently connect them to non-clinical supports and services within the community by co-producing a social prescription – a non-medical prescription – to improve health and wellbeing and strengthen community connections"[16].*

Social prescribing aims to improve health and wellbeing for individuals by addressing unmet non-clinical needs, which are known to influence health outcomes[16,17]. In this report, 'non-clinical needs' are defined as the social, socioeconomic, practical, emotional and behavioural factors that influence health and wellbeing, but are not directly related to the diagnosis or treatment of a medical condition. Examples of non-clinical needs include social isolation, loneliness, low health literacy and food and housing insecurity, as well as behaviours related to the major risk factors for chronic disease (e.g. physical inactivity, unhealthy diets). Non-clinical needs also closely align with many of the factors commonly referred to as the 'wider determinants of health', such as socioeconomic status, housing, educational attainment and access to resources and social support networks[8–10].

Social prescribing represents a shift away from the more traditional, siloed conceptualisation of healthcare and social care as distinctly separate from each other, to a more integrated approach that emphasises the provision of holistic care and seeks to address the non-clinical factors that significantly influence health and wellbeing.

Box 1: Nomenclature – Social prescribing

The term 'social prescribing' was reportedly first introduced by the UK Department of Health in 2006[20]. It draws on existing use of 'prescribing' within medical terminology – which refers to the process of health professionals, particularly doctors, advising and authorising the use of a specific medicine or other health intervention for a patient. 'Social' acknowledges the importance of social, non-clinical interventions within holistic healthcare.

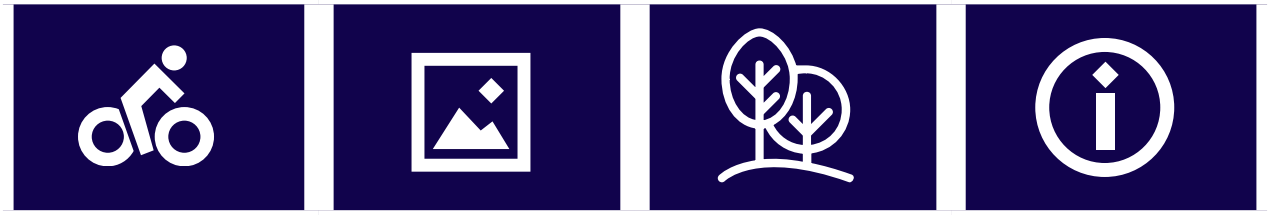
The consultations that informed this report suggested that the term social prescribing is somewhat contentious and not universally endorsed by primary care and community sector stakeholders. Some concerns included that the term is too 'medicalised' and that it implies that the person receiving the prescription is a passive recipient rather than an active participant in their own care.

There are various other terms used around the world that are largely synonymous with social prescribing, including 'non-medical prescribing' and 'community referral', among others. In this report, 'social prescribing' is used for consistency and because it is the widely accepted term internationally.

It should be noted that in Australia, Aboriginal Community Controlled Health Services (ACCHSs) have been integrating health and social care for several decades, however, the term 'social prescribing' is not commonly used within the ACCHS sector.

Social prescribing is a means by which general practitioners (GPs) and other primary healthcare professionals (e.g. allied health professionals, community pharmacists, primary care nurses) can connect patients with community programs, services and other social supports to address non-clinical needs and improve health and wellbeing[17,21]. In most social prescribing programs, this is facilitated by a referral from a health professional to a 'link worker' (see Box 2 for further details on the link worker role), who then works with the individual to assess their specific non-clinical needs and co-produce an appropriate 'social prescription' and action plan[22]. In this report, social prescription is defined as the non-clinical intervention/s (e.g. community resource, program or service, or other social support) that an individual is referred to by a link worker or link worker equivalent role.

Social prescriptions can be categorised into four main intervention types:



Physical activity (e.g. exercise groups, community dance classes)

Arts, culture and heritage (e.g. art or music classes, community-based cultural activities)

Nature-based prescribing (e.g. bushwalking, gardening programs)

Advice and information (e.g. community legal services, housing support services)[23]

Social prescribing is not a one-size-fits-all approach. Social prescriptions should be designed collaboratively between the person referred and the link worker, to ensure that they meet the unique needs, circumstances and preferences of the individual. Both in the literature and in existing social prescribing initiatives, there is a strong emphasis on the empowerment of individuals, shared decision-making and the role of social prescriptions as an important adjunct to clinical interventions in holistic healthcare[16,17].

A critical step in the development of co-produced, personalised social prescriptions (and an integral aspect of the social prescribing process more broadly) is the 'what matters to you' conversation, between the referred person and a link worker. The purpose of this conversation is to ascertain what is important to the individual and then identify appropriate supports that align with their interests and unique strengths[17,19].

There is significant variability in the specific community-based resources and activities included in a social prescription, even among individuals presenting with similar non-clinical needs. In this report, 'community resources' describes the broad range of community activities and services, social supports and other non-clinical interventions that individuals can be referred to through social prescribing to address their non-clinical needs. This also includes community infrastructure assets relevant to social prescription activities (e.g. parks, sports facilities, libraries, community centres etc.)[4].

Box 2: Nomenclature – Link worker

'Link worker' is the common title of the workforce role established in social prescribing programs that connects individuals to appropriate community resources, activities and other supports, to address the non-clinical factors which influence health and wellbeing. Individuals are most commonly referred to a link worker by a GP or other health professional with some social prescribing programs also enabling referrals from a range of community-based referrers.

The link worker role has various names, both in Australia and internationally, including community connector, wellbeing advisor, social prescriber and care navigator, among others[24]. The role is a key feature in Australian social prescribing pilot programs, however, the specific title given to the role varies across different initiatives. For example, the link workers in a Melbourne-based social prescribing program led by IPC Health are known as 'wellbeing coordinators'. In this report, the term 'link worker' is used consistently to describe the role.

In the ACCHS sector, there is no specific 'link worker' role. Instead, the functions of a link worker are undertaken as part of usual practice by a wide range of health professionals, particularly Aboriginal Health Workers and Aboriginal Health Practitioners.

Figure 1 provides a visual representation of a generic social prescribing model in mainstream primary healthcare[25]. It illustrates an individual with unmet non-clinical needs being referred by a health professional or other service provider to a link worker, who then undertakes a non-clinical needs assessment and connects the individual to appropriate community resources, supports and activities. While the model depicted in Figure 1 accurately portrays a simple social prescribing model with a linear referral pathway, in practice social prescribing ecosystems usually are not so linear and feature complex networks of people, services and community resources[26].

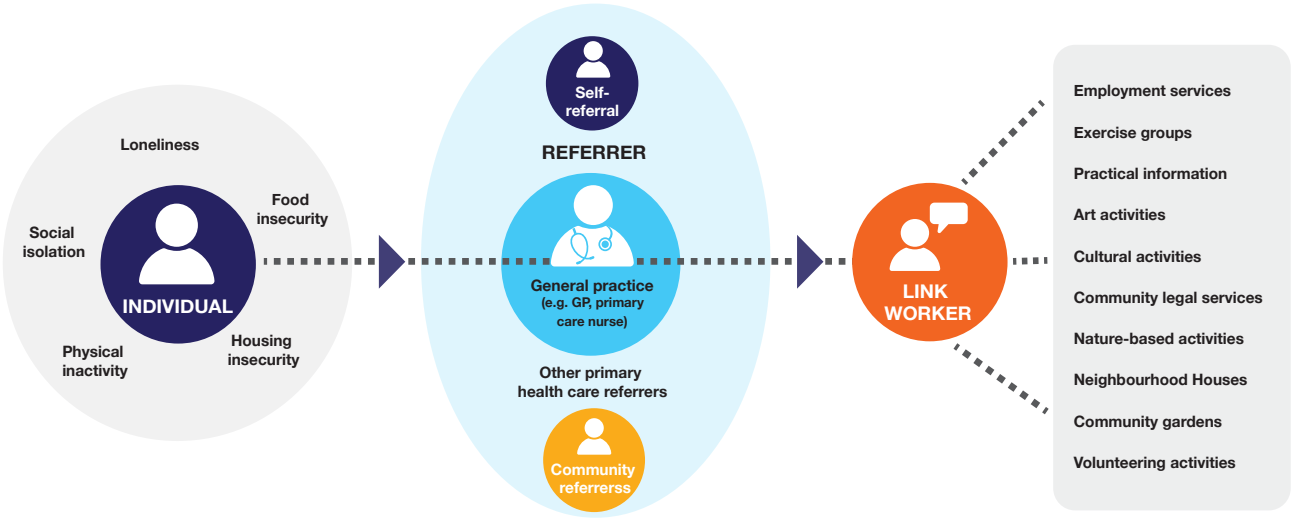


Figure 1: A social prescribing model in brief (adapted from [25])

1.2 Social prescribing: Global origins and current international context

More than 25 countries have started to implement social prescribing to address unmet non-clinical needs in the population and contribute to long-term systemic changes in preventive health and service delivery models. There is considerable variability in the design and implementation of social prescribing initiatives globally, resulting in an array of different service models, which encompass a diverse range of referral networks and pathways, workforce roles and funding arrangements[27,28].

Social prescribing as an adjunct to healthcare originated within the United Kingdom (UK) several decades ago, beginning with localised small-scale initiatives[29], as a response to growing awareness that non-clinical factors can significantly influence health and wellbeing. More recently, social prescribing has been systematically established within England's primary care system through specific funding arrangements, including the 2019 *NHS Long Term Plan*[29].

Social prescribing has expanded globally with localised adaptations in various countries, including Wales, Scotland, Ireland, Spain, Portugal, Canada, the United States of America (US) and Singapore[27]. However, the scale and breadth of international social prescribing developments vary greatly, ranging from local small-scale initiatives to large government-funded schemes integrated across national health and social care systems[27,28]. This reflects the diverse health systems, cultural contexts and service environments in the countries that have adopted social prescribing in some form. For example, countries like Spain and Portugal have local programs where existing healthcare professionals are upskilled to take on the link worker role, rather than create a dedicated workforce[27]. Conversely, England and Scotland have dedicated link worker roles within national schemes[27]. In other countries, such as Canada, a mixed approach is employed across different regions depending on local context[27].

To support the wide array of international initiatives, national organisations focused on social prescribing research, professional education and advocacy have also been established in several countries. These include the Social Prescribing Network[30] and the National Academy for Social Prescribing (NASP)[31] in England; the Canadian Institute for Social Prescribing (CISP)[32]; the Wales School for Social Prescribing Research (WSSPR)[33]; and Social Prescribing USA[34] among others.

The World Health Organization (WHO) supports the integration of social prescribing into healthcare systems globally, especially in contexts and population groups with high levels of socioeconomic disadvantage and social care complexity[35]. This includes social prescribing being identified in a recent WHO report as an essential tool for combating rising social disconnection, which is increasingly being recognised as a significant global public health issue[36]. WHO support for the concept of social prescribing goes all the way back to the WHO 1978 *Declaration of Alma-Ata*, which emphasised the fundamental importance of primary healthcare systems that connect effectively to the community and social care sectors for improved health and social outcomes[37].

Appendix 2.6 in the accompanying Technical Appendices provides further detail on social prescribing developments internationally.

1.3 Social prescribing in Australia

In line with the rapid global expansion of social prescribing over the last decade, various small-scale, local initiatives have also been implemented across Australia. These have been initiated by Primary Health Networks (PHNs), primary care service providers (e.g. general practices), Neighbourhood Houses/Centres, or other community and consumer organisations[38,39]. Since 2021, multiple state-government supported pilot programs have also been established , including the Victorian Government's 'Local Connections' social prescribing services in six Mental Health and Wellbeing Locals[40]; the Queensland Government partnership with Neighbourhood Centres for the 'Putting Kids First Social Prescribing Trial'[41]; and the now concluded South Australian 'Nature Prescription Trial'[42].

Several organisations have emerged to champion the advancement of social prescribing in Australia. The Australian Social Prescribing Institute of Research and Education (ASPIRE) was established to support social prescribing in Australia through research, connections, evidence and education. ASPIRE aims to bring together global best practice and help facilitate the development of localised social prescribing models for different Australian contexts[43].

The Australian Disease Management Association (ADMA) is a national forum and resource centre promoting chronic disease quality of care, integrated care and care coordination information and programs for healthcare professionals. ADMA has previously hosted a Social Prescribing Network – an informal community of practice to share knowledge, resources and experiences of social prescribing across Australia. The network includes various health professionals, health service providers, consumers, social care workers, researchers, volunteers and policy professionals. ADMA also hosts a resource hub and collates a list and map of current social prescribing programs across Australia[44].

The Victorian Social Prescribing Collaborative (VSPC), a network of Victorian social prescribing stakeholders, was brought together in 2023 by the Wellbeing Promotion Office (WPO) of the Victorian Government Department of Health to support the evidence-based emergence of social prescribing across Victoria[45]. The RACGP has also recognised the potential of social prescribing, co-hosting a roundtable with the CHF in 2019[46] and establishing a members' Specific Interest Group on social prescribing[47].

It is important to acknowledge that the concept of addressing an individual's non-clinical needs alongside their healthcare needs through integrated health and social care is not new in Australia – it has been a key feature of the ACCHS model for several decades[48].

Many of the existing Australian initiatives have established that, while they have recorded promising outcomes, they experience persistent challenges to social prescribing implementation, which include precarious funding and limited support for link workers[39]. This precarity dictates the capacity and scope of the programs being delivered[49].

Despite these funding and system barriers, social prescribing in Australia is continuing to gain significant traction at the state and national levels, as evidenced by the state-based programs and dedicated support structures discussed above[40–43,50]. This reflects the continued demand and ongoing efforts to embed social prescribing into Australia's health and social care landscape.

1.4 Benefits of social prescribing

Social prescribing is associated with a wide range of benefits related to individual health and wellbeing, health system efficiency, community collaboration and cohesion and the broader national economy[17,51]. By providing a bridge between the health and community sectors, social prescribing facilitates greater intersectoral collaboration and holistic, wrap-around care[16,17]. It also enables opportunities for prevention and addressing the wider determinants of health that are typically beyond the reach of primary healthcare[17].

Research examining the benefits of social prescribing is promising, but the quality of evidence is mixed and there are challenges in assessing the long-term impacts of interventions[128,195]. However, most researchers conclude that while evidence of social prescribing effectiveness is limited, it is emerging as an important and helpful adjunct to healthcare[17,195].

1.4.1 Health and wellbeing benefits – individuals

Social prescribing can help to address non-clinical issues that influence health and wellbeing across a broad range of population and age groups. It is particularly relevant for people experiencing social isolation and loneliness and those living with chronic health conditions[17]. By connecting people with community-based activities and supports, such as exercise groups, community programs, volunteer opportunities and/or appropriate services, social prescribing has been shown to reduce health risks and improve overall wellbeing[52–54].

Social prescribing is associated with a wide range of health and wellbeing benefits for individuals, including improvements in:

- self-reported health, wellbeing and quality of life;
- mental health indicators (e.g. reduced anxiety, improved mood);
- physical health status;
- social isolation and loneliness; and
- community participation and connectedness[55–65].

There is also emerging evidence that social prescribing can contribute to improved health literacy and self-management capabilities and help to address some of the major risk factors for preventable chronic disease (e.g. physical inactivity and unhealthy diets)[52–54].

Much of the research on the health and wellbeing benefits of social prescribing has focused on adults, particularly those 65 years and older. However, recent research suggests that social prescribing can be an effective preventive intervention to reduce health risks across the lifespan, including in children and young people[66–69].

1.4.2 Community benefits

Social prescribing generates direct benefits for communities by fostering stronger social connections and networks, facilitating community participation and volunteering, and providing opportunities for cross-sector collaboration between local stakeholders[70–72]. By strengthening social connections, it reduces social isolation and can improve overall community cohesion, particularly among priority population groups[15,35]. Social prescribing initiatives also enhance awareness and utilisation of community activities and infrastructure, local services and social supports, and encourage investment in these community assets and resources[17,73].

Social prescribing programs facilitate intersectoral collaboration between health service providers, non-government organisations (NGOs), community organisations, government agencies and other relevant stakeholders within the local context[17]. They also improve 'social capital' – used in this report to describe the social connections, networks and relationships that enable individuals to work cooperatively in a group towards a common goal – within local communities[15]. Building social capital and establishing strong connections between primary healthcare providers, community organisations, service users and other local stakeholders can subsequently enhance community cohesion and capability and can drive collective action to improve community health and wellbeing[15,70–72].

Social prescribing can also contribute to various long-term community benefits that persist beyond an individual's engagement with the service or program. Improving the health and wellbeing of individuals subsequently enhances the social and economic wellbeing of the broader community, which in turn contributes to better education outcomes, enhanced productivity and increased long-term community participation[74]. Community participation facilitated through a social prescription can include various forms of volunteering, as well as engagement with community groups and activities. Evidence suggests that social prescribing programs can contribute to increased rates of community volunteering over the long term, which results in a range of additional, ongoing benefits for local communities[75].

1.4.3 Economic and health system benefits

In addition to the wide-ranging positive impacts on communities and individual health and wellbeing, social prescribing can also provide significant benefits to the health system and broader national economy. Social prescribing relieves pressure on overloaded, capacity-constrained health systems by reducing demand for both primary and acute care services and improving system efficiency[76–78]. Multiple studies have found that individuals require fewer GP appointments, are less likely to present to an emergency department and have fewer preventable hospital admissions after engaging with a social prescribing program or service[17,76–79].

Findings from a NASP (England) report examining the health system benefits attributable to social prescribing across multiple localities in the UK, highlight a 42-50% reduction in GP visits and a 23-66% reduction in emergency department presentations for individuals engaged with a social prescribing service[76]. An earlier NASP report also details the important role of social prescribing in alleviating pressure on overstretched nursing and mental health services[77].

Social prescribing seeks to improve health system efficiency by addressing individuals' unmet non-clinical needs in community-based, non-clinical settings, rather than in more resource-intensive clinical settings[17,56,77]. By addressing unmet non-clinical needs, social prescribing helps to prevent the escalation of issues that could otherwise lead to repeated GP visits and/or presentations to acute care services[17,56,77,78]. This results in less demand for already overstretched GP services and greater GP capacity to focus on clinical issues and the ongoing management of complex chronic conditions, rather than the non-clinical needs of patients[17,77–79]. Relieving pressure on capacity-constrained primary care and hospital services can also contribute to a range of subsequent health workforce benefits, including lower rates of health professional burnout and improved staff recruitment, retention and wellbeing in healthcare services[80].

Social prescribing also promotes more holistic service models, better care coordination and enhanced integration across the health and social care sectors, streamlining patient pathways and contributing to a more efficient, responsive, and sustainable health system[17,35,76–78].

The system benefits associated with social prescribing programs closely align with long-term health policy objectives in the Australian context – particularly more efficient service utilisation and reduced healthcare expenditure[81]. This further reinforces the potential role of social prescribing in contributing to a fit-for-purpose, sustainable and efficient health system into the future.

The economic benefits of social prescribing can extend beyond improved health system efficiency and reduced healthcare expenditure, to include broad positive impacts on workforce participation, productivity, and increased investment in local community resources and infrastructure assets. By improving mental health, reducing social isolation and supporting individuals in managing chronic conditions, social prescribing can help people remain engaged, or reengage in, work, education and volunteering, and contribute to reduced workplace absenteeism[78].

1.4.3.1 Social prescribing economic analyses

Numerous economic analyses of social prescribing programs, both in Australia and internationally, have consistently demonstrated positive returns on investment, further reinforcing the strong economic case for social prescribing[78,82,83]. Several of these analyses have been Social Return on Investment (SROI) studies. SROI studies utilise a comprehensive economic modelling framework to systematically measure the holistic value of a program or activity, including the social, environmental and economic value. It differs from traditional return on investment analyses by assigning a monetary value to outcomes that don't typically have a market price, such as improved wellbeing[84], making it a useful tool to assess the economic impact of social prescribing.

There are multiple international examples of SROI analyses examining the overall value of social prescribing programs, which demonstrate strong returns on investment. These include:

- a large study of over 10,000 social prescribing service users in England over 30 months, which estimated an SROI of £3.42 per £1 invested[78,83]; and
- a KPMG economic analysis commissioned by the Canadian Institute for Social Prescribing (CISP), which estimated an SROI of CA$4.43 for every CA$1 invested in social prescribing programs[85].

An SROI analysis was also completed as part of this feasibility study, to assess the potential value of social prescribing in the Australian context. It used data provided by a NSW-based social prescribing program which focused on supporting injured workers to return to work (refer to Appendix 8 of the Technical Appendices). Development of the feasibility study SROI analysis was further informed by undertaking a review of three other economic analyses (one cost analysis, two SROIs) conducted on social prescribing programs in the UK[82,83,86]. The analysis estimated that the NSW program achieved an indicative overall return on investment of AUD$5.80 for every AUD$1 invested.

The NSW Government insurance and care agency (icare) commissioned a different economic evaluation on the same NSW program, which estimated a return of AUD$3.80 for every AUD$1 invested[87]. The variation between these two analyses is largely due to the attribution of value to partial or full return to work in the modelling undertaken for this report, as this outcome was not included in the icare assessment[87].

Further detail on the various benefits associated with social prescribing can be found in Appendix 2.3 of the supporting Technical Appendices.

1.5 Social prescribing and priority population groups

There are a range of different population groups within society who experience a disproportionate burden of disease and health inequities. The National Preventive Health Strategy (NPHS) 2021-2030 identifies these 'priority populations' as including, but not limited to:

- Aboriginal and Torres Strait Islander people;
- culturally and linguistically diverse (CALD) populations;
- lesbian, gay, bisexual, transgender, intersex, queer, asexual and/or other sexuality and gender diverse people (LGBTIQA+);
- people with mental illness;
- people of low socioeconomic status;
- people with disability; and
- rural, regional and remote populations[9,11].

In this report, these groups, and others who may experience health disparities, are referred to collectively as 'priority population groups'.

Social prescribing is particularly relevant to priority population groups as these groups experience disproportionately high rates of premature death, chronic disease and non-clinical needs, such as psychological distress, social isolation and sedentary lifestyles. Evidence suggests that people experiencing the highest burden of health inequalities and non-clinical needs have the greatest potential to benefit from social prescribing programs[88,89]. There was strong agreement throughout the feasibility study consultations that social prescribing services in Australia should be accessible to all, with an emphasis on priority population groups.

While not defined as priority population groups in the NPHS, older people, carers and younger people were consistently identified through consultations for this feasibility study as individuals who would benefit from social prescribing. Older people, particularly those aged 65 years and older, were identified due to the recognised prevalence of loneliness in this demographic[90]. Young people at risk of poor mental health were highlighted as a group where social prescribing could offer crucial early intervention[16]. Carers were identified because their non-clinical needs are often deprioritised, as the focus typically remains on the individuals they care for[91]. NASP (England) has also recognised social prescribing as a valuable support for carer health and wellbeing[92].

1.5.1 Aboriginal and Torres Strait Islander people

Social prescribing as an integrated, holistic approach to improve health and wellbeing aligns with the description of Aboriginal health in the National Aboriginal Community Controlled Health Organisation (NACCHO) Constitution.

> *"Aboriginal health means not just the physical well-being of an individual but refers to the social, emotional and cultural well-being of the whole Community in which each individual is able to achieve their full potential as a human being thereby bringing about the total well-being of their Community. It is a whole of life view and includes the cyclical concept of life-death-life"[93].*

The ACCHS model takes a 'wide lens' approach to health and wellbeing, incorporating wider health

determinants and connection to culture, country and community, amongst other aspects of quality of life. ACCHSs also regularly provide non-clinical supports that normally sit outside the remit of mainstream services, without explicitly labelling this practice as 'social prescribing'[94,95].

While a significant proportion of Aboriginal and Torres Strait Islander people engage with ACCHSs for their healthcare needs, access is not universal across Australia and some choose to use mainstream services instead. It is therefore critical that mainstream services are also culturally safe and trauma-informed, to ensure that Aboriginal and Torres Strait Islander people can access appropriate and respectful care across the health system[1]. Box 3 outlines examples of ACCHS sector social prescribing.

Box 3: Examples of ACCHS sector social prescribing

Social and Emotional Wellbeing (SEWB) programs

SEWB programs aim to enhance social and emotional wellbeing and reduce rates of psychological distress, self-harm and suicide in Aboriginal and Torres Strait Islander communities. Informed by local needs, SEWB programs use a strengths-based and holistic health approach to address the various and wide-ranging cultural needs of Aboriginal and Torres Strait Islander peoples and communities[96,97]. Evaluations of SEWB programs indicate improvements in social and emotional wellbeing for program participants, through stronger connections to culture, kinship and social support networks, acceptance of and pride in self and culture, and enhanced self-confidence and resilience[97].

Health justice partnerships[i]

Some ACCHSs partner with community legal centres or legal aid to provide on-site legal support services. These health justice partnerships assist individuals with various legal concerns, such as credit and debt issues, fines, Centrelink or housing issues, family breakdown, child protection and domestic and family violence. Access to these services helps address systemic factors contributing to social, health and justice inequities, and improves health and justice outcomes for Aboriginal and Torres Strait Islanders[99].

1.5.2 People with mental illness

People with mental illness could benefit significantly from social prescribing. A 2024 report, Analysis of unmet need for psychosocial supports outside of the National Disability Insurance Scheme (NDIS) (2024)[100], estimated a substantial unmet demand, with approximately 263,100 people aged 12-64 with moderate mental illness and 230,500 with severe mental illness requiring, but not receiving, psychosocial supports. Defined as "non-clinical, recovery orientated services, delivered in the community and tailored to individual need", these supports can include assistance with material needs such as housing as well as socialisation, building relationships and engaging in education[100]. Social prescribing is designed to address these non-clinical needs and could contribute to reducing the gap in access to psychosocial support for individuals.

i Health Justice Partnerships also operate in some mainstream primary care services[98]

1.5.3 People of low socioeconomic status

Low socioeconomic status (i.e. high levels of disadvantage) is strongly correlated with high non-clinical needs, greater psychosocial complexity and poorer health and wellbeing outcomes[101,102]. In Australia, individuals and communities with lower socioeconomic status experience disproportionately high rates of premature mortality and preventable chronic disease, including heart disease, cancer, diabetes, lung disease and mental illness[103]. These disparities between the least and most socioeconomically disadvantaged communities are persistent and increasing. Disadvantaged communities also often have limited community infrastructure, further compounding the entrenched socioeconomic health disparities observable in Australia and internationally[102,104].

Evidence indicates that while all population groups can obtain health and wellbeing benefits from social prescribing, it is particularly beneficial for individuals most affected by the wider determinants of health, including those experiencing high levels of socioeconomic disadvantage[35].

1.5.4 Other priority population groups

Other priority population groups that can benefit from social prescribing initiatives include culturally and linguistically diverse groups, people with disability and LGBTIQA+ people, among others. These groups, along with Aboriginal and Torres Strait Islanders, people with mental illness and people of low socioeconomic status, often face systemic barriers to accessing healthcare, disproportionately high rates of chronic disease and high levels of non-clinical needs[9,17,105].

As well, many individuals will fit into multiple priority population groups and many of the underlying causes of health inequity overlap and interact, amplifying their effect[9,106]. This concept is sometimes referred to as 'intersectionality', which describes the interconnected nature of factors such as race, gender, socioeconomic status, sexual orientation, employment, education and various other social categorisations[9,106].

Social prescribing, grounded in culturally safe and person-centred care, can help to reduce health disparities by addressing some of the non-clinical factors which disproportionately affect priority population groups[17].

1.6 Australian policy context

The integration of social prescribing as an adjunct to primary healthcare in Australia would align with and complement various Australian policy initiatives, frameworks and national strategies that are currently being or soon to be implemented. These include:

- the *Mid-Term Review of the National Health Reform Agreement Addendum 2020-2025* (2020)[107];
- the NACCHO *Core Services and Outcomes Framework* (2021)[94];
- the *National Aboriginal and Torres Strait Islander Health Plan 2021-2031* (2021)[1];
- the *National Preventive Health Strategy 2021-2030* (2021)[9];
- *Future Focused Primary Health Care: Australia's Primary Health Care 10 Year Plan 2022-2032* (2022)[108];
- *Strengthening Medicare* (2022)[109];
- the *National Health and Climate Strategy* (2023)[110];
- the *Unleashing the Potential of our Health Workforce - Scope of Practice Review* (2024)[111];
- the *Review of General Practice Incentives - Expert Advisory Panel Report* (2024)[112]; and
- the *National Suicide Prevention Strategy 2025-2035* (2025)[113].

Specifically, there are several structural funding reforms proposed in various recent government-initiated policy reports, which aim to expand and enhance multidisciplinary team-based care within general practice. These include the *Strengthening Medicare Taskforce Report*[109], the *Unleashing the Potential of our Health Workforce - Scope of Practice Review*[111] and the *Review of General Practice Incentives - Expert Advisory Panel Report*[112], the latter of which also explicitly calls for link workers to be embedded in multidisciplinary primary care teams.

Several relevant policy initiatives have also been implemented in recent years across the social care, community support and disability sectors. These include the independent review of the National Disability Insurance Scheme (NDIS) and subsequent policy response from the Australian Government[114]; the 2023 aged care reforms[115]; and the introduction of the Australian Government's *Measuring What Matters* wellbeing framework (2023)[116], which centres on a more holistic and comprehensive approach to measuring population wellbeing[116].

In 2023-2024, the Australian Government Department of Social Services (DSS) facilitated work on a National Centre for Place-Based Collaboration (then the Nexus Centre), recognising that programs and policy solutions should be tailored to the needs and context of individual communities to maximise their efficacy[117]. After this initial phase of work, DSS partnered with six philanthropic co-funders to establish Partnerships for Local Action and Community Empowerment (PLACE). PLACE is a national organisation established to address social and economic challenges in communities by supporting community-led, place-based approaches[118]. The Australian Government has also tasked DSS with undertaking work related to the 2022 election commitment for a stronger, more diverse and independent community sector, including the development of a *Community Sector Grants Engagement Framework* (2024)[119,120].

There is a strong strategic alignment and clear fit for social prescribing within many of these policy initiatives. Social prescribing can play a practical and immediate role in supporting the effective implementation of these policy agendas by:

- addressing the wider determinants of health;
- improving care integration and coordination across the health, social services and community sectors;
- enhancing the long-term sustainability of the health system; and
- contributing to a more productive and resilient society[26].

For more detail on the policy context, refer to Appendix 3 in the supporting Technical Appendices.

1.7 Primary healthcare in Australia

Primary healthcare describes any service that is the first point of contact with the health system for treatment or management of non-emergency medical issues, typically outside of a hospital or specialist setting[13]. Primary care is a central function of a country's health system and contributes significantly to the overall social and economic development of the community[37].

In Australia, primary care encompasses a broad range of non-specialist health services delivered by a wide variety of service providers in community (i.e. non-acute) settings. This includes general practices, community health organisations, community-based allied health (e.g. physiotherapy, psychology, occupational therapy, etc.), community pharmacy, maternal and child health services, alcohol and drug treatment services, community mental health services and ACCHSs[13].

1.7.1 Primary healthcare and non-clinical needs

Many individuals who seek medical care for clinical issues also have unmet non-clinical needs that are adversely affecting their health and wellbeing[121–124]. Addressing non-clinical needs is generally considered out of scope of routine clinical practice, particularly in mainstream services[56]. Despite this, in the UK, GPs reportedly spend about a fifth of their time on social (non-clinical) issues, reducing the time available to address the clinical needs of patients[121,122]. A similar trend may exist in Australia, where GP service utilisation is higher in people experiencing socioeconomic disadvantage and complex non-clinical needs [124,125], and GPs report spending a significant proportion of their time addressing non-clinical issues[124,126].

The health and wellbeing impacts attributable to non-clinical issues are significant and wide-ranging, with one US study estimating that 80% of health outcomes are shaped by factors beyond direct clinical care[127]. These factors include various health behaviours related to diet, physical activity, smoking and drug and alcohol use, as well as broader socioeconomic conditions related to educational attainment, employment status, income and family and social support networks[127].

While these factors significantly influence health and wellbeing, many are most effectively addressed outside of clinical settings. However, the majority of primary care services in Australia do not effectively facilitate referrals to non-clinical settings, due to limited existing social prescribing pathways and funding and structural arrangements which fail to support such referrals[46]. This often means that non-clinical needs are either inefficiently being addressed within a clinical setting or not being addressed at all. Many primary care clinicians have insufficient time within a standard consultation, and often have limited active links to appropriate community resources and activities, to address patients' non-clinical needs [57,128–130]. This leads to inefficient utilisation of primary care resources, poorer health outcomes and places additional strain on the health system, as unmet non-clinical needs can progress into clinical issues requiring more resource-intensive interventions[101]. Establishing and maintaining such connections requires a considerable commitment of time and resources[124,126].

1.7.2 Social prescribing in Australian primary healthcare

In Australia, the practice of referring people to non-clinical interventions by health professionals in mainstream primary care services, particularly GPs, appears to be limited. A 2019 survey conducted by the RACGP and CHF, found that 82% of GP respondents said they 'always' (7%), 'often'(38%) or 'sometimes' (37%) referred patients to non-health services in the community where appropriate as part of their treatment plan[46].

However, this contrasts sharply with the patient experience. Many consumer respondents (~84%) said their primary care provider 'never' (57%) or 'rarely' (27%) discussed using community programs or services to improve their health[46]. This discrepancy suggests that GPs are more commonly engaging in 'signposting' (i.e. providing brief, informal advice about potentially helpful community resources or activities), rather than a structured, active social prescribing referral that includes a discussion with the patient and support to help them make appropriate connections with the community. The current approach often lacks the deliberate, supported linkage that is necessary for effective social prescribing.

Social prescribing has emerged as an adjunct to clinical care in response to several driving forces, including the increased recognition of the importance of preventive health mechanisms and rapidly increasing pressure on primary care services and other parts of the health system[46]. Its core aim is to alleviate this pressure by providing appropriate support to individuals with unmet non-clinical needs, particularly those who are frequent primary care service users[46,131].

2
Implementation design principles

Implementation design principles

A rapid review of social prescribing evidence and the preliminary phase of project consultations, guided the development of a set of design principles and operational components for the effective implementation of social prescribing in Australia. They were then tested and further refined through a secondary round of consultations and targeted semi-structured interviews with a range of Australian and international social prescribing experts.

The implementation design principles and operational components were developed for application to social prescribing services associated with mainstream primary care in Australia. It is noted that many, if not all, of the design principles may be already embedded into the service models implemented by the ACCHS sector. The design principles provide a set of high-level considerations to help guide the development and implementation of a national social prescribing scheme. They were developed with consideration for the design and roll-out of a large-scale, national scheme as an adjunct to mainstream primary care, and also aim to support the design and implementation of individual social prescribing services at the community level.

2.1 Whole-of-system

A national social prescribing scheme should be designed with a whole-of-system approach to ensure its sustainability, effectiveness and integration across the health, social care and community sectors. This involves engaging a diverse range of relevant stakeholders, including multiple departments across all levels of government, health and community service providers, health professionals, community organisations and service users, to build a coordinated and collaborative national framework for social prescribing. Using a whole-of-system approach is consistent with national policy objectives[109,111,112] and also adheres to the whole-of-system implementation approach recommended in the WHO *Framework on integrated, people-centred health services* (2016)[132].

A whole-of-system approach supports consistent funding models, shared data systems, clear and accessible referral pathways, workforce development and the integration of link workers to work collaboratively with primary care teams. Systemic coordination also facilitates greater community sector capacity to respond to increased demand and ensures that social prescribing is embedded within broader health reform agendas. Without systemic coordination, social prescribing risks becoming fragmented, under-resourced, or inconsistently implemented[17,133].

2.2 Person-centred

Social prescribing is inherently person-centred as it places an individual's unique non-clinical needs, circumstances and preferences at the heart of care and emphasises the active participation of the referred person in co-producing a tailored social prescription and action plan[17,19]. Social prescribing recognises that an individual's health and wellbeing are shaped by a range of social, emotional, economic and environmental factors and aims to work with the referred person to address the issues of most importance to them. A central consideration of any social prescribing initiative that has developed in international programs is the 'what matters to you' conversation, which occurs between the referred person and link worker. By prioritising what matters most to the person, social prescribing enhances engagement with care and promotes sustainable improvements to health and wellbeing. This personalised approach fosters a sense of autonomy and empowers individuals to take an active role in their own care by connecting them with community-based supports and activities that align with their priorities and interests[17,19].

Social prescribing is consistently referred to as person-centred in international research and literature, including the WHO social prescribing implementation toolkit[35], the Welsh *National Framework for Social Prescribing*[19] and key publications from the Canadian Alliance for Social Connection and Health (CASCH)[17]. Social prescribing is also a key component of the 'universal personalised care' model currently being implemented by the NHS England[134].

The ACCHS sector recognises person-centred care as a central tenet of their service model to meet the holistic needs of an individual[94]. Person-centred social prescribing also strongly aligns with the *Primary Health Care 10 Year Plan and Strengthening Medicare* policy agenda[108,109].

2.3 Trusted partnerships

Social prescribing services need well-developed connections across the local communities in which they are established. Successful and sustainable models of social prescribing are underpinned by cooperation, collaboration and coordination across a diverse range of health and community service providers, service commissioners (e.g. PHNs) and other community stakeholders – to build trusted, reciprocal partnerships across sectors. This includes recognition of the inherent tensions arising from differing sectoral, organisational and cultural perspectives[135]. Trusted intersectoral partnerships between multiple diverse stakeholders are built over time and require aligned priorities, clear lines of responsibility, mutual accountability for outcomes, adequate resources and a shared vision[136]. Local social prescribing services should be co-designed by key stakeholders at both the local community level (e.g. future service users, local community organisations and service providers and other community representatives as appropriate) and the service commissioner/designer level (e.g. PHNs, Local Hospital Networks (LHNs), local governments, national health and community service organisations and other government agencies as appropriate).

At the social prescribing service level, trusted relationships between referrers, link workers and individuals are vital. Primary healthcare professionals have a strong sense of responsibility for their patients and need to trust the safety and efficacy of a service before they are likely to make referrals to it[137]. Link workers establishing collaborative relationships

and feedback loops with GPs and other referrers will help to build this trust and ensure that referrers recognise the potential value of social prescribing.

Equally as important are trusted relationships between link workers and the referred individual. For social prescribing to be successful, it needs to be relational, rather than transactional. The design and implementation of social prescribing service models must allow for a process of building rapport and trust between the link worker and each individual. This may require several sessions. Trusted partnerships allow individuals to feel more comfortable in disclosing non-clinical needs to a link worker and more likely to engage in the process and social prescription activities[133,138,139].

2.4 Accessible and inclusive

Social prescribing should be inclusive and accessible to all. Services should be tailored to various population groups and age demographics as appropriate. There was strong agreement through the consultations for this feasibility study that social prescribing should have a 'cradle to grave' or whole-of-life approach and be available to all, with emphasis on those experiencing the most disadvantage. The WHO social prescribing implementation toolkit notes that, whilst social prescribing can improve the lives of all, it is particularly beneficial for those who experience high levels of disadvantage and are impacted by wider determinants of health (e.g. poverty, trauma, unemployment, social exclusion)[35].
The NHS (England) also reinforces the importance of social prescribing being inclusive and accessible to all, describing it as "an all-age, whole population approach"[140].

Initiatives within social prescribing services may need to be targeted to specific populations. For example, services for young people may need to integrate with schools or use digital technology. Further research is necessary to determine the models best suited to different population groups.

It is also important to note that while social prescribing should be accessible to all, it is unlikely to be suitable for some groups or individuals (e.g. people with acute medical needs or individuals who are unwilling to engage)[17], and that referrals to social prescribing services should only be made where appropriate.

2.5 Culturally safe

Culturally safe practice provides spiritually, socially, emotionally and physically safe environments with shared respect, shared meaning and shared knowledge[141]. It emphasises the critical importance of healthcare and other community settings free of racism and discrimination and requires health and other care professionals to undertake ongoing reflection of their cultural knowledge, attitudes, practising behaviours and power imbalances[142]. Culturally safe care is particularly important for culturally and linguistically diverse individuals, Aboriginal and Torres Strait Islanders and other priority population groups.

The need to improve cultural safety across the Australian health system has been identified in various policy documents, including as a specific 2030 policy aim in the *National Preventive Health Strategy 2021-2030*[9] and a key finding of the *Review of General Practice*

Incentives[112]. Additionally, recommendation 16 of the *Unleashing the Potential of our Health Workforce – Scope of Practice Review* is to incorporate cultural safety as a foundational shared capability in the first iteration of the National Skills and Capability Framework and Matrix (Recommendation 1 of the review)[111]. Cultural safety is a hallmark of ACCHSs and is determined by Aboriginal and Torres Strait Islander individuals, families and communities[94,142].

Culturally safe care should be a fundamental requirement in all services across the health and community sectors, and this would apply to all social prescribing services implemented as part of a national scheme.

2.6 Flexible and tailored to local context

Social prescribing services should be co-designed with community stakeholders and with flexibility to adapt to a diverse range of community needs and local contexts. Different local communities will each have unique social, cultural, socioeconomic and health-related characteristics, which will influence design and implementation considerations for a social prescribing service in that geographical area[143]. Flexible, locally tailored design ensures that social prescribing services are responsive to the unique needs and specific priorities of local communities.

An important aspect of tailoring service design to the local context is understanding if there are existing initiatives within a community and ensuring that new social prescribing services complement or build on what has already been established. There is a growing number of place-based social prescribing initiatives established by local community organisations, PHNs and other health service providers. There was strong consensus in the consultations undertaken for this project that already established social prescribing initiatives should inform and be complemented by any new programs or services. Failure to do so would risk limiting community engagement with any new programs and overlooking important local knowledge and expertise.

Enabling place-based variation and local tailoring of service design also allows social prescribing services to build around the existing primary care ecosystem and available community resources in a local area, and leverage a community's strengths[144]. Employing a strengths-based approach is important when implementing any place-based programs, as it fosters community ownership, sustainability and relevance. Every community possesses unique assets and strengths, and by recognising and building on these, social prescribing programs can enhance community engagement, trust and participation, making interventions more likely to be successful[145]. Tapping into local capabilities can enrich program design, enhance community capacity and empower communities to take an active role in shaping their own health outcomes[54].

2.7 No wrong doors

'No wrong doors' refers to the concept of service users being able to access the care or support that they require, regardless of their entry point into the system[146]. In the context of social prescribing, 'no wrong doors' refers to individuals being helped and referred on to the appropriate place, even if the initial referral to social prescribing is inappropriate. This ensures that service users will not be turned away even if their needs are potentially outside the scope of the social prescribing service. A 'no wrong doors' approach also means that social prescribing services or programs will accept referrals from a range of sources across the health and community sector. For example, an aged care program could link someone to social prescribing if the individual was identified as experiencing loneliness or social isolation.

A 'wrong door' could consequently delay the provision of appropriate care for the individual and/or prevent them from engaging with non-clinical interventions, which may be of significant benefit to them. Established social prescribing initiatives in Australia talk about taking a 'no wrong door' approach, attempting to help connect an individual referred to social prescribing to a service that would be better placed to meet their needs, where appropriate.

A 'no wrong doors' approach to social prescribing also creates potential opportunities to involve individuals who do not frequently engage with clinical supports in the primary care system. Ensuring two-way referral (i.e. link workers can both receive referrals from and make referrals to primary care as appropriate) allows social prescribing services to connect individuals, particularly those who have reached the service via a non-medical referral route, to clinical supports that they might otherwise have been unlikely to access.

2.8 Supported communities and community sector

In addition to leveraging any existing initiatives where possible, the implementation of social prescribing services nationally must be accompanied by specific support for community capacity-building. The effectiveness of any social prescribing program relies upon there being sufficient capacity within the community and in community organisations to respond to any increases in service demand attributable to social prescribing[17]. Investment in social prescribing needs to include investment in the community and local community service providers. This includes investment in public infrastructure for communal spaces such as parks, libraries and community centres, as well as adequate funding for services and associated service providers[17].

Limited or insufficient capacity of community organisations and groups to manage increased demand for the services and activities that they offer is likely to result in long waiting lists, and/or social prescribing services providing a 'road-to-nowhere' for referred individuals. This can lead to individuals experiencing further health and wellbeing deterioration and/or lost confidence in the potential for a social prescription to assist them. Lack of community and community sector capacity also adds increased pressure on link workers, as they can become the ongoing support for referred individuals if there is a lack of available community supports to connect people to. This can have the flow-on effect of contributing to longer waiting lists for social prescribing services as more of the link worker's time is spent providing support to individuals instead of connecting them to services. This can subsequently lead to burnout and staff turnover[147].

3
Operational components

Operational components

As outlined in section 2, the design principles and operational components were developed through a rapid evidence review and preliminary phase of project consultations, then tested and further refined through a secondary phase of consultations and semi-structured interviews with relevant experts.

The operational components were distilled from the emerging social prescribing evidence base and the extensive expertise of key stakeholders within the sector as the key ingredients for successful social prescribing programs. Whilst not all services/programs would need or be able to implement all operational components, they are indicated in the evidence and through the feasibility study consultations as strongly associated with successful initiatives.

The operational components and implementation design principles were developed for application to social prescribing services associated with mainstream primary care in Australia. It is noted that the existing service models within the ACCHS sector enable the effective integration of health and social care to holistically address non-clinical needs alongside clinical issues[94], without specifically featuring the operational components outlined in this report. While some of these components might be reflective of practice in ACCHSs, they were not developed for application to the ACCHS sector.

3.1 Actively engaged referrers and a range of referral sources

Social prescribing services need to actively engage the full spectrum of potential referrers to maximise the potential reach and impact of the service within a local community. This should be primarily focused on GPs and general practice teams, however, efforts to engage other primary care and community-based referrers are also important to ensure a diverse range of referral sources. Primary healthcare professionals, particularly GPs, primary care nurses and mental health support workers, are often best placed to identify unmet non-clinical needs, due to their high frequency of interactions with individuals experiencing social isolation and/or living with chronic conditions. However, it is not standard practice to screen for unmet non-clinical needs in mainstream primary care settings, and addressing the wider determinants of health is generally considered beyond the scope of primary care professionals in Australia[148,149]. This highlights the importance of potential referrers, particularly those in primary care, being aware of and engaged with local social prescribing services to ensure patients with unmet non-clinical needs can be referred appropriately.

3.1.1 GPs and other general practice referrers

Social prescribing provides GPs and general practice teams with an additional resource to complement existing healthcare options[46] and a formal means to facilitate appropriate support for patients with unmet non-clinical needs[46]. However, the capacity constraints faced by general practice in Australia are well known, and this contributes to the challenges in engaging GPs and general practices reported by many social prescribing programs[57,150,151].

Social prescribing is aligned with the intent of primary healthcare – to support good health and wellbeing through both treating and preventing disease. However, recognition of the wider determinants of health and their relevance to prevention is inconsistent across general practice services and there is a lack of incentives for services to prioritise preventive health[152]. Improving GP awareness of the preventive health benefits associated with social prescribing and how it can support the role of general practice in prevention, is important to maximise their engagement with social prescribing programs.

However, increased awareness on it's own is unlikely to achieve consistent engagement. General practices must also be provided with the resources, tools and information required to screen patients effectively and make appropriate social prescribing referrals[57]. This includes having access to easy-to-use screening and assessment tools designed to assess non-clinical needs, integration of social prescribing referral options into general practice software management systems and ensuring that general practice staff have sufficient time and capacity to engage with social prescribing programs. Policy settings and funding mechanisms that support GPs and general practice teams to fully embrace their important role in prevention and addressing the non-clinical needs of patients are also essential.

Supporting evidence:

Feasibility study consultations concurred with the existing evidence base in identifying various enablers and barriers to the engagement of general practice as a key referral source in social prescribing initiatives. Enablers include:

- clarification of the role of the GP (and other general practice professionals) in social prescribing;
- GP champions advocating for social prescribing across the primary care sector;
- specific general practice education and training resources on the purpose, process and benefits of social prescribing;
- financial incentives and/or workflow supports for GPs or general practice professionals to engage with social prescribing programs; and
- GP awareness and understanding of the potential indirect benefits of social prescribing, such as enhanced general practice capacity[153].

Barriers to engagement include:

- health professional beliefs or concerns about the scope of their role;
- fragmented interdisciplinary communication;
- lack of culturally competent staff;
- lack of incentives to make social prescribing referrals;
- scepticism about the effectiveness of programs and appropriateness for patients; and
- unclear lines of responsibility for patient care once referred[153].

The feasibility study consultations also suggested bolstering the profile of non-clinical health determinants and social prescribing in health professional tertiary education and training courses. This could improve GP awareness and knowledge of the wider determinants of health and contribute to greater emphasis being placed on addressing the non-clinical needs of patients[154].

Box 4: General practice referral to social prescribing case study

A Melbourne-based community primary care social prescribing program case study written from the perspective of the link worker (reproduced with permission).

Dave* led a life characterised by profound isolation as a single man facing a multitude of chronic health issues. His life had become highly medicalised, and his primary source of social interaction revolved around the healthcare system. Despite his isolation, Dave expressed a desire to become more physically active. His doctor recognised the importance of increased social contact for Dave's overall wellbeing and referred him to our program. Upon initial assessment, it became apparent that Dave required support in multiple areas, including financial support and various services. In my first meeting with Dave, he mentioned he rarely left his house, except for essential activities such as food shopping and medical appointments.

Across five face-to-face sessions, Dave and I focused on creating a Personal Support Plan to address his concerns. I realised we needed to support Dave with a gradual approach into a more active lifestyle, so I encouraged him to consider joining the men's walking group. Dave, however, expressed concerns about his ability to keep up with the group, given his physical limitations. To address this, I recommended he walk as far as he felt comfortable and then 'Tram' back (he could use public transport). This would allow him to participate at his own pace. During his initial walk with the group, Dave walked for a certain distance and returned to the Community Hub with not only a sense of achievement, but with a big smile on his face!

This experience was the beginning of his regular participation in the Men's Walking Group, and he continues to join the group every week. Through our ongoing interactions, we have created a safe and supportive environment which has enabled us to identify numerous issues affecting Dave's health and wellbeing. The GP, Dave and I felt his positive response underscores the effectiveness of a holistic approach in improving health and quality of life for individuals facing complex challenges.

*Name has been changed

3.1.2 Other primary care referrers and community-based referrers

Other primary care professionals, including community pharmacists and allied health professionals (e.g. social workers, psychologists etc.), are also often well placed to recognise unmet non-clinical needs[147]. Compared to GPs, these health professionals often have more time with patients and can have non-clinical issues raised with them. Implementation of a social prescribing program should consider the potential for a range of primary healthcare professionals to refer individuals with unmet non-clinical needs to link workers.

The social prescribing service should be responsible for promoting engagement by the wider range of primary care providers within local communities. *Box 5* presents a case study of a patient referral by a mental health worker to a social prescribing program.

Some social prescribing programs, depending on what is considered the optimal mix of referrers in a local context, also accept referrals from outside of healthcare providers, including from sources such as community organisations, schools, family members and self-referrals[147]. Community-based referral pathways have the potential to assist with reaching individuals who do not normally engage with health services, but have unmet non-clinical needs that significantly impact their health and wellbeing[155].

Participating in community-based social prescribing can also make it more likely that an individual will engage with health services to address clinical needs, further reinforcing potential health benefits[156].

Box 5: Other primary care referral to social prescribing case study

Janice was referred to the SocialRx program by her mental health worker, with a focus on helping her find more stable housing and addressing ongoing mental health concerns. At first glance, the referral highlighted some practical barriers—but from our very first conversation, it was clear that what Janice really needed was to feel part of something again.

At 64, Janice was living in a friend's granny flat in a remote rural town. Her experiences of domestic and family violence had left her wary of others, and over time, she'd become increasingly disconnected. Living with PTSD, anxiety, and depression had only deepened that sense of isolation. "It's not just that I'm alone," she told me. "It's that I don't really feel part of anything anymore."

Janice wasn't looking for someone to fix things—she just wanted to find a way back into community life. We spent time exploring what felt safe and meaningful for her. She shared that she used to love swimming, and that she missed being around other women in a relaxed, everyday kind of way. Together, we looked at local opportunities, and she chose to try a women's group and a community swimming group.

A few weeks in, she told me she was really enjoying them. "I didn't think people would talk to me," she said. "But they did. And I want to go back." These two simple activities became more than just appointments in her week—they were places where she felt welcome, where she didn't have to explain herself, and where connection happened gently and naturally. She started to ask about other events, talked about volunteering, and even began making small plans again.

While those relationships were forming, we also worked through the more structural challenges. Janice couldn't afford private rental—her chronic health conditions made work impossible, and she had left her previous life with no savings. We completed an application for high-priority social and affordable housing in her area and explored government supports that could help her remain safe and independent at home.

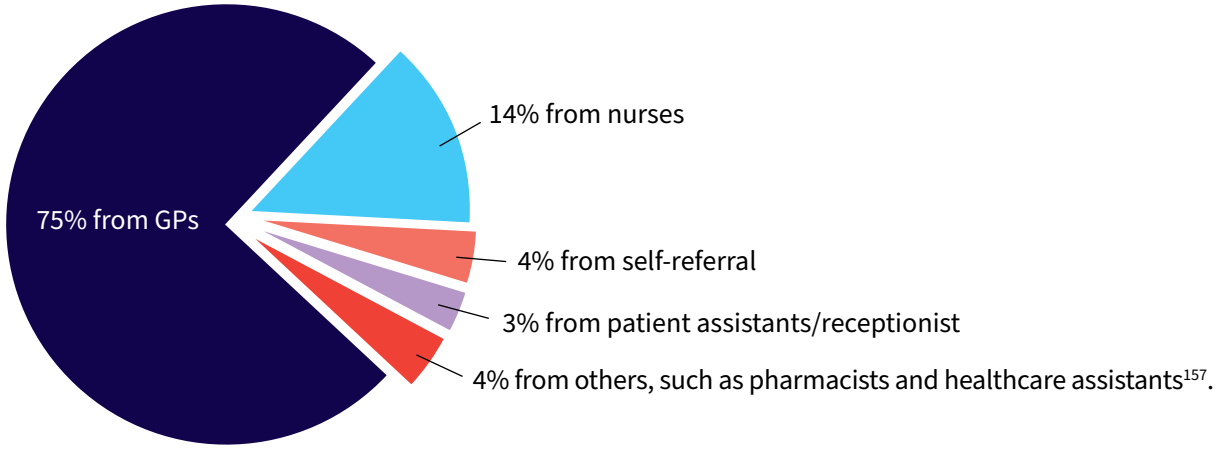
Finding the right mental health support had also been difficult. Janice hadn't connected with previous providers, but through conversation, she identified that what she really needed was someone who understood trauma. We found a counsellor through Victim Support Services who she felt more comfortable with. We also explored additional support through the NDIS and aged care system. While her NDIS application was unsuccessful, she is now accessing aged care services and feeling more confident about what lies ahead.

"Thank you for your compassion and professionalism, you have a rare balance of understanding and compassion that sets me at ease but also a professionalism that gives me hope in your ability and that I might be able to access supports."

*Reproduced with permission

Supporting evidence:

Throughout England, community agencies such as local charities and social care services as well as health services refer people to a community-based social prescribing link worker[140]. The Bromley by Bow Centre is widely acknowledged as one of the UK's pioneering social prescribing services[157]. Their 2018-19 annual report detailed the program's diverse range of referral sources, which included:



Several Australian social prescribing initiatives have also recognised the importance of having multiple referral sources and access pathways[39]. A University of Queensland evaluation of five different Australian social prescribing programs over 18 months identified referral sources from medical services, self and/or family, community services, and community health and social workers.

In the ACCHS model of integrated primary care, visibility of the wider determinants of health is ensured through a focus on community health[94]. Multiple referral pathways are enabled through GPs, nurses, Aboriginal Health Practitioners, Aboriginal Health Workers and allied health professionals who facilitate connection to services and community in response to non-clinical needs[1,94].

Recent research from the UK found that non-medical referral routes (e.g. schools, self-referral or community referral) reached certain groups more equitably. These included people from socioeconomically disadvantaged communities, young adults and ethnic minority groups[155]. Self-referral pathways are also a common feature of various international social prescribing programs[56,57,158].

The consultations that informed this report showed strong support for the provision of multiple referral pathways, not limited to general practice only. This is of particular importance to ensure that people without a regular GP, many of whom are young people, are able to benefit from social prescribing[159].

While most people in Australia (90%) see a GP at least once per year[123], many do not access GP services regularly enough to comprehensively address their needs, or do not visit the same GP to enhance the continuity of their care. This can be due to the cost[160]; language and communication difficulties[161]; lack of accessible GP services and social isolation[108,162]. The 10% of the population who do not visit a GP at least once per year and those who don't engage with GP services as frequently as their health needs indicate, are likely to derive benefits from social prescribing interventions[156,163]. Ensuring there are a range of referral sources, including community referrals instigated from outside the health system, means that people with limited access to primary healthcare can be referred to social prescribing services through community organisations or service providers, family members or themselves (i.e. self-referral).

3.2 Screening and assessment of non-clinical needs

Accurately identifying individuals with unmet non-clinical needs within the community is important to ensure that the people referred to social prescribing programs are those most likely to benefit. Non-clinical needs assessment is identified as a critical element of effective social prescribing across the literature[133,139].

Screening and assessment are related but distinct processes in health and social care[164,165]. Screening is a quick, broad procedure used to identify individuals who may be at risk of a condition or issue, often through brief questionnaires or simple tests[164]. Its purpose is to flag potential concerns and determine whether further evaluation is needed[164]. Assessment is a more comprehensive and detailed process that gathers in-depth information about a person's health, functioning, or circumstances to inform diagnosis, treatment, or support planning[164].

Comprehensive non-clinical needs assessments could be undertaken by either a link worker or a primary care professional, depending on the design characteristics of the social prescribing model being implemented and the local context of implementation. If the social prescribing program includes a specific link worker role, it is logical for them to undertake the comprehensive non-clinical assessments, as the link worker generally initiates the 'what matters to you' conversation and co-produces the social prescription with the individual, both of which will be largely informed by the outcomes of the assessment[19]. Including comprehensive non-clinical needs assessments in the link worker role also aligns with one of the overarching objectives of social prescribing – to reduce the proportion of GPs' time spent addressing non-clinical needs. In social prescribing models that don't feature a specific link worker role, or in certain contexts where it is most appropriate for a GP or nurse to undertake the comprehensive non-clinical needs assessment, there should be accessible tools and specific funding provided to primary care service providers to support their expanded role in assessing non-clinical needs[136].

In social prescribing models that feature link workers undertaking comprehensive non-clinical needs assessments, effective screening by referrers is necessary. Screening in general practice and other primary care settings is necessary to identify those patients with unmet non-clinical needs and ensure that referrals to social prescribing services are appropriate[133,139]. This should be supported in primary care by appropriate easy-to-use screening tools that can be completed within a standard GP or primary care nurse appointment[133,139].

Primary healthcare professionals can use screening and/or assessment to triage an individual to the most appropriate social prescribing pathway (refer to section 3.3) based on the complexity of the person's non-clinical needs and individual capacities.

Identifying non-clinical needs is already a well-established practice in ACCHSs. For example, the community health promotion and empowerment domain within the NACCHO core services and outcomes framework includes a remit to "identify social determinants within control of the ACCHS, those within its sphere of interest and those within its sphere of concern"[94]. While it is common practice, the development of an appropriate screening tool for social prescribing has been identified as an enabler for the practice to be enhanced in ACCHSs[48].

Supporting evidence:

Evidence indicates that screening by GPs before referring to a link worker is important for the success of a social prescribing program[133,139]. There is consistent evidence that social prescribing services can be overwhelmed by individuals with specific or complex social needs and that this is best addressed by providing for referrals to specific specialist social prescribing services. This requires referrers to be able to assess the complexity of non-clinical needs of individual patients to enable appropriate referral[17]. Screening and assessment tools that identify complexity and guide referrals, with minimal burden on the referring practitioner, are therefore necessary (refer to section 3.3 below).

Screening and assessment tools developed for social prescribing, should be standardised and validated. There is no standard tool to assess social needs used by social prescribing referrers identified in studies[133]. In the NHS England social prescribing programs, this absence of a standardised assessment tool has resulted in a lack of clear guidance for GPs on how to assess social needs[166].

Consultations for this study emphasised the need for comprehensive non-clinical needs assessment to be undertaken by link workers and subsequently shared with the referring health professional as appropriate.

Findings from the feasibility study consultations also suggested that comprehensive assessments undertaken by link workers should include wide-ranging assessment items on key indicators of non-clinical needs, including:

- loneliness;
- social networks and social capital;
- employment history;
- income and dependents;
- housing status/living arrangements;
- educational attainment;
- health literacy;
- food security; and
- other relevant domains associated with the wider determinants of health.

Assessments should also include some high-level items regarding medical history, physical and mental health issues, and an individual's perception of their own health status.

Oster et al.[167] developed a self-reported social determinants of health questionnaire called the Steps to Better Health Questionnaire (STBH-Q). This Australian-developed questionnaire is intended to be used by both health professionals and link workers. The STBH-Q "explores multiple social determinants of health and has potential applicability for identifying need and linking clients to social support services in a range of settings, such as primary healthcare or via social prescribing programmes"[167].

The 2016 Health Leads Social Needs Screening Tool[168], a screening tool developed in the US, was modified for the Cultural Pathways Program. The Cultural Pathways Program, designed and implemented by the Wardliparingga Aboriginal Health Equity research team in the South Australian Health and Medical Research Institute, identifies unmet social and emotional wellbeing needs and facilitates connection and access to services and programs. The program modified the Health Leads Needs Screening Tool through a community process led by Aboriginal and Torres Strait Islander researchers. The modified tool covered domains including mental health, cultural and community connection, financial and food security, transport, employment, housing and social isolation[95]. Screening tools could be developed using this approach of adapting an existing screening or assessment tool through a community-led process to ensure local and cultural relevance.

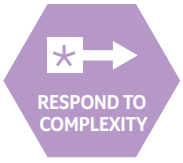
Recent Australian literature suggests that a better understanding of some of the barriers to engagement with social prescribing activities could inform the development of screening tools[26]. Psychological barriers to joining social activities, alongside individual differences that impact willingness to engage, play a significant role in determining the success of social prescribing for individuals. Development of screening tools to identify non-clinical needs would benefit from consideration of these psychological barriers. Additionally, understanding how link workers can help individuals overcome these barriers could directly inform the design of these screening tools[26].

3.2.1 General practice assessments for complex needs referrals

Under current Medicare Benefits Schedule (MBS) general practice funding arrangements, GP screening or assessment for non-clinical needs with provision of a social prescription would most likely be billed under General Attendance items (23, 36, 44, 123). These items range from 6-minute consultations to 60+ minute consultations. While screening may be achievable in short consultations, longer consultations would be required to undertake comprehensive non-clinical needs assessments. However, with the well-known demand and cost pressures on general practice[46], GPs and practices are unlikely to be able to increase the proportion of long consultations they provide due to the overall decreasing remuneration rate per hour for longer appointments (refer to Appendix 4 in the Technical Appendices document for further information).

Supporting evidence:

Routine screening of patients presenting with risk factors for underlying non-clinical needs should be considered. However, evidence suggests that screening for non-clinical needs happens infrequently in primary care in Australia[148,149]. Recent data from the Commonwealth Fund (US) International Health Surveys (2022-2023) compared primary care across ten countries, including Australia. Among the wide range of results, only 13% of Australian primary care providers reported screening for at least one social need, significantly lower than the almost one-third of US primary care physicians who routinely screen for a range of social and economic needs[148,149]. This may indicate that additional time and funding capacity would be required for screening by GPs and for assessment within general practice. Adding and enhancing multidisciplinary capacity within general practice to undertake comprehensive non-clinical needs assessments could help facilitate social prescribing referrals.



3.3 Sufficient capacity to respond to complexity

Social prescribing services should be designed to cater for varying levels of non-clinical needs and psychosocial complexity. There is currently limited access to critical supports for individuals who are most affected by non-clinical risk factors in Australia[169]. This can mean that a significant proportion of people for whom social prescribing is likely to be beneficial, have a cluster of non-clinical risk factors adversely affecting their health that all need to be considered and addressed. Those experiencing income, housing and/or food insecurity and domestic and family violence, for example, have high needs[17]. Social prescribing referral for these individuals can be considered complex, requiring specific support and potentially including supported access to statutory services.

This could be enabled by link workers with specialist skills or specific qualifications (e.g. a social worker, refer to section 4.1.4.1 for specialist link workers) in addition to non-specialist link workers. This would also require triage capacity for referrers to identify individuals with high or complex non-clinical needs. This is important to both prevent the potential exclusion of people with high needs from social prescribing services and prevent unintended restriction of access and long waiting lists for people with less complex social needs and circumstances. It is also important to prevent stress and burnout amongst link workers who may not have the skills or support to manage complex or specific individual needs[147].

Screening and assessment tools (refer to section 3.2) would help identify appropriate referral pathways for individuals.

Supporting evidence:

Figure 2 and *Box 6* outline three tiers of non-clinical needs and the appropriate referral pathways

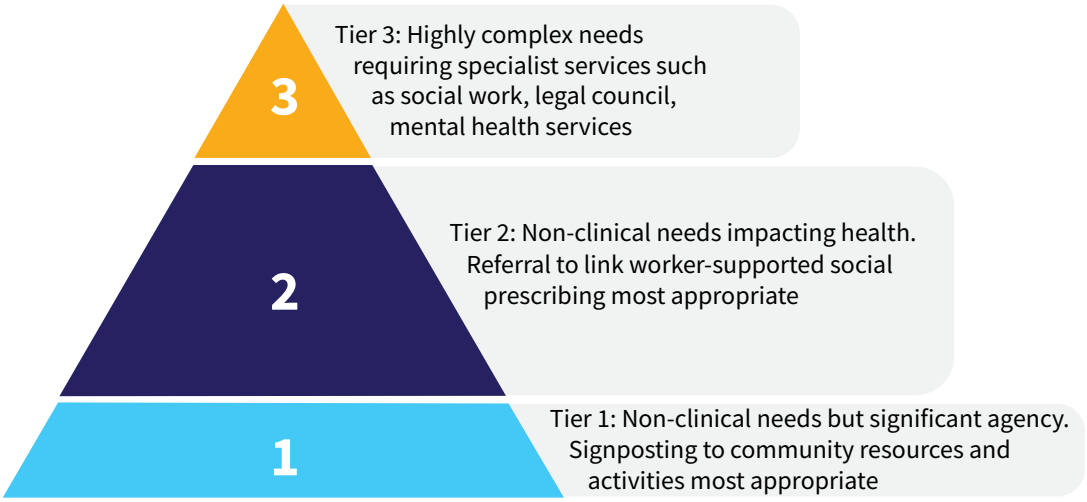


Figure 2: Three tiers of non-clinical needs

Box 6: Three tiers of non-clinical needs and appropriate referral pathways

Tier 1: Individuals for whom signposting is appropriate (light blue)

This tier describes the pathway for people with unmet non-clinical needs who are able to act on a referral to social supports without being referred to a specific social prescribing service. As this group of people have the capability and agency to follow the prescription and to make their own connections to the recommended supports, they can be provided with a 'signposted' referral. The 'signposting' referral consists of providing an individual with sufficient information about potential activities for them to follow up with independently. An individual who is 'signposted' to a community resource would self-report on their progress to the clinician who provided them with the information at a subsequent appointment. By its nature, this is a limited aspect of social prescribing referrals, as the evidence indicates a high proportion of social prescribing referrals are for individuals needing link worker support to engage with social supports that are appropriate to their needs.

Tier 2: Individuals for whom link worker social prescribing is appropriate (dark blue)

This tier describes the pathway for people who have non-clinical needs that would benefit from social prescribing and who need support to access appropriate services. These individuals benefit from referral to a link worker to identify and connect them with community resources and assets most relevant to their needs and preferences. The link worker would both maintain contact with the individual and provide feedback to the original referrer on the individual's progress.

Tier 3: Individuals for whom more intense support to access social prescribing is required (dark yellow)

This tier describes the pathway for people who are identified as having complex or high levels of non-clinical needs. These individuals most likely need a referral for specialist support from one or more social services, sometimes including statutory services, as well as community resources or assets. The link worker or specialist support (potentially a specialist link worker (see section 4.1.4.1) would both maintain contact with the individual and provide feedback to the original referrer on the progress of the individual.

There is strong evidence, both in Australia and internationally, that social prescribing services with just one pathway designed for individuals in Tier 2 (see above) can easily become overburdened by people with complex non-clinical needs (i.e. those more suited to tier 3). Tier 3 individuals require more support and time from a link worker, which reduces the capacity of the social prescribing service to take other referrals, leading to extended waitlists and delays in being able to connect individuals to appropriate non-clinical supports.

Evidence and experience to date have identified that some referrals from GPs to a social prescribing program can be inappropriate, leading to program ineffectiveness[133,170]. An Australian study of the qualitative perspective of social prescribing link workers by Sharman et al.,[147] highlighted that a lack of understanding of social prescribing among referrers resulted in inappropriate referrals to link workers. This included link workers reporting that a significant proportion of individuals referred into the program were experiencing acute and/or complex non-clinical needs, which required specialised support and intervention that was beyond the scope of the link worker role. Section 4.1.4.1 outlines the evidence for capacity to manage complex needs.

3.4 Adequately trained and supported link workers

In a social prescribing service or program, the link worker role entails working with the referred individual to co-produce a social prescription and action plan tailored to their specific non-clinical needs, interests and preferences. This includes the 'what matters to you' conversation and comprehensive non-clinical needs assessment more broadly, undertaken by the link worker with the individual, to identify appropriate community resources, activities or supports and inform the development of a personalised social prescription. This process is considered a core function of the link worker role[166].

Teams of link workers can be established as the central workforce roles within new, dedicated social prescribing services, or alternatively, individual link workers may be embedded into existing health or community services. Link workers may service a specific geographical catchment area or a particular population group within a local community. There is strong evidence indicating that a dedicated link worker role is a significant determinant of social prescribing success in mainstream primary healthcare[147,171,172]. Having a link worker role as part of a broader multidisciplinary team enhances capacity to address non-clinical needs and allows GPs and other primary care professionals more time to comprehensively address the clinical needs of patients[173].

The link worker role lends itself to a diverse range of established health and social workforce disciplines, such as social workers and other allied health professionals, nurses, community health workers and peer support workers in certain contexts[147]. The successful development of a link worker workforce in Australia will require relevant modelling of workforce availability and proper planning, as it is likely to have implications for the existing health and social care workforces.

The place-based nature of social prescribing programs requires that the link worker role is developed and implemented flexibly to adapt to local factors and community contexts.

In the ACCHS sector, assessing non-clinical needs and connecting individuals to appropriate community supports, are well-established and an important element of the ACCHSs integrated model of primary healthcare. This is undertaken by a range of health professionals, including GPs, nurses, allied health, Aboriginal Health Workers and Aboriginal Health Practitioners, effectively fulfilling the role of both referrer and link worker as outlined in this report.

3.4.1 Link worker skills and competencies

The link worker role can either be a dedicated role or a function undertaken by a health professional as part of their role. While there may be specific contexts where the latter may be appropriate, this feasibility study has affirmed that, due to the existing workforce capacity issues in mainstream primary care services, the link worker should primarily be a dedicated role with specific expertise.

The link worker role has three overarching functions, which are to:

- Work with referred individuals to co-produce a social prescription/action plan and facilitate access to appropriate community resources and activities.
- Form and actively maintain relationships with primary care providers and other health services, as appropriate, to facilitate referral practices and pathways (refer to section 3.1.2) and support practice capability.
- Work with the community and community services to facilitate referral pathways and build capacity including identifying gaps and advocating for improvements in service availability[17].

For link workers to successfully fulfil the overarching functions, they require a comprehensive set of supports. This includes a diverse range of knowledge and skills, coupled with ongoing learning and development opportunities to keep their expertise current. Essential tools are also important to their practice, such as fit-for-purpose assessment tools and tools to develop personalised support plans for referred individuals. Additionally, effective two-way communication with general practice is critical (as detailed in sections 3.2.1 and 3.6). A robust structure to facilitate collaboration with general practice teams is necessary to build engagement and enhance capability in social prescribing referrals across the healthcare system[17,147].

Link workers in certain contexts may also need clinical, community development and/or health promotion skills[147].

The essential link worker competencies identified through the consultations for this feasibility study include:

- communication skills;
- understanding of both the health and social care systems;
- knowledge and information of available local community resources and assets;
- understanding of the local context in which they work;
- empathy and active listening that build trust;
- collaboration with various health and community professionals;
- collaboration with communities to build local networks;
- data recording, monitoring and management;
- ethical, inclusive and respectful practice;
- self-care and appropriate scope of practice boundaries
- continuous learning; and
- contribution to communities of practice and learning resources.

Various link worker competency frameworks or guidelines have been developed internationally[174,175], and ASPIRE is working towards the development of Australian standards.

As previously identified, social prescribing services require capacity to manage individuals presenting with multiple, complex, non-clinical needs. As such, social prescribing services should include, or have access to, link workers with specialised skills, such as social work or accredited mental health qualifications and training in cultural safety. Depending on community needs, some specialised skills, e.g. domestic and family violence,

youth mental health and wellbeing, suicide prevention and cultural safety, could be provided through service linkages established by collaborative planning and co-design with all relevant stakeholders in a community. This will also have to consider workforce availability, for example, a rural or remote location may have a very different workforce pool to utilise compared to an urban area.

It is essential that link worker training includes awareness and sensitivity to these complex issues without crossing into specialist practice territory, to preserve safe scope of practice boundaries and reduce liability.

Box 7: Social prescriptions should not be too 'prescriptive'

When a link worker works with a referred individual, the outcome should be a co-produced, person-centred and non-directive plan and should acknowledge that the effects of social prescribing may not be linear.

Some prescriptions have a direct and targeted purpose. For example, connecting someone experiencing housing insecurity to a housing support service is a clear and intentional action aimed at meeting a specific unmet non-clinical need. The mechanism is straightforward: a linear response to a defined problem.

Other prescriptions work through more indirect pathways. An activity like joining a book club might seem simple, but it can have multiple downstream effects. It may enhance cognitive stimulation, reducing dementia or frailty risk; involve physical movement through travel to and from the venue; encourage social connection and conversation; and expose participants to new environments, all of which can contribute to improved physical and mental health. These effects are diffuse, accumulative, and less easily attributed to a single causal link, but they are no less meaningful.

The value lies not in isolating a single mechanism of change, but in acknowledging that meaningful change can occur – whether through direct or indirect means. A robust social prescribing model should recognise and support both forms of intervention, embracing complexity in how health and wellbeing are improved.

Supporting evidence:

The link worker role has been identified as a key feature of effective social prescribing[57,58,128,130,133,176,177], increasing the uptake of referrals by individuals compared to simple 'signposting' in mainstream primary care[58]. The consultations that informed this report emphasised the link worker role as an essential element for success in social prescribing programs. Those programs that started without a link worker role have identified that a key learning was the importance of the role, with future developments likely to include a link worker in these programs.

The NHS (England) describes the role of link workers as giving people time, focusing on 'what matters to me?', co-producing a simple personalised care and support plan, and supporting people to take control of their health and wellbeing. Link workers also support community groups to be accessible and sustainable, and help people to start new groups, working collaboratively with all local partners[140]. Similarly, the Wales National Framework for Social Prescribing[19] identifies the purpose of the role as being based on a conversation about 'what matters to you' and places this as a principle of social prescribing services.

There was mixed opinion throughout the consultations on the appropriate or minimum qualifications of a link worker and whether these should be tied to specific disciplines. The general consensus was that the link worker role and recruitment should be determined on the basis of community needs.

An Australian review by Sharman et al.,[147] looked at the link worker role in a range of social prescribing programs. They found that link workers came from varied backgrounds with various prior qualifications, including social work, nursing, business, counselling and community development. Whilst individuals from these backgrounds broadly possess the skills necessary for the link worker role, there is a lack of training in competencies and professional support. A workforce framework encompassing link worker guidelines, training, and professional networks would support recruitment from a range of professions and skills and facilitate workforce and skills development. The authors of the Australian review suggest that link workers should be trained in interpersonal skills; relationship management; risk assessments; the social determinants of health; mental health first-aid; and trauma-informed care[147].

A systematic review of outcomes of primary care social prescribing programs that used linking or coordinating roles, variously described as link workers, navigators or coordinators, found that the principal activities for this role are:

- motivational interviewing and individual assessment of service users to identify non-clinical needs;
- facilitating access for service-users to non-medical sources of support;
- providing ongoing and needs-driven support;
- data collection for evaluation; and
- giving feedback to the referring clinician and/or the individual's GP[58].

Research also suggests that establishing trusted relationships with individuals, collaborating with community organisations and groups and building trusted relationships with referrers were all aspects of the link worker role that are important to its success[133,138,139].

Evidence shows that recruiting link workers from the local community is important to build trust and strong community connections[133].

3.5 Visible and appropriately supported community resources

The capacity of the community sector to deliver community resources or activities is an integral part of the success of a social prescribing program. Overburdening the community sector by new demand created through establishing a social prescribing program is likely to be detrimental to community organisations and lead to a loss of community trust[178,179].

Whilst link workers can help build local capacity to improve the community resources, services and activities utilised in social prescriptions, this should be primarily in a facilitating role. Comprehensive planning and sufficient resourcing are essential to strengthen the capacity of community activities, groups and services within a social prescribing program and avoid the pitfall of a 'road-to-nowhere'.

In social prescribing, people are typically referred to free or low-cost community resources and activities, which will vary between different local communities. Box 8 outlines some examples of community resources. Appendix 6 in the supporting Technical Appendices document outlines some other examples of what could be considered social prescribing community resources.

Community resources also need to be visible to all relevant social prescribing stakeholders. Link workers need to have a clear understanding of what is available in the community so they can connect individuals with the most appropriate resources, activities and supports to address their needs. A comprehensive, up-to-date community resource and asset directory should include:

- the community resources, activities and assets (e.g. social supports, community groups and other relevant services) that are available in a local community;
- the capacity of available community activities, resources and local infrastructure assets to cope with increased demand and utilisation;
- the target group or demographic of available resources and assets (e.g. older people, culturally and linguistically diverse individuals, Aboriginal and Torres Strait Islanders and other specific groups);
- any costs to individuals associated with participating in the activity or accessing the resource, asset or service; and
- accurate and up to date contact details.

Community resource directories would both assist link workers in carrying out their role and support signposting undertaken by health professionals and other referrers in guiding individuals to non-clinical supports and community activities. This ensures that social prescribing services have the necessary information to co-produce appropriate social prescriptions with the referred individual.

Community resource directories need to be consistently revised and updated to ensure the information they provide is accurate and up to date. Their effectiveness and usefulness is contingent on long-term funding for the ongoing management and upkeep of the directory.

ACCHSs not only refer individuals to existing community resources and assets, but they also establish their own. An ACCHS board might secure funding to launch or commission a program to address an identified community need, particularly in the absence of culturally safe services and/or community organisation with resources to provide them[94]. The provision of appropriate funding to ACCHSs to continue similar work is essential and aligns with the National Agreement on Closing the Gap[180], which prioritises Building the Community Controlled Sector as a priority reform area[180].

Box 8: Examples of community resources and activities

Dead or Deadly program
Dead or Deadly program is a holistic health program designed to enhance health, wellbeing and cultural connection of Aboriginal women. It initially focused on four main areas: smoking cessation, nutrition/diet information, chronic disease prevention and management and physical activity/exercise. The program now also includes yarning groups, holistic health and lifestyle medicine. The program is designed by and for Aboriginal women[181,182].

Men's Sheds
Men's Sheds are community-based, non-profit, non-commercial organisations whose primary activity is the provision of a safe and friendly environment where men are able to work on meaningful projects. There is significant diversity in Men's Sheds, including some restricted to Aboriginal and Torres Strait Islander men for cultural purposes and those open to female members, sometimes called 'Community Sheds'[183].

Rrala milaythina-ti (Strong in Country)
The *rrala milaythina-ti* project provides immersive trips across Lutruwita (Tasmania) for Aboriginal community members to access country. It includes walks, camps and heritage excursions. It was developed to showcase that Aboriginal people are mentally, physically and spiritually stronger 'On Country'. The program improved health and wellbeing and created ongoing relationships between Aboriginal Community members[184,185].

parkrun
parkrun is an international community activity based on a 5km event that takes place in involved communities every Saturday morning. It is a free, community event where individuals can walk, jog, run, volunteer or spectate. There are over 500 parkrun events around Australia[186].

Supporting evidence:

A common finding among social prescribing program evaluations is resource pressures within the community and volunteer sectors[170,172,187]. An evidence review commissioned by the NASP (England) on sustainable funding models for social prescribing concluded that, regardless of how a program is funded, the community sector's capacity to deliver services is a significant challenge[135].

In both the UK and Australia, community organisations are commonly reliant on short-term grants to provide community supports, usually from local authorities (councils), but also from other levels of government. This makes them vulnerable to budget cuts[135] and limits their flexibility to adapt to changing community need, such as a sudden increase in referrals from social prescribing[147]. Researchers consistently conclude that the

voluntary and community sectors should be adequately funded to prevent them from being overwhelmed by increased referrals.

The effectiveness of social prescribing also relies on the visibility and accessibility of community resources and assets[188]. If referrers and link workers don't know what's available, they can't effectively connect people with appropriate services[153].

To address this, social prescribing initiatives and programs in Australia and internationally have invested in creating community resource directories or maps. However, these quickly become outdated and require continuous updating to remain current. While some programs rely on existing online directories such as *Ask Izzy*[189] or *My Community Directory*[190], there are concerns that these currently do not meet program needs due to the lack of universal coverage. This highlights the central importance of accessible, up-to-date and reliable information on relevant community resources and assets.

Digital software platforms and applications are rapidly expanding to collect, collate and make accessible similar information. Individual initiatives are considering the utility of these.

In Wales, community sector directory services such as Dewis Cymru[191] and infoengine[192] have been developed and are particularly used by social prescribing referrers and practitioners (link workers).

3.6 Feedback loops

Regular feedback loops should be established between link workers and the referring health professional (e.g. GP). A feedback loop is a system where a referring health professional is kept informed about how the individual they referred is progressing with their social prescription[6]. This would include information on the results of a non-clinical needs assessment, the specific social prescriptions, how those interactions went and the individual's progress with the support they received from the link worker[58].

Feedback from the link worker to the referring health professional would not only build trust in the service but also promote a shared understanding of what constitutes an appropriate and effective referral. Sharing success stories and individuals' outcomes firsthand can help referrers see the benefits of social prescribing, encouraging them to make more referrals. This dialogue, along with consistent follow-up and continuity of care (as outlined in section 3.4.1), is a critical element of the link worker function[17].

In addition, while getting feedback from community resources and activities would be advantageous, this may be challenging to implement in practice. Link workers should therefore also maintain contact with referred individuals to gather feedback on their experiences and outcomes. This information is important for monitoring the effectiveness of social prescriptions and for providing feedback to referrers. Software management systems developed for social prescribing services could include specific functionality to facilitate feedback loops between link workers and referrers.

Supporting evidence:

Open channels of communication and regular feedback loops between link workers and referring health professionals were identified through the consultations for this feasibility study as a key enabler of successful social prescribing. Research also suggests that feedback loops are more easily facilitated when the link worker has physical proximity to the primary care referrer, as this proximity helps build trust[193]. Regular visitation by the link worker to the healthcare setting would allow for informal, in-person discussions to complement digital or written communication.

3.7 Appropriate evaluation and monitoring

Comprehensive evaluation and monitoring processes should be embedded in all social prescribing initiatives, to:

- ensure that data on program effectiveness and outcomes are collected as standard practice within social prescribing services;
- demonstrate the wide-ranging benefits associated with social prescribing; and
- support the rapidly emerging social prescribing evidence base[17].

Monitoring outcomes helps to understand the impacts for individuals, services and the health system. It helps to refine and improve approaches and evaluate the success of a social prescribing initiative. Outcomes related to the social prescribing referral process and impacts on mental and physical health, social and emotional wellbeing, the community and health system are relevant measures to collect to contribute to social prescribing evaluation[17].

There are several limitations and challenges associated with the comprehensive evaluation of social prescribing programs and services. These include:

- the range of data required to comprehensively assess the various outcomes potentially attributable to social prescribing, including data related to both physical and mental health, as well as non-health outcomes such as social connections, community participation and socioeconomic factors.
- challenges in attributing longer-term indirect outcomes to social prescribing (e.g. increased workforce participation); and
- the diverse network of multisectoral organisations and other stakeholders involved in the delivery of social prescribing programs.

Supporting evidence:

The feasibility study consultations emphasised the need for comprehensive social prescribing evaluations to strengthen the evidence base, particularly regarding longer-term impacts.

Various tools are being used in existing social prescribing programs to evaluate program effectiveness and attributable health and wellbeing outcomes in Australia. For example, the 18 month evaluation of social prescribing programs in Queensland by Dingle et al.[39] used the ULS-8, a shortened version of the UCLA Loneliness Scale (ULS), to measure loneliness; the Kessler-6 (K6) for psychological distress; a single-item scale for perceived overall health; and the Warwick Edinburgh Mental Well-being Scale (WEMBS) 14-item for measures of wellbeing. Other programs have reported using tools such as variations on the UCLA Loneliness Scale, the EQ-5D-5L or the PROMIS-Global-10 for health-related quality of life and the Kessler-10 (K10) for psychological distress.

The South Wales Social Well-Being Scale (SWSWBS) was developed specifically for social prescribing to measure overall experience of social wellbeing. It looks beyond the subjective mental and emotional states that a person has experienced, to also uncover the social dynamics of wellbeing[194]. The 14-item scale includes questions related to:

- everyday life, activities and pastimes;
- family and friends;
- connecting with others and supporting needs;
- community involvement;
- engaging with and reflecting on the wider world; and
- self-growth and security[194].

It is expected to be used alongside tools like the WEMBS to develop a multidimensional understanding of an individual's subjective experience of wellbeing[194].

Research examining the benefits of social prescribing is promising, but the quality of evidence is mixed and there are challenges in assessing the long-term impacts of interventions. Studies to date have rarely looked beyond 12 months post-referral and there is significant variation in program design and evaluation methods[128]. Consistent and comprehensive evaluation studies, which assess both the short and long-term outcome measures, are essential to continue developing and strengthening the evidence base for social prescribing in Australia[17,195].

4

Options for implementing social prescribing in Australia

Options for implementing social prescribing in Australia

This section presents four options for the implementation of social prescribing as an adjunct to primary healthcare in Australia. Development of these options was informed by the evidence review and stakeholder consultations undertaken for this feasibility study, as well as the advice and experiences of leading Australian and international social prescribing experts.

The various elements included in each of the options refer to social prescribing developed as an adjunct to mainstream primary care services, except where explicitly indicated otherwise. One of the options is presented in significant detail as the optimal model for implementation. The optimal model presents a feasible, comprehensive approach for systematic and equitable implementation of a national social prescribing scheme within primary care. The optimal model aligns with the design principles and the operational components set out in this report (refer to sections 2 and 3). It was widely endorsed through the consultation process and by social prescribing stakeholders and experts.

The optimal model proposes a national social prescribing program, funded and coordinated by the Australian Government, that would include:

- development of a National Social Prescribing Framework;
- establishment of a National Centre for Social Prescribing;
- funding and support for PHNs to co-commission place-based social prescribing services and/or scale-up existing social prescribing initiatives in communities across Australia; and
- investment in national infrastructure and other implementation enablers to support the national rollout of social prescribing.

The optimal model would also include additional resources and support for the ACCHS sector to continue delivering their integrated, holistic models of care, appropriately funding ACCHSs based on need and demand in the communities they service.

Three other options for implementing social prescribing in Australia are also presented in this report. These options are less comprehensive than the optimal model, however, they may also be less resource-intensive and could still deliver significant benefits to population health and wellbeing. The three alternative options are for the Australian Government to:

- Establish a National Centre for Social Prescribing as a standalone initiative.
- Establish a grants program for PHNs and/or community consortia to implement localised link worker services and a National Centre for Social Prescribing.
- Establish a grants program for general practices and other health service providers to embed link workers within existing primary care settings and a National Centre for Social Prescribing.

These options could potentially be used as an interim 'stepping-stone' to future implementation of the optimal model. While there are distinct differences, there are also strong commonalities between certain aspects of each option. For example, the establishment of a National Centre for Social Prescribing is a central element of all four implementation options.

4.1 **Option 1**: The optimal model

The optimal model describes a national scheme which enables the implementation of social prescribing services as a nationally consistent adjunct to primary healthcare across Australia. Development of the optimal model was informed by a rapid review of international and Australian social prescribing evidence and comprehensive program of consultations with leading social prescribing experts and key stakeholders.

The optimal model provides for systematic national establishment of social prescribing as an adjunct to primary healthcare and facilitates the development of integrated health and social care nationally.

This model effectively integrates the implementation design principles and operational components outlined in this report (refer to sections 2 and 3).

The optimal model includes:

- development of a National Social Prescribing Framework;
- establishment of a National Centre for Social Prescribing;
- funding and support for PHNs to co-commission place-based social prescribing services and/or scale-up existing initiatives with local stakeholders; and
- investment in implementation enablers and national infrastructure to support rollout of the optimal model.

The optimal model includes PHNs as the appropriate bodies to integrate and support social prescribing as an adjunct to mainstream primary healthcare (refer to section 4.1.3). It would also include additional resources and support for ACCHS sector to continue delivering their integrated, holistic models of care, appropriately funding ACCHSs based on need and demand in the communities they service.

Implementation enablers are the factors and resources that make it possible to successfully integrate social prescribing into the wider primary care system. National infrastructure is a key enabler that provides essential tools to support and scale services. Implementation enablers, including national infrastructure, for the optimal model comprise:

- a social prescribing workforce strategy;
- support for referrer engagement;
- validated non-clinical needs screening and assessment tools for the Australian context;
- a national evaluation framework and National Minimum Data Set (NMDS) for social prescribing;
- community resource and asset development guidelines;
- a national community resource/asset/activity database; and
- digital transformation readiness planning.

These enablers, when co-designed through partnerships with the ACCHS sector could have the potential to bolster existing holistic health and social care within the ACCHS sector as well as support social prescribing in mainstream primary care.

4.1.1 National Social Prescribing Framework

A National Social Prescribing Framework would support the implementation of locally tailored social prescribing services Australia-wide. There has been a proliferation of social prescribing initiatives in Australia over recent years without standardisation or consistency in program development, models, terminology, funding or governance. The importance of nationally coordinated and equitable service provision guided by a national framework has had strong consensus among all stakeholders throughout the feasibility study consultations.

A national task-force or committee with appropriate expertise should be established to design the National Framework. It should comprise various social prescribing experts and representatives from key stakeholder groups, including consumers, PHNs, primary healthcare professionals, health service providers, the ACCHS sector, local government and community service and activity providers.

A National Social Prescribing Framework would provide guidance on a standardised approach for co-design and implementation of social prescribing services and set out infrastructure requirements and implementation supports for localised services. This should include information on social prescribing workforce development, community and community sector capacity building, community resource support and evaluation guidance (refer to section 4.1.4).

Consultations for this feasibility study strongly emphasised the need for a National Framework to ensure equitable access to social prescribing in Australia. There was consensus that the framework should outline the core components, key characteristics and accountability mechanisms for social prescribing programs, while allowing for flexible implementation tailored to individual communities.

4.1.2 National Centre for Social Prescribing

The establishment of a National Centre for Social Prescribing is considered a fundamental requirement to support the development of social prescribing initiatives in Australia. It is included as an essential component of all options for systematic implementation of social prescribing services presented in this report, and as a standalone or first-stage option.

The service enhancement and innovation necessary to develop social prescribing as an adjunct to mainstream primary healthcare, will require support with implementation for providers and services. Implementation and ongoing support could be most efficiently and effectively delivered by a specialised centre that curates research, provides education, information and resources, undertakes and supports national evaluation and engages all stakeholder groups in these.

A National Centre for Social Prescribing should be established as an independent, non-profit entity with an advisory or governance board. Consultations for this feasibility study specifically highlighted that a national social prescribing body would need to provide essential functions such as setting national standards, ensuring quality, developing comprehensive training and education resources and facilitating widespread adoption.

Potential functions for a National Centre are listed below:

- Compile and curate research evidence related to social prescribing to inform best practice.
- Design and implement a national evaluation framework for social prescribing, which would identify the data items required to establish a National Minimum Data Set and outline appropriate outcome metrics to measure the impact of social prescribing initiatives.
- Support collaboration and foster the development of cross-sector, multi-jurisdictional networks and partnerships between social prescribing stakeholders.
- Guide the development of individual community-focused directories for local services and resources.
- Support through education, training and professional development opportunities. This would include:
  - establishing a 'Community of Practice (CoP)' for link workers;
  - facilitating formal cultural safety training; and
  - working with educational institutions to embed social prescribing within the curricula of Australian medical, nursing, psychology and social work courses, as well as general practice training and professional development activities.
- Provide information and resources to Australian communities to improve public awareness of social prescribing.'
- Identify research priorities and facilitate research collaborations to further build the social prescribing evidence-base.
- Monitor and provide advice on the application of emerging evidence to enhance the uptake and effective implementation of social prescribing.

A National Centre would be instrumental in facilitating collaboration and supporting cross-sectoral social prescribing partnerships. National Centre would need to engage with ACCHSs to define the potential relationship between the Centre and ACCHSs. It would actively promote collaboration between primary healthcare service providers, the community services sector, government agencies and NGOs to create a cohesive social prescribing ecosystem.

The feasibility study consultations emphasised the importance of national leadership and resourcing for the successful implementation of social prescribing. Establishing a National Centre for Social Prescribing would be consistent with international developments where social prescribing research, professional education and advocacy organisations have been established. These include:

- the Social Prescribing Network[30] and National Academy for Social Prescribing (NASP)[31] (England);
- the Global Social Prescribing Alliance (GSPA)[204];
- the Scottish Social Prescribing Network (SSPN)[205];
- Social Prescribing USA[34];
- All Ireland Social Prescribing Network[206];
- the Wales School for Social Prescribing Research (WSSPR)[33];
- the Japanese Social Prescribing Laboratory[27];
- the national knowledge network of 'Welzijn op Recept' (Netherlands)[27]; and
- the Canadian Institute for Social Prescribing (CISP)[32].

Locally, the Australian Social Prescribing Institute of Research and Education (ASPIRE)[43] has been established to promote many of the same functions undertaken by the international organisations listed above. All provide leadership, research and resources to support service development and workforce roles.

NASP, a government-funded national charity, was set up in 2019 through a collaboration between the UK government, Sport England, Arts Council England and voluntary sector partners[207]. NHS England provided £650,000 in funding to cover initial start-up costs in 2019, with the Department of Health and Social Care committing a further £5 million in 2020[208]. NASP works to collate and improve the evidence base, share best practice, develop training and accreditation and advance social prescribing through working with local communities and creating partnerships across sectors in England[31,208].

Research suggests that institutes that provide leadership and evidence curation are vital for guiding effective practice and driving progress. They help direct investments, share valuable insights and ensure stakeholders adopt best practice. These institutes also improve how sectors approach evaluation and lead new developments through contemporary research[210]. For an institute to be effective, it needs a clear purpose, strategic independence, strong connections with stakeholders, high-quality evidence, effective communication and robust measurement[210]. In the Australian context, it will be important for a National Centre for Social Prescribing to collaborate with commissioning bodies as proposed in this report.

4.1.3 Co-commissioning of place-based social prescribing services led by PHNs

The scope and geographical reach of PHNs, their existing relationship with the Australian Government and their established roles as service commissioners and distributors of government-funding, uniquely positions them as appropriate bodies to lead the co-commissioning of localised social prescribing services as part of a national scheme.

However, outcomes from the feasibility study consultations emphasised that PHN catchment areas are too large for social prescribing services to be established centrally, and that the commissioning model should facilitate the development of locally tailored, co-designed services within discrete geographical communities. These could include local government areas (LGAs); subdivisions such as suburbs, wards or zones within an LGA; or larger communities or towns within a PHN catchment area.

Co-commissioning and collaborative networks

Established social prescribing models in Australia have been initiated by some state governments, some local governments and a number of communities. International developments and the national consultations for this report emphasised the importance of complementing existing programs and of strengthening the engagement of governments and communities in design, implementation and ongoing support for social prescribing services. This could be achieved by requiring collaborative planning and PHN-led co-commissioning of local social prescribing services with relevant health and community service providers, government bodies and community organisations. Co-commissioning and shared governance would help to minimise service gaps arising from fragmentation of separately funded health and community services within communities.

The PHN commissioning role is more than just the procurement of services. It is described by the Australian Government Department of Health as "the continual and iterative cycle involving the development and implementation of services based on needs assessment, planning, co-design, procurement, monitoring and evaluation"[196].

Co-commissioning involves two or more organisations jointly commissioning services under a shared contract. This could involve a collaborative network within a local community coming together to design and deliver services tailored to the local context. Such a network would include PHNs and co-commissioning organisations with non-commissioning collaborating organisations. The networks would undertake co-design and implementation to support services that are relevant and adequate to meet local community needs.

Potential co-commissioning partners with PHNs would include state and territory governments, local governments, LHNs, Neighbourhood Houses/Centres or community health organisations, among others. Co-commissioning with councils and community organisations could help broaden the reach and accessibility of social prescribing programs, particularly in communities with limited availability or accessibility of general practice.

Co-commissioning would require co-design, development and ongoing support of social prescribing services by the partner organisations in the collaborative network. The collaborative network may also play a key role in ensuring that community resources, services and groups have the capacity to respond effectively to increased demand resulting from social prescribing referrals. Co-commissioning partnerships could include philanthropic organisations, private health Insurers and substantial employer organisations, where appropriate.

For collaborative networks to function effectively and equitably, they require:

- a common understanding and shared vision;
- clear leadership and governance structure with role definitions and mechanisms to facilitate decision-making, coordination and accountability, including conflict resolution management;
- resource alignment including the potential for pooled funding arrangements; and
- community engagement and co-design, including fostering partnerships with community organisations.

Establishing robust collaborative networks between key stakeholders, including co-commissioners, local service providers and community organisations is considered essential for the successful implementation of social prescribing programs[135,197].

The Welsh National Framework for Social Prescribing designates Regional Partnership Boards (RPBs) as key leaders in implementing the framework[19]. RPBs support the needs of a local area by bringing together health boards, community organisations, local government authorities and other NGOs[198].

A 2019 report commissioned by Bromley by Bow Centre, the site of one of the first social prescribing programs in England, investigated co-commissioning approaches for social prescribing services, identifying several benefits[136]. The report noted that co-commissioning facilitates the integration of complementary and diverse perspectives and expertise, for example, drawing on the experience of local authorities (local government) in working in the community space, and aligning the priorities of the organisations involved. Additionally, the report noted that co-commissioning broadens the scope of social prescribing approaches and the range of outcome and measurement tools applied to services[136].

The Bromley by Bow report also detailed key factors influencing the effectiveness of collaboration and co-commissioning. It identified enablers such as building on existing initiatives, establishing shared ownership

and vision, and fostering effective communication and reciprocal relationships. The report also mentioned the importance of expanded funding options and buy-in from both executive and front-line staff. Conversely, the report identified misaligned priorities and commissioning processes, unclear lines of responsibility and an under-resourced community sector as barriers to co-commissioning success[136].

The consultations for this report emphasised that commissioning criteria should include a requirement to work with relevant agencies for collective impact. This would require minimum standards for collaboration. Collaborative networks would have the potential to provide blended funding for social prescribing services and to utilise the skillsets and connections of partnering organisations to enhance connections and complementarity between health and community sectors.

Collaborative partnerships and networks have emerged within the Australian social prescribing landscape. For example, North Western Melbourne PHN, IPC Health and the local Neighbourhood House have collaborated to deliver social prescribing through IPC Health[199]. The Victorian Department of Health's Wellbeing Promotion Office and Western Victoria PHN have piloted a project in the Geelong region to:

- broker and test a social prescribing partnership approach;
- understand the necessary resources for establishing partnerships;
- evaluate if the partnership approach supports social prescribing;
- identify opportunities for shared resources; and
- develop a toolkit to support future social prescribing partnerships[200].

Commissioning criteria for place-based social prescribing services

Nationally consistent PHN commissioning criteria should be developed to support community-based implementation of social prescribing services. These should be developed in collaboration with commissioning bodies, service providers and other social prescribing stakeholder organisations.

Based on the consultations that informed this report, commissioning criteria should include information and guidance on:

- Embedding social prescribing as a core function within the organisational infrastructure of PHNs, by integrating it into the operations of relevant programs and services (such as ageing, youth and mental health programs).
- Relevant processes for commissioning and co-commissioning new social prescribing services and/or scaling existing services within identified local communities, through term-based (3-5 years), renewable service agreements to support long-term service sustainability.
- Actively supporting the integration of social prescribing referral pathways into general practice and other primary care services, including relevant capacity-building for GPs and other primary care professionals.
- Integrating community needs assessments to help inform the design and implementation of local social prescribing services.
- Applying principles that account for remoteness as well as population density and consider the availability and accessibility of local infrastructure.
- Establishing robust monitoring and evaluation frameworks to assess program effectiveness, quality, outcomes and service capacity to inform ongoing population needs assessments.
- Ensuring strong clinical governance and accountability mechanisms are in place across all levels of implementation.

A commissioned service should not 'break' what is already there and should leverage the expertise of various local and other stakeholders to avoid service duplication and/or fragmentation. This would include, where appropriate, PHNs integrating learnings and knowledge from the ACCHS sector in the design and implementation of local social prescribing services. While general guiding principles for ACCHSs and PHN collaboration already exist, specific provisions for partnerships in the context of social prescribing could be developed. *The National Agreement on Closing the Gap*[180] priority reform area 'Formal partnerships and shared decision making' commits to a joined-up approach between governments and Aboriginal and Torres Strait Islander representatives in key areas, including social and emotional wellbeing. The essential elements identified in the agreement, formal agreements, representation, shared decision-making and appropriate support[180], could guide these partnerships.

The feasibility study consultations also identified hospitals and emergency services in various parts of Australia that have begun programs similar to or described as social prescribing to address the non-clinical factors influencing frequent presentations to emergency departments and hospital admissions. PHN social prescribing partnerships and collaborations would need to include other health services relevant to their catchments, both those currently delivering social prescribing and those that potentially could do so in the future.

Co-design of social prescribing services with the local community was strongly supported in the consultations for this study. There are existing examples of co-designed social prescribing programs in Australia which could be used as the basis for co-design guidance for a national framework. Oster et al. (2024) have published a case study on co-designing a model of social prescribing in Australia[6] and Ostojic et al. have co-designed a program for families of children with cerebral palsy[201,202].

Additionally, the ACCHS model of integrated primary healthcare is based on community co-design. The *NACCHO Core Services and Outcomes Framework* outlines what core services can be expected by individuals and communities and that each ACCHS is responsible for co-designing with community to decide how the core service is delivered[94].

Box 9: A common sense approach to social prescribing service catchment areas

Catchment areas for local social prescribing programs should allow for flexibility, with coordination and collaboration between neighbouring PHNs. A pragmatic approach should guide decisions about service eligibility and access. For example, if an individual resides within one PHN but is geographically closer to a local social prescribing service in an adjacent PHN, mechanisms should be in place to enable their participation in the closer program. This approach maximises service efficiency.

Link worker elements in commissioning criteria

Funding for link workers should be allocated based on population size and identified community needs, ensuring sufficient capacity to undertake core functions and including personnel, necessary infrastructure, such as physical workspace, equipment and digital infrastructure, logistics and resource costs. This will ensure that workload capacity is sustainable and that referred individuals are not adversely impacted by waiting lists. Funding could also include 'brokerage funding' to assist the cost to an individual of connection to community services or support (e.g. funds to cover childcare and/or transport). This would be used at the discretion of the link worker in accordance with appropriate criteria.

Link workers need to be geographically based within the area served by the social prescribing service. There is significant support from stakeholders for the link worker role to be situated within the community rather than within healthcare services, whenever feasible. This would include being within common and universally accessible community resources, such as libraries, which are increasingly providing a community connection and support role (*see Box 9*). GPs, however, have indicated a preference for the co-location of link workers for ease of referral and collaboration. While proximity to referrers is identified as an enabler of social prescribing, the substantial logistical and resource implications may make co-location unrealistic for many areas and programs. Additionally, consultations that informed this report emphasised that community-based link workers enhanced community engagement. For some local communities, such as those with limited health and community service infrastructure, co-location with an appropriate health service may be appropriate. The physical location of the link worker/s and social prescribing services should be determined by local co-design to ensure the most accessible and enabling location for the community and population demographics that would most benefit from social prescribing.

As noted above, funding for social prescribing services should include provisions for necessary infrastructure, including hardware and software. Patient management software would be required for case notes, including information on assessment, referral and follow-up, and should also enable collection of data to align with a national minimum data set for social prescribing.

Box 10: The Campaspe Social Prescribing Library[203]

The Campaspe Library Service developed a social prescribing program. They aimed to use the project to develop an evidence-informed toolkit to "support public libraries to develop a sustainable social prescribing service that aligns to their community, health and organisation's priorities by either contributing to an existing social prescribing program or developing their own community-led service".

The Campaspe Library Service Social Prescribing program received referrals from allied health (67%), family (11%), library staff (8%), self-referral (8%), lifestyle coordinators (5%) and other sources (2%). The program participants were varied, with the majority of individuals being female (64%) and older (68-94yr). There was also variation in the length of engagement with the program. 20% spent less than 3 months engaged, while 9% were engaged for 3 years.

The program referred individuals to a range of activities and supports, including internal activities such as 'books on wheels' and external supports such as carer support. 47% of 'prescriptions' were signposting.

Signposting, activities/programs and assertive outreach were identified through the project as the three main opportunities for libraries to be involved with social prescribing initiatives[203].

4.1.4 Implementation enablers/national infrastructure

This section sets out the implementation enablers, including national infrastructure, for a national social prescribing scheme. Implementation enablers would facilitate effective and sustained social prescribing as an adjunct to primary healthcare within local communities. As outlined in section 4.1, national infrastructure could significantly strengthen existing efforts within the ACCHS sector and mainstream primary care, while also fostering new social prescribing initiatives. This infrastructure should be developed and co-designed through appropriate partnerships. Developing these implementation enablers, including national infrastructure, will lead to more consistent and rigorous development and operation of local social prescribing services.

4.1.4.1 Social prescribing workforce strategy

A dedicated social prescribing workforce strategy, including link worker competencies and standards, should be developed. Given that link workers will come from diverse professional backgrounds and disciplines (as outlined in section 3.4), a workforce strategy is essential to ensure consistent, high-quality care for everyone in social prescribing programs. The workforce strategy needs to set standards for link worker supervision, practice quality and safety and establish a code of conduct[46]. Link workers will come from a variety of backgrounds, including both registered healthcare disciplines and non-registered fields and development of a workforce strategy should include consultations with the Australian Health Practitioner Regulation Agency (AHPRA) and the Australian Commission on Safety and Quality in Health Care (ACSQHC).

This report and the accompanying Technical Appendices describe the diverse, somewhat ad-hoc and limited development of dedicated social prescribing programs in Australia. Currently, the emerging social prescribing workforce in mainstream programs is diverse[147]. A dedicated workforce strategy would address staff recruitment and retention within social prescribing services, as well as the broader implications of developing this new workforce on the availability of health and social care professionals for other services, including the NDIS, aged care and social work.

A workforce strategy should examine the breadth of professional roles engaged in social prescribing. This would involve co-design with GPs, primary care nurses, allied health practitioners and Aboriginal Health Practitioners and Health Workers that already undertake social prescribing as part of their usual practice. The workforce strategy should outline the additional skills development needed for mainstream primary healthcare professionals, especially GPs and primary care nurses, to effectively assess non-clinical needs and provide informed referrals to social prescribing services. Furthermore, the strategy needs to address the intersections between social prescribing and the care coordination and services navigation supports emerging across health, disability and aged care sectors.

Link workers

Several countries have developed competencies for the link worker role. The development of Australian link worker competencies as part of a workforce framework would therefore be consistent with global best practice. The *NHS England Workforce development framework: social prescribing link workers* aims to provide clear, consistent standards for social prescribing link worker practice, offer guidance on their support and supervision, to ensure quality and consistency and to advise on integrating link workers into multidisciplinary teams[174]. *The Competence Framework for Social Prescribing practitioners* in Wales outlines the desired and ideal competencies of a social prescribing practitioner (link worker), providing a shared foundation of core knowledge, skills and behaviours. This includes a 'Professional Competences' domain, which underpins standards of conduct, confidentiality, consent and safeguarding for social prescribing practitioners[175]. For individuals working under the NHS in Wales, their employing organisation is responsible for 'duty of care'. Complementing this, the Health and Social Care (Quality and Engagement) (Wales) Act 2020 has established a 'duty of quality'[211]. This statutory guidance works to enhance and safeguard the health, care and wellbeing of individuals in Wales. Since it applies to Welsh Ministers and NHS bodies, both clinical and non-clinical, it ensures accountability for all staff involved in social prescribing under the NHS[212]. Canada is in the process of developing a Link Worker Competency Framework[213]. These, and local Australian initiatives, including work underway by ASPIRE on Australian link worker competencies, could inform the development of a workforce framework and link worker competencies for Australian social prescribing services.

The NDIS workforce capability framework[214] is a contemporary Australian example of a workforce framework. It was developed to ensure a consistent, quality service experience for NDIS participants from the NDIS workforce. It also provides workforce planning and management information for providers. This framework is recommended but not mandatory for NDIS providers to use[214]. A similar approach could be taken with a social prescribing workforce framework.

To ensure link workers operate safely and effectively, link workers require defined boundaries, adequate training and clinical supervision[138]. These essential elements should be a core part of any workforce strategy. While appraisal and evaluation of link workers vary throughout the literature, a scoping review by Sandu et al.[171] highlights several key factors for successful link worker services. These include:

- recruiting link workers from the community they will serve;
- providing standardised training;
- establishing supervision standards;
- strategically determining the locations and distribution of link workers across services;
- monitoring and evaluating intervention intensity to guide capacity; and
- clearly defining the scope of link worker interventions[171].

Commissioning guidelines and a workforce strategy will need to consider and provide guidance on the following issues.

- **Skills mix and numbers:** The number of link worker positions, the skills mix and scale of social prescribing services should be determined based on community needs assessments and local co-design.

- **Workload for link worker role:** The workload for a link worker should be managed with consideration for the complexity of individual needs, the capacity of the system to avoid wait lists and to avoid burnout.
- **Supervision of link worker role:** Regular clinical and casework supervision provided by a clinical, social or mental healthcare professional is essential for link workers. This is important for managing workload, addressing risk management, preventing burnout, supporting quality of care and professional development. Supervision would be supported by PHNs, through partnerships or co-commissioning arrangements. A workforce strategy should consider the implications that providing this supervision would have on existing professional workforces and areas with workforce shortages.
- **Community of Practice (CoP) support for link workers:** Communities of Practice have been established in a range of industries as professional learning and knowledge-sharing groups focused on improving organisational and professional performance. In healthcare, CoP are established to generate and share knowledge, improve clinical practice and facilitate the implementation of evidence-based practice[215]. ADMA has previously facilitated an informal social prescribing link worker CoP.

The feasibility study consultations supported establishing a formal CoP for link workers. This could be a national initiative identified under a National Social Framework for Social Prescribing (refer 4.1.1). It could be implemented through a National Centre for Social Prescribing (refer to section 4.1.2) and build on the expertise from the CoP previously facilitated by ADMA. Additionally, ACCHSs or PHNs could support smaller, more local CoPs within their catchments. This could be encouraged through place-based partnerships.

GPs and other primary healthcare professionals

GPs and other primary healthcare professionals need to be familiar and confident with the process of identifying patients with unmet non-clinical needs and making appropriate referrals to a link worker, including supported transfers (warm referrals) as required. GPs and other primary healthcare professionals should also ensure that there is appropriate follow-up on progress and outcomes for all social prescribing referrals.

Specialist link workers for complex needs

As previously stated, access in Australia to services to support complex social non-clinical needs is limited[169]. Despite not being designed to do so, established social prescribing programs frequently become the 'catch-all' for individuals with complex needs, overwhelming link worker capacity and social prescribing services. To prevent these issues in both new and existing programs, it is essential to simultaneously increase capacity to offer extended support for individuals with complex needs. This can be achieved by creating specialist link workers and facilitated access to specialist community supports.

A specialist link worker could have existing professional qualifications in a relevant health discipline (e.g. social worker, psychologist, occupational therapist) and appropriate skills and capability to work with individuals who experience high levels of psychosocial complexity and unmet non-clinical needs. Specialist link workers would work with non-specialist link workers within a social prescribing service.

Specific funding arrangements will be necessary to establish specialist link worker roles. This could involve direct funding to PHNs to enable these services to be commissioned. Community co-design of the social prescribing service should determine if specialist link workers are integrated within social prescribing services, operate externally or if a blended approach is more appropriate.

Specialist link workers are already being utilised to some extent, both in Australia and internationally[216–218]. In England, Social Prescribing Advice Workers are emerging roles to assist people needing debt or financial guidance, social welfare, legal information, or housing advice. The Social Prescribing Advice Worker is commonly a qualified social worker with skills in addressing these issues[217]. Community link workers (CLW) in Scotland sometimes have a specialty area. For example, there are CLWs in Edinburgh that specialise in addressing homelessness and CLWs in Glasgow that specialise in working with asylum seeker populations[27].

In Australia, the 'Recognise, Respond, Refer' (RRR) program and the Local Link service is a domestic and family violence (DFV) program developed by Brisbane South PHN. Now operating within six PHNs, it is designed to support general practice to respond to DFV. It provides education for GPs to recognise and respond to DFV and gives them a pathway to refer to a Local Link Coordinator for patients impacted by DFV[218]. The Local Link Coordinator is essentially a specialist link worker for people experiencing DFV.

4.1.4.2 Engagement of referrers

General practice referrers

Engagement of referrers is a significant implementation enabler for a national social prescribing scheme. As stated in section 3.1.1, social prescribing programs in Australia routinely report difficulty in engaging GPs and general practice teams in their programs. For GPs and general practice teams to embrace and benefit from social prescribing, and to ensure patients are identified appropriately, practices will need support. GPs and general practice teams will need to be aware of the evidence that a significant number of general practice patients have unmet non-clinical needs, and that assessing and referring these individuals may require dedicated time and resources. PHNs should therefore support general practices to integrate social prescribing referral pathways into their existing patient care, workflows, systems and overall practice ethos. To build strong working relationships, link workers may need to regularly visit general practices, to continually engage GPs in social prescribing and to emphasise the link worker's role and the benefits they offer the practice and their patients.

Potential funding arrangements

To engage GPs and general practice teams in undertaking non-clinical needs screening/assessments and referrals, appropriate funding arrangements should be established. There are various options to enhance the assessment or screening for social care and non-clinical needs within the primary care system. One approach would be to create a new MBS

item specifically for development of a social care plan. Alternatively, within current funding arrangements, screening, assessment and management of non-clinical needs could be integrated with existing MBS items, such as GP chronic condition management plans, GP mental health treatment plans or Health Assessments. Refer to 4.2 in the accompanying Technical Appendices document for a brief analysis of the benefits and issues related to each of these options.

Throughout the feasibility study consultations, there was some concern that undertaking a non-clinical needs assessment and referral, akin to chronic disease management plans, could 'medicalise' non-clinical issues. This should be considered when implementing any such arrangements within general practice or MBS.

Additionally, the *Strengthening Medicare Taskforce Report*[109], *Review of General Practice Incentives*[112] and *Scope of Practice Review*[111] all recommended a shift towards comprehensive, multidisciplinary team-based models of care within general practice. This included explicit references in the *Review of General Practice Incentives*[112] to the potential role for link workers in general practice multidisciplinary teams. The funding mechanisms proposed for these should be considered as opportunities to embed social prescribing as an adjunct to primary care.

Digitally enabled referral

To embed social prescribing as an adjunct to general practice, the referral process for GPs and general practice teams to link workers should be simple and streamlined. Ease of referral is considered an important enabler for GP engagement[80]. Therefore, developing software solutions for workflow integration should be considered.

There are a number of practice management software systems used across Australian general practice, and social prescribing assessment and referral tools should be designed for universal integration with these.

Optimally, digital infrastructure at the clinical systems level (general practice and primary care) should encompass necessary tools, data, and workflows needed for GPs, pharmacists and allied health providers to effectively identify, screen for and respond to non-clinical needs. This would include embedding prompts for needs assessment and referral mechanisms directly into workflows to avoid additional burden on clinicians. Ideally, this digital infrastructure should enhance existing systems by operating either within or alongside standard GP software. This view was strongly affirmed through stakeholder consultations for this project.

A National Social Prescribing Framework could establish appropriate assessment and referral requirements for consistent integration into practice management software.

Other primary healthcare referrers

Engaging the range of primary care providers within the social prescribing network would be consistent with policy objectives and recommendations from the *Strengthening Medicare Taskforce Report*[109], *Unleashing the Potential of our Health Workforce - Scope of Practice Review* (2024)[111] and *Review of General Practice Incentives Report* (2024)[112], as well as aligning with other health policy priorities, including improved preventive healthcare. Funding support may need to be considered to account for the additional time or capacity required for some allied health professionals to participate in social prescribing.

Community-based referrers

For social prescribing services to be used, they need to be highly visible to a broad range of potential referrers. In addition to engaging primary care, social prescribing services should actively engage and make the service visible to other healthcare providers, such as ambulance and hospital emergency and to community members, family, carers, and individuals themselves. Community referral sources are particularly important for individuals who may have limited or no contact with healthcare services, including people from culturally and linguistically diverse backgrounds and other priority populations who may not access traditional general practice settings.

The optimal mix of social prescribing referrers and access points to link workers should be determined collaboratively between PHNs and community stakeholders or co-commissioners. This should be reviewed over time as services mature.

4.1.4.3 Validated screening and assessment tools and appropriate triage pathways

Non-clinical needs screening and assessment tools

A specific screening tool should be developed for use by social prescribing referrers to enable easy identification of the of non-clinical need complexity and facilitate referrals to general or specialist link worker services. A comprehensive non-clinical needs assessment tool should be developed for use by referrers and link workers. This is outlined in section 3.2. These tools should be standardised, validated, easy to use and be able to indicate both the complexity of an individual's non-clinical needs and their capacity to be an active participant in social prescription activities. It is also important that these tools are culturally informed and reflect the diversity of the Australian context.

Appropriate referral pathways for complexity

As already discussed, the capacity of a social prescribing program can be affected when individuals with high levels or complex non-clinical needs are referred, as these individuals require more dedicated time and often specific skills to address their needs. Three tiers of non-clinical need complexity and likely referral pathways are discussed in section 3.3 of this report. Appropriate referral pathways for individuals with high-level, complex needs are necessary to ensure these individuals are not excluded from accessing social prescribing services and to prevent long waiting lists and reduced capacity to meet community demand.

A national social prescribing scheme would provide for link workers with a range of skills, enhancing capacity to address complex non-clinical needs (refer to section 4.1.4.1 for link workers and specialist link workers). For referrers, particularly GPs and general practice teams, triage capacity via validated screening and/or assessment tools (see above) and appropriate funding for complex assessments (refer to section 4.1.4.2) will be required to encourage and facilitate appropriate referrals.

For individuals with complex needs, facilitated support for the individual to access appropriate services is considered essential. This can include 'warm referrals', where the health professional or practice provides personal assistance to connect the patient with the specialist link worker, ensuring a smoother transition and engagement with the necessary support.

Referral between link workers

Enhancing the flexibility of pathways and the diversity of link worker skills within social prescribing services would enable non-specialist link workers to refer individuals to specialist support (i.e. a specialist link worker) where appropriate. Figure 3 illustrates these three referral pathways (refer to section 3.3) from primary care, including the essential feedback loops for communication (refer to section 3.6).

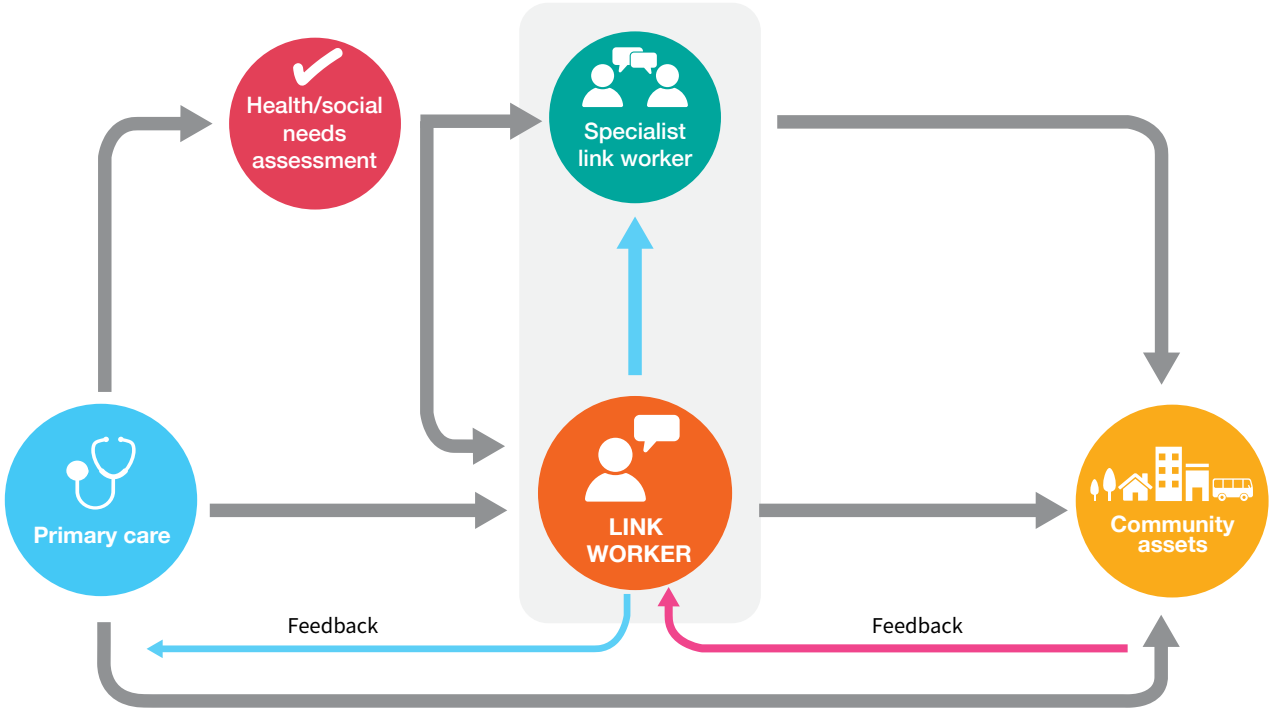


Figure 3: Primary care referral pathways

4.1.4.4 National Minimum Data Set and evaluation framework

A National Minimum Data Set (NMDS) is important for the effective evaluation and planning of social prescribing initiatives. To achieve this, data items for evaluation measures should be developed collaboratively with stakeholders, through partnerships that form a national framework, taskforce or steering committee.

A recent integrative review of link worker programs in Australia by Baker et al. (2024), highlighted that the development of standardised data items and outcome measures is critical for robust evaluation of social prescribing in Australia. This would require consensus from all stakeholders, including researchers, healthcare professionals, link workers, funding bodies and consumers[173]. Given the often complex and individualised nature of social prescribing interventions, a 'multi-criteria' approach to assessing implementation and outcomes is necessary. This is because outcomes can vary across physical, emotional, social and quality of life domains, necessitating diverse evaluation methods[173].

Service data collection should occur at the link worker level and, where appropriate, at the point of referral (e.g. general practice or other referral source). Contemporary initiatives to integrate various standards and classification systems into all health, aged care, mental health and disability software systems[219] will facilitate data interoperability and aggregation against common types of service provision. To effectively incorporate these into social prescribing practice, identification of the diverse service and provider types involved, is necessary. Standardising the inclusion of social prescribing data in practice management software should be mandated through a national framework.

The consultations undertaken as part of the national feasibility study identified that potential data items for an NMDS could include:

- demographic information (e.g. age, gender, ethnicity, language needs, interpreter requirements);
- data on referrals (number of referrals (incl. those not taken up), reason for referral, assessed non-clinical need/s);
- data on service engagement (e.g. service type referred, frequency of link worker interactions);
- data on service user outcomes (e.g. general wellbeing, quality of life, volunteering or engagement in workforce outcomes);
- data on health system outcomes (e.g. health service usage), and
- data related to broader environmental and public health contributions (e.g. active transport that reduces car use, community gardens which reduce reliance on industrial food systems etc).

Evaluation of social prescribing is essential and should be a core component of both the National Social Prescribing Framework and PHN co-commissioning guidelines. A national evaluation framework should be developed in collaboration with a wide range of stakeholders, including consumers, PHNs, health professionals, service providers, community organisations, ACCHSs and policy makers. Consistent data and measurement approaches across services would improve comparability, making an evaluation framework instrumental in driving service consistency.

The consultations for this report strongly supported the importance of an evaluation framework to identify the benefits of social prescribing as well as highlight areas needing improvement. International developments have also underscored the importance of long-term evaluation for social prescribing initiatives[77,195].

Service evaluation should be guided by a national evaluation framework, utilising measures based on a NMDS. Data collection should be integrated into general practice referral support software and link worker software support. PHNs should be responsible for collating and analysing this data, as well as for program evaluation. A National Centre could collate evaluations from all programs, facilitating continuous improvement based on these insights.

Collated data would enable valuable feedback to general practices and social prescribing services for ongoing monitoring and evaluation. It would also inform collaborating organisations about the capacity, outputs and outcomes of social prescribing services. Additionally, this data could help determine appropriate link worker capacity, ensuring an adequate number of link worker roles are available to meet demand in specific areas.

The Social Return on Investment (SROI) study conducted for this project (refer Technical Appendices, Appendix 8) proposes that an evaluation framework should include an economic evaluation. This should be based on both an effectiveness-focused evaluation, which includes a comparator, and a dedicated SROI study.

4.1.4.5 Community resource and asset development guidelines

Community resource and asset development guidelines should be identified as part of the National Social Prescribing Framework. This would guide PHNs, co-commissioning organisations and other social prescribing stakeholders on:

- Collaborative commissioning to boost the capacity of existing services to offer local solutions, aligning with regional planning and coordination.
- Building community-supported place-based partnerships to improve the capacity and diversity of available community resources and assets, including through commissioning, grants and micro-commissioning to fill gaps in local service provision.
- Developing support for community resources and assets to meet minimum standards or possess essential knowledge, being mindful of not making it too onerous for grassroots community groups[136,220].
- Addressing equity and deficits in social capital in disadvantaged communities.
- Supporting unincorporated community groups to have access to insurance and other requirements.

The consultations that informed this report identified concerns over the varying capacity and standards among community resources. Many referrers want reassurance that the groups and activities individuals are connected to are adequate and appropriate. A significant challenge is that many grassroots community groups and informal activities lack infrastructure and resources, such as public liability and other insurance. While there are potential concerns

about liability for those making referrals, it is important to remember that a co-produced plan means the individuals select activities for themselves, rather than being strictly prescribed by a referrer or link worker. Social prescribing should offer multiple options for social support and community connection, not merely direct individuals to a single or specific group or activity[17,19].

Community resource and asset development guidelines should also facilitate the involvement of smaller organisations through auspicing arrangements with larger organisations. This would allow for umbrella provisions of standards, policies and infrastructure, ensuring these smaller groups and activities have appropriate capacity and rigour. Neighbourhood Houses Victoria (NHVic) provides an example of how this can be achieved (*see Box 10*).

Box 10: Neighbourhood Houses Victoria auspicing arrangements

NHVic offer auspice arrangements for unincorporated community groups, particularly those who have emerged from or are connected to a Neighbourhood House. These arrangements support groups that require assistance with public liability insurance or financial management but wish to remain unincorporated. This is made possible through the Victorian Government-funded insurances, managed through the Victorian Managed Insurance Authority Community Service Organisations Insurance Guide 2024-2025.

Formal auspicing requires supporting documentation and legal responsibility for the finances and activities of the program. In addition, NHVic provides space for more than 4,500 community groups to meet and supports over 2000 groups with activities such as grant writing, governance and general advice.

NHVic have also worked with the Australian Charities and Not-for-profits Commission (ACNC) to develop a bulk registration process, allowing streamlined registration via an online tool. This tool is now available to other similar peak bodies across Australia to support their member organisations[221].

Investment in the community sector

Social prescribing relies on collective infrastructure and shared access. It draws on volunteering, peer and community connections and the shared use of local spaces. It needs to be supported by adequate and appropriate infrastructure and sustainable funding. Curating and reinvesting in shared resources and assets will not only improve the accessibility and outcomes of social prescribing, it will also boost the overall capacity and wellbeing of the entire community[17].

The consultations that informed this report consistently highlighted the need to build capacity within the community sector and to avoid shifting burden from the health system to the community sector without providing additional support. Administrators of Care Finders, a program connecting older people with community care services for PHNs, encountered a shortage of “recipient services” and warned that PHNs implementing social prescribing would face a similar obstacle. There was strong consensus that community development and identifying service and population needs must be core components of social prescribing developments. For social prescribing to succeed, “a significant investment in community sector organisations” is essential.

Current grant and funding programs for community organisations are widely considered to be insufficient to meet the existing community need[120]. The 2023 Australian Council of Social Services (ACOSS) *Australian Community Sector Survey* highlighted this, finding that "only 9% of community sector leaders agreed that funding covers the full cost of service delivery"[222].

The potential impact of social prescribing on community organisations is substantial. NHVic, for example, estimates that, if every full-time equivalent GP in Victoria referred just five people to a Neighbourhood House through social prescribing, it would result in 36,220 additional referrals. This translates to an average of 90 new participants for each of Victoria's 401 funded Neighbourhood Houses[221]. Considering the estimated extent of non-clinical needs that present in primary care, the actual number of community referrals could be significantly higher.

To enable community organisations to effectively participate in social prescribing by receiving referrals and adequately managing increased demand, investment in public infrastructure, capacity building and reliable funding is essential. This is not just important for social prescribing but also for fostering connected and compassionate societies and communities more broadly[17]. Refer to section 4.1.5 for funding considerations for potential options for expanded community sector support.

The Australian Government Department of Social Services has released a *Community Sector Grants Engagement Framework* (2025) aimed at improving the sustainability of community sector organisations[223]. The establishment of community resources and asset development guidelines should consider this framework.

4.1.4.6 National infrastructure for local community resource information

As outlined in section 3.5, easily accessible information on available community resources, activities and services is fundamental for social prescribing. Directories are resource-intensive to build and maintain, making it impractical to establish and maintain stand-alone directories for each social prescribing service.

To avoid duplication of effort and ensure consistent governance over community resource directories, a national online community resource information portal is proposed. This portal would serve as a national 'scaffold', interacting with locally curated directories to deliver a comprehensive online information service for community resources across Australia. Social prescribing referrers and link workers could use this directory to identify community resources for potential use in a co-produced social prescription. The portal would also be publicly accessible, enabling anyone in the community to find groups or services to support their health and wellbeing.

Existing or purpose-designed infrastructure could provide a national online capability (online portal) where community groups can upload and maintain current information about themselves, their activities, supports and services. This should be consistent for all groups,

whether they are entirely volunteer-run or large community organisations. The portal would need to be built and sustained with sufficient capacity to:

- provide regular prompts to remind participating community organisations and groups to update their information using simple formats;
- respond to an ever-changing landscape of temporal services and shifting times and locations of services;
- promote the portal's services to social prescribing initiatives, health and care providers, disability and aged care navigators and directly to community groups and organisations;
- incorporate safeguarding mechanisms into the data custodianship by also receiving user feedback on services listed; and
- oversee the quality of the information provided.

Community resources should be searchable by various geographical markers, including postcode, suburb, local government areas, LHN and/or PHN catchments.

4.1.4.7 Digital transformation readiness planning

The future potential of technology to assist and enhance social prescribing is obvious. This could include online access to prepared resources for social prescribing participants; online engagement for participants in community activities or groups; and provision of prompts to participants to support engagement and to provide feedback on engagement. For some, digital access encourages self-navigation and the use of online options, with digital communities potentially helping to overcome geographical and other access barriers.

Integration of supportive technology into social prescribing programs and services will be important. This could involve enabling software systems for care planning, screening and assessment; interactive and real-time online directories to support referrals; and/or virtual service delivery methods, such as nudge messaging and chatbots to reinforce and encourage the uptake of social prescriptions. It is important to consider the scalability, sustainability, reliability and accuracy when adopting emerging technologies.

In the two years since the feasibility study consultations were undertaken, the capabilities and potential applications of AI have increased exponentially. The use of AI in social prescribing and particularly in identifying community resources and assets should be explored, while ensuring essential safeguards for privacy and the protection of personal and professional information are in place.

However, the digital divide, the gap between those with easy access to digital technology and those without, means access to these services will be limited for some individuals. Careful consideration must be given to the digital divide to ensure that digital applications do not add to or exacerbate healthy inequity.

A National Social Prescribing Framework should actively support implementation of digital technologies in social prescribing services. The integration of any digital services into a national social prescribing program must align with the Australian Government's *Digital Health Blueprint*[224] (2021-2030) and *Digital Services Standard*[225] (2023).

4.1.5 Funding considerations

Seven key funding requirements and investment priorities were identified to support the systematic implementation of the optimal model:

1. Funding to develop a National Social Prescribing Framework.
2. Funding to establish and support ongoing operation of a National Centre for Social Prescribing.
3. Commissioning funds provided to PHNs that would cover:
   a. Development of local social prescribing services in collaboration with co-commissioners.
   b. Implementation and operation of social prescribing services.
   c. Engagement activities aimed at establishing and supporting relationships with referrers, including GPs and other primary care providers.
   d. Maintenance of current and relevant community resources and assets information for referrals.
   e. Integration of service evaluations into a national program evaluation.
4. Ongoing funding and sufficient resourcing of ACCHSs to sustain and scale the integrated health and social care services of the sector.
   a. Appropriate funding for the ACCHS sector should be established through a co-design process and could be informed by ongoing work led by NACCHO on funding models based on needs.
5. Appropriate funding arrangements for engagement of general practice and other primary care providers in social prescribing referrals.
6. Investment in community resource and asset development and strengthened capacity of the community sector. Potentially through either:
   a. Australian government funding: the Department of Health, Disability and Ageing could collaborate with the Department of Social Services to jointly design and fund additional community capacity. This could be delivered through existing commissioning bodies.
   b. Multi-level government funding: state and territory government agencies and relevant Australian government agencies could jointly fund community sector capacity within each jurisdiction.
7. Funding for other implementation enablers and national infrastructure.

The overall program funding parameters of the optimal model will dictate its potential for implementation and scale, which could be phased in over time (refer to section 4.1.9).

Funding for individual social prescribing services should be term-based, ideally with renewable 3 to 5 year agreements. This approach would ensure stable service development, fostering trust between referrers, the service and the community. Funding levels could be determined by identified community catchments, population numbers and profiles and population needs assessments.

4.1.6 The optimal model and the design principles

Alignment with design principles	
 WHOLE OF SYSTEM	• The optimal model proposes a whole-of-system approach, embedding social prescribing within the broader health and social care sectors. This would be achieved through the national framework, establishing a National Centre, support for ACCHSs and co-commissioning of social prescribing services through PHNs.
 PERSON-CENTRED	• The optimal model would ensure services are person-centred by centring the experience of the individual and making the 'what matters to you' conversation an integral component of the link worker's assessment and co-designed social prescription.
 TRUSTED PARTNERSHIP	• Requirements for co-commissioning would foster trusted partnerships between PHNs and local organisations (refer 3.1.3). • Program design would prioritise supporting relationships for individuals at the local level. • The National Centre would promote and support the application of trusted partnerships through activities and resources.
 ACCESSIBILE & INCLUSIVE	• Embedding social prescribing systematically across PHNs and bolstering ongoing practice within ACCHSs would support accessibility across Australia. • Individual program design would need to determine who can access a program based on community needs assessment and population demographics. The National Centre would promote and support services to be accessible and inclusive through activities and resources.
 CULTURALLY SAFE	• Embedding cultural safety would be crucial for addressing Priority Reform three from the National Agreement on *Closing the Gap* – transforming government organisations[180] and would need to be part of program design. • The optimal model would prioritise cultural safety by both supporting ACCHSs to continue delivering holistic care and through local social prescribing programs commissioned by PHNs, that are community-led, culturally safe and respond to local priorities. • The National Centre would promote and support services to be culturally safe through activities and resources.
 FLEXIBLE & LOCALLY TAILORED	• Co-commissioned social prescribing services should ensure services are flexible and tailored to the local context, with services co-designed by a diverse range of community stakeholders.
 NO WRONG DOORS	• No wrong-doors operating principles and guidelines would need to be built into program design. • Programs being developing as part of PHN core business and with links to existing services should facilitate a no wrong doors approach. • The National Centre would promote and support the application of the no wrong doors design principle through activities and resources.
 SUPPORTED COMMUNITIES	• This approach would include supporting communities and the community sector to build on or complement what already exists; avoid duplication and build community sector capacity.

4.1.7 The optimal model and the operational components

The optimal model incorporates the suite of operational components as these are considered important for effective, implementable and sustainable social prescribing services. However, the need for services to be flexible and tailored to the local context means that not all social prescribing services and initiatives will need or be able to incorporate all operational components.

Inclusion of the operational components in local services will be dependent, in some instances, on system-level policies, funding and/or service design and implementation. For example, promoting actively engaged referrers can be facilitated through PHN-led integration of social prescribing as an adjunct to primary care; through appropriate funding arrangements for general practice teams to undertake non-clinical needs screening and referral (e.g. MBS or future funding arrangements such as those suggested in *Strengthening Medicare*[109]; or the *General Practice Incentives Review*[112] Report) and by digitally enabled referrals.

The development and implementation of screening and assessment tools designed to identify patients' non-clinical needs will facilitate appropriate referrals to social prescribing services. Additionally, to provide for complex cases, the optimal model creates flexible pathways with built-in triage capacity to identify and respond to complex non-clinical needs. This includes the development of both non-specialist and specialist link worker roles to provide for appropriate levels of support.

Link workers would be central to social prescribing services co-commissioned by PHNs, with their roles and defined competencies developed as part of a national social prescribing workforce strategy. A National Centre would facilitate a community of practice, ensuring ongoing professional development, knowledge sharing and continuous learning by the workforce.

The optimal model also recognises the importance of a visible and appropriately supported network of community resources and assets. It recommends developing community resource and asset development guidelines and national infrastructure for local community resource information. This would ensure link workers have access to a comprehensive and up-to-date database of available community resources.

For quality and continuous improvement, the optimal model establishes clear feedback loops between social prescribing services and referrers. This process, led by PHNs, would be complemented by digital integration of referral pathways within existing general practice software, making communication between referrers and link workers seamless.

Finally, a robust system of monitoring and evaluation would be built into the optimal model. This includes establishing a National Minimum Data Set and a National Evaluation Framework. Data would be collected at the local service level, collated and analysed at the regional PHN level and then linked for a system-wide evaluation at the national level. The National Centre could manage this final stage, providing a comprehensive view of the national scheme's effectiveness.

4.1.8 Social prescribing ecosystem

Figure 4 (see next page) provides a high-level illustration of what the broader Australian social prescribing ecosystem might look like with implementation of the optimal model. It outlines the multidimensional, cross-sectoral system that is required for effective implementation of a national scheme, including the linkages between key system elements and stakeholders, at both the national coordination/service commissioning level, and at the individual social prescribing service level.

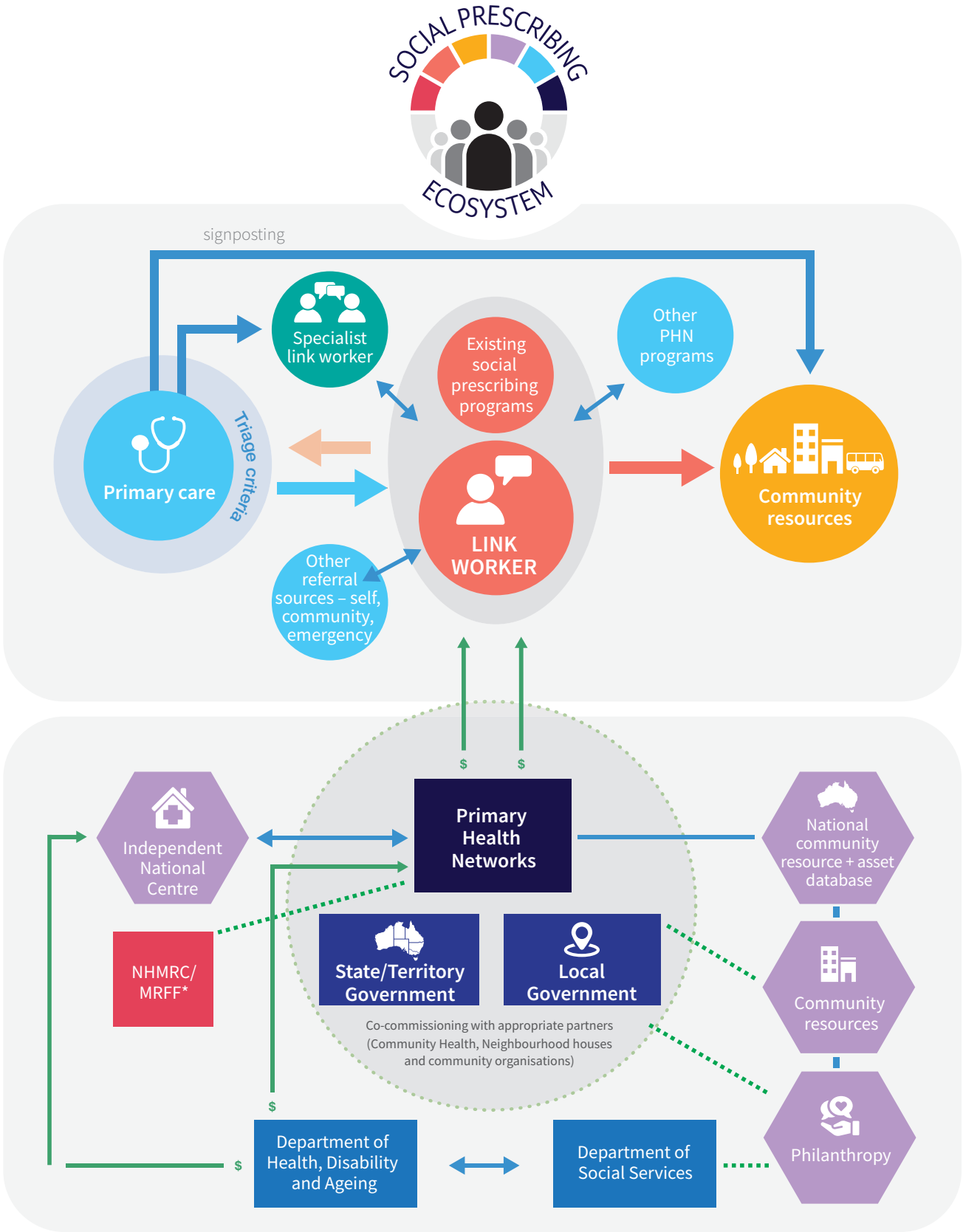


Figure 4: A social prescribing ecosystem map

4.1.9 Staged implementation

A national social prescribing scheme could be implemented in stages. This staged approach would consider existing resources, geographical locations and the capacity for scaling the model within available funding and other resource constraints.

Staged implementation should also account for organisational readiness to engage in social prescribing. For example, NHS England utilises a draft Social Prescribing Maturity Framework for Primary Care Networks (PCNs) and Integrated Care Systems (ICSs). This self-assessment tool helps organisations evaluate their capabilities across five key domains: leadership and governance; workforce; planning and commissioning, digital; and evidence and impact. It allows organisations to assess themselves against identified competencies crucial for successfully delivering social prescribing[226].

Consistent with the recommendation associated with the optimal model, all potential staged implementation options described below should recognise existing practice within ACCHSs, with appropriate funding based on need, informed by existing and ongoing work led by NACCHO.

4.1.9.1 First stage implementation

All staged implementation options should include establishment of a National Centre for Social Prescribing and development of implementation enablers and infrastructure, as detailed in section 4.1.4. Several approaches to staged implementation are outlined below.

Build on established initiatives

This approach would include an initial rollout with PHNs that already have established social prescribing initiatives. A small number of PHNs expressing interest could also be included.

This approach would facilitate the sharing of knowledge and expertise from PHNs with existing social prescribing initiatives and ACCHSs within their catchments, contributing to the ongoing development of commissioning guidelines.

Prioritise socioeconomically disadvantaged communities

Implementation of the optimal model could be focused on selected PHNs based on the overall levels of socioeconomic disadvantage in their communities or could specifically target the most disadvantaged areas within each PHN.

A report on social prescribing in England[227] found significant geographic inequalities in link worker availability. Populations with higher needs, particularly in more disadvantaged areas and areas with higher proportions of minority ethnic groups, reported receiving less support, with fewer full-time equivalent (FTE) link workers compared to less disadvantaged areas with equivalent population size[227]. The evidence from the England report underscores that targeting social prescribing programs to disadvantaged areas should be prioritised in a staged rollout.

Bi-lateral jurisdictional rollout

A developmental roll-out could occur in collaboration between the Australian Government with one or more state and territory jurisdictions and relevant PHNs.

A bi-lateral roll-out with one or more state or territory jurisdictions could prioritise communities with significant needs, as jointly identified by the participating government agencies and relevant PHNs.

Longer-term staged implementation

Alternatively, the optimal model could be viewed as a long-term strategy. This approach would involve implementation of other options (refer to section 4.2), starting with establishment of a National Centre and a grants program, followed by further expansion over time.

4.1.9.2 Second stage implementation

The second stage of implementation would involve a phased expansion to gradually include all PHNs. This would be reflective of the optimal model and would ensure equitable access to social prescribing for communities across Australia.

4.1.9.3 Potential expansion of the optimal model post-implementation

Further expansion options include:

- the ratio of link worker capacity to primary healthcare services and the wider community population could be scaled up over time;
- organisations pursuing a similar social prescription strategy outside direct primary care delivery could be linked to the model over time (e.g. referral programs from outpatient clinics, emergency departments, police and emergency services etc); and
- expanded eligibility for services (based on the first stage implementation program) to a wider range of communities and organisations (e.g. expand beyond PHNs).

Further scale-up beyond first stage implementation would be informed through demonstrated outcomes and evaluation.

4.2 Other implementation options

Implementation of a systematic national program for social prescribing as an adjunct to primary care will require a substantial investment by government and will establish an additional service component within health services. It will place a substantial demand on community services. It is likely that potential adoption of a national program will be dependent on economic and political influences and community expectations. Implementation of the optimal model may not be given consideration in the immediate future. This section outlines three other implementation options that could be established as standalone policy initiatives – or be used as 'stepping stones' towards gradual scale up to the optimal model over time.

Establishment of a National Centre for Social Prescribing (National Centre) is considered a fundamental component of all four implementation options presented in this report. Option 2 comprises the establishment of a National Centre as a standalone initiative, with no additional implementation components. Options 3 and 4 include establishing both a National Centre and a specific grants program for the limited implementation of social prescribing services across Australia. While options 3 and 4 are presented as distinctly separate options, a grants program could, in practice, combine elements of both.

4.2.1 **Option 2:** National Centre for Social Prescribing

This option proposes funding for establishment of an independent National Centre for Social Prescribing as a standalone initiative. A National Centre is considered an essential and basic support for existing and future social prescribing services in Australia. The potential establishment of a National Centre and its proposed functions are discussed in detail in section 4.1.2 above. In summary, those functions would include:

- curating research and shaping research priorities;
- support workforce development;
- designing and implementing an evaluation framework;
- fostering cross-sector collaboration;
- guiding the development of coordinated local community resource and activity directories;
- facilitating education, training and professional development; and
- monitoring innovations in the social prescribing landscape.

This option is consistent with several international examples. The proposed National Centre is conceptually like the functions performed by the Wales School for Social Prescribing Research (WSSPR). Funded by the Welsh Government through Health and Care Research Wales, WSSPR is led by the University of South Wales in collaboration with the Wales Council for Voluntary Action. WSSPR uses a translational research model to foster consensus and promote standardisation and consistency in social prescribing throughout Wales[33].
As part of the role, WSSPR has developed or is in the process of developing:

- a glossary of terms for shared understanding of social prescribing in Wales;
- a Competence Framework for Social Prescribing Practitioners (link workers and referrers);
- a National Framework for Social Prescribing;
- a skills and knowledge programme;
- national standards guidance for community resources and assets;
- core data guidance for evaluation; and
- an outcomes framework[33].

A National Centre could consider similar outputs depending on sector priorities and needs.

Funding considerations

Establishing and operating a National Centre for Social Prescribing will require sufficient funding for the National Centre to both support social prescribing initiatives across Australia and to work with both the health and community sectors within local communities where initiatives are established. This includes initial set-up costs and ongoing annual operating expenses, which would cover a core team of professional, project and administrative staff, along with their associated costs. This funding would enable the National Centre to collate and improve the evidence base, share best practice, develop training and accreditation and advance social prescribing through working with local communities and creating partnerships across sectors.

A standalone National Centre and the design principles

Alignment with design principles	
 WHOLE OF SYSTEM	• A National Centre would connect and support existing social prescribing programs and resource new initiatives. Without systematic investment in social prescribing through a national scheme, this will not, of itself, achieve universal and equitable provision of social prescribing within the health and social care systems.
 PERSON-CENTRED	• This would rely on individual programs to embed person-centred care as core to their service. The National Centre would promote and support services to be person-centred through activities and resources.
 TRUSTED PARTNERSHIP	• Without a broader ecosystem of social prescribing, partnerships rely on individual programs developing them through community connections and need. • At the individual level this would rely on individual programs to embed a focus on relationships as core to their service. • The National Centre would promote and support services to develop trusted partnerships through activities and resources.
 ACCESSIBILE & INCLUSIVE	• Without funding for establishing programs, the option could contribute to a 'postcode lottery' with social prescribing services developing in areas with significant community will and resources to sustain them. • Program inclusivity relies on the individual program definition of their target population. This is sometimes restricted by the funding source.
 CULTURALLY SAFE	• This would rely on individual programs to embed cultural safety as core to their service. • The National Centre would support services to ensure that community activities and resources being included in social prescriptions were culturally safe and appropriate.
 FLEXIBLE & LOCALLY TAILORED	• Individual programs would be creating locally based services that should suit the needs of their community. • The National Centre would promote and support services to be tailored to the local context through activities and resources.
 NO WRONG DOORS	• A lack of existing support services in Australia can make the 'no-wrong-doors' principle difficult to achieve. It is often what leads to social prescribing services becoming overwhelmed as they become the only available or visible pathway to primary care providers for people with complex needs.
 SUPPORTED COMMUNITIES	• The National Centre would work with established social prescribing services to further develop evidence of effective design, implementation and operation of social prescribing within primary healthcare services. • Community sector capacity would be variable and potentially inadequate without specific additional funding and support for community development

A standalone National Centre and the operational components

A National Centre for Social Prescribing would support social prescribing initiatives, whether established or potential, by assisting them to incorporate the operational components. The specific implementation of these operational components would, however, be determined by the design and capacity of existing or emerging programs.

Strengths and limitations

Strengths

Leadership and resources: the National Centre for Social Prescribing would offer leadership, research and resources to current and developing social prescribing services, workforce roles and community networks.

Advocacy: the National Centre could play a vital advocacy role, raising awareness of social prescribing's potential for implementation as an adjunct to primary healthcare and communities.

National coordination: It would foster coordination of implementation across Australia through the development of national principles, standards and outcomes measures.

International collaboration: the National Centre would be well-positioned to establish collaborative relationships and adapt from, or share resources with, similar centres in the UK, Canada and other relevant international bodies.

Limitations

Limited development: if implemented in isolation, a National Centre will not facilitate the systematic development of embedded social prescribing services as an adjunct to primary healthcare. Its scope would be confined to raising awareness, curating evidence, providing resources and support to established and emerging social prescribing services and engaging in relevant research.

Inconsistent service establishment: as this option is limited to information provision, resource curation, research support and assistance to services, the establishment of social prescribing services will be limited to existing initiatives and new initiatives started by individuals or organisations. This is unlikely to occur consistently across Australia.

Sustainability challenges: this option will not address funding constraints restricting the development and sustainability of social prescribing services and the community sector.

4.2.2 **Option 3:** Grants program for PHNs and/or community consortia to implement localised link worker services with a National Centre for Social Prescribing

This option proposes establishment of a grants program to support development of link worker services within communities, together with establishment of a National Centre for Social Prescribing. These localised services would include one or more link workers and could be established as new standalone initiatives, scaled-up existing services or link workers being embedded into local community organisations/settings.

A nationally coordinated, Australian Government-funded grants program for PHNs and/or community consortia would enable the development and implementation of these services.

Community consortia could include:

- community service providers and organisations (e.g. Neighbourhood Houses/Centres);
- primary and community healthcare services;
- local government; and
- LHNs.

Where PHNs are the service providers, this option would facilitate the integration of link worker services with existing connector programs, such as Aged Care Finders. Implementation of social prescribing should complement and not duplicate these parallel services.

Evidence suggests that social care and non-clinical needs are best addressed outside the traditional health system through engagement in the local community. As in the optimal model, services established under this option should be tailored to local community contexts and needs. This directly addresses concerns raised during the feasibility study consultations that funding or commissioning arrangements through regional bodies like PHNs could lead to services being spread too thinly across multiple communities, potentially disconnecting them from local communities and characteristics.

Regardless of the specific implementation approach, all proposals for link worker services should demonstrate comprehensive engagement of local communities in the design, implementation and governance of the proposed service. This should include engaging with all relevant local stakeholders from across the health, community and local government sectors, to ensure a service is tailored to the local context and community need.

A grants program for PHN/community-consortia-led link worker services should also require provision of both Tier 2 (non-specialist) and Tier 3 (specialist) link worker roles (refer to section 4.1.4.1). This would ensure that there are appropriate referral pathways for individuals with complex non-clinical needs being referred to the service and reduce the risk of the service being unable to meet local community demand.

Program design and eligibility criteria for funding of this option could require applicants to meet appropriate design principles and operational components, focusing on ‘what’ should be done, not ‘how’. This allows for national coordination while maintaining local flexibility, ensuring services are co-designed with and tailored to their specific communities.

Parallel establishment of a National Centre for Social Prescribing is considered essential. Depending on funding, the Centre would support the development of some national infrastructure, facilitating service consistency across Australia. It would foster partnerships and collaborations with and between stakeholders including ACCHSs.

This option could be implemented through either a staged or targeted approach, using an expression of interest process. Eligibility criteria for service providers could be based on levels of community disadvantage and risk factors for poor health and wellbeing.

Funding considerations

For a grants program for PHN or community consortia-led link worker services to be effective, funding would need to provide for:

1. Participation and establishment costs for community consortia.
2. Engagement and support for primary health providers to participate in social prescribing.
3. Services that are appropriate and adequate for community needs. This will require further work to determine the specific funding provisions required.
4. Development and maintenance of local community resources directory to support social prescriptions.
5. Integrated evaluation of the program.
6. Establishment and operational costs for a National Centre for Social Prescribing.

Funding for link worker services should be term-based, ideally with renewable 3 to 5-year agreements. This approach would ensure stable service development, fostering trust between referrers, the service and the community. Funding could also be weighted based on the disadvantage and specific needs of communities, accounting for both standard and specialist link workers.

The scale and eligibility considerations of any social prescribing grants program would be dictated by overall funding parameters. The grants program could be rolled out nationally, or a more targeted rollout could focus on communities with high levels of relative socioeconomic disadvantage. Implementation could also be scaled over time to gradually include more communities.

Grant funding for community consortia would need to be determined based on identified community catchments, population numbers and profiles. Further work would be required to establish a capacity measure for link workers. This is crucial to ensure sustainable workloads for link workers, effective collaboration with local general practices and community services, and to prevent referred individuals from being negatively impacted by waiting lists. This capacity assessment could be undertaken through a focused study of existing social prescribing programs implemented by PHNs or through an initial, limited implementation stage.

PHN/community consortia-led link worker services and the design principles

Alignment with design principles	
 WHOLE OF SYSTEM	• Parallel development of a National Centre could help bring together and support existing and new social prescribing programs. • The grants program could contribute to an inequitable distribution of services as it may not provide for a whole-of-system establishment of and support for services
 PERSON-CENTRED	• This would rely on individual programs to embed person-centred care as core to their service. This requirement should be built into grant guidelines. • The parallel development of a National Centre would promote and support services to be person-centred through activities and resources.
 TRUSTED PARTNERSHIP	• Trusted partnerships could be developed between PHNs and community consortia. • At the individual level this would rely on individual programs to embed a focus on relationships as core to their service. This requirement should be built into grant guidelines. • The parallel development of a National Centre would promote and support services to develop trusted partnerships through activities and resources.
 ACCESSIBILE & INCLUSIVE	• A grants program could contribute to a 'postcode lottery' with link worker services developing in areas with significant community will and resources to sustain them. • Program inclusivity relies on the individual program definition of their target population. The grants program should provide adequate funding for services to have capacity to be accessible and inclusive for all people.
 CULTURALLY SAFE	• This would rely on individual programs to embed cultural safety as core to their service. The grants program should provide adequate funding for services to have the capacity to be culturally safe for people accessing the services. • The parallel development of a National Centre would promote and support services to prioritise cultural safety through activities and resources.
 FLEXIBLE & LOCALLY TAILORED	• Individual programs would be creating locally based services that should suit the needs of their community. • The parallel development of a National Centre would promote and support services to be tailored to local context through activities and resources.
 NO WRONG DOORS	• A lack of existing support services in Australia can make the 'no-wrong-doors' principle difficult to achieve. It is often what leads to social prescribing services becoming overwhelmed as they become the only available or visible pathway to primary care providers for people with complex needs. • The grants program should encompass adequate funding for services to provide for 'no wrong doors' for people accessing the services.
 SUPPORTED COMMUNITIES	• Community sector capacity would be variable and potentially inadequate without specific additional funding and support for community development. • Parallel establishment of a National Centre would provide support to communities and the community sector by working with established and future social prescribing and link worker services to gather evidence on effective design, implementation and operation.

PHN/community consortia-led link worker services and the operational components

PHN/community consortia-led link worker services would develop networks of social prescribing stakeholders within their communities. The program's design and funding requirements should ensure these services incorporate relevant operational components.

Establishing a National Centre for Social Prescribing in conjunction with this option would significantly enhance the quality and consistency of both non-specialist and specialist link worker roles. However, this option does not provide additional capacity for general practice and does not directly support community development.

The development and implementation of link worker services across Australia could vary significantly based on the interest and capacity of PHNs and local communities. This variability could worsen existing inequities in healthcare access and benefits for some communities.

Strengths and limitations

Strengths

Provides referral pathways for primary care: Establishing community-based link worker services through PHNs and community consortia would offer primary care providers (GPs, primary care nurses, potentially others) referral pathways for patients with non-clinical needs affecting their health and wellbeing.

Promotes connected health and social care: By enabling link worker services to be initiated by community consortia, this option provides for services that are place-based and connected to individual communities, their cultures and unique characteristics.

This option also:

- Strengthens a key function of PHNs to integrate care and improve regional care systems, and leverages investments already made by some PHNs.
- Allows for targeted support to disadvantaged communities and support for the development of community-level initiatives.
- Complements or augments existing social prescribing initiatives.
- Provides scope for staged implementation and continuous improvement

Limitations

Risk of 'postcode lottery' and inequitable service provision: The capacity of communities to respond to an applications process for funding to establish link worker services could create a 'postcode lottery'. Communities with limited resources may be less likely to have capacity to do so. Provision of initial funding for proposal design and funding application for applicant communities would offset this.

No direct support for community resources and assets services: This option does not include direct support for community service capacity to respond to increased demand through referrals from link workers. Nor does it provide for establishment and maintenance of locally relevant directories of community resources.

No direct support for general practice and primary care: This option does not actively support general practice participation (e.g. through remuneration) in identifying and referring patients to the available service.

4.2.3 **Option 4**: Grants program for general practices and other health service providers to embed link workers within existing primary care settings with a National Centre for Social Prescribing

This option proposes establishment of a grants program for general practices and other primary healthcare providers, including nurse-led clinics, urgent care and mental health clinics and community pharmacies, to integrate social prescribing into their practices. These healthcare settings are frequently accessed by individuals most likely to benefit from social prescriptions. There is opportunity in the clinical workflows and service models of these services, through health assessments, routine consultations and home-based services, such as home medication reviews, to identify these patients.

Implementation of this approach would require comprehensive funding. This grants program would offer initial support to eligible primary healthcare organisations to establish and sustain social prescribing link workers within their practices. Existing social prescribing services that met the eligibility criteria for new services should be considered for inclusion in this grants program.

The funding would specifically support establishment of link worker capacity within each practice or service. Development or adoption of user-friendly non-clinical needs-assessment/screening tools would be required. These tools should seamlessly integrate with existing practice management systems, to ensure referrals are efficient and easy to initiate.

Parallel establishment of a National Centre for Social Prescribing would support the development of some national infrastructure, depending on funding, contributing to service consistency across Australia. It would foster partnerships and collaborations with and between stakeholders including ACCHSs.

Funding considerations

This option would require sufficient grant funding to provide for:

1. Eligible general practices and other primary health services to establish and maintain link worker capacity.
2. Physical infrastructure to host link workers within general practice and other primary health service settings.
3. Development and maintenance of local community resource directories to support social prescriptions.
4. Integrated evaluation of the program.
5. Establishment and operational costs for a National Centre for Social Prescribing.

Funding for link workers within general practice and other primary care services should be term-based, ideally with renewable 3 to 5-year service agreements. This approach would ensure stability of service development, fostering trust between referrers, the service and the community. Funding could also be weighted based on the level of relative disadvantage and specific needs of communities.

The scale and eligibility considerations of any social prescribing grants program would be dictated by overall funding parameters. The grants program could be rolled out nationally, or a more targeted rollout could focus on communities with high levels of relative socioeconomic disadvantage. Implementation could also be scaled over time to gradually include more communities.

Embedded link workers in primary care settings and the design principles

Alignment with design principles	
 WHOLE OF SYSTEM	• Parallel development of a National Centre could help bring together and support existing and new social prescribing programs. • The grants program could contribute to an inequitable distribution of services as it may not provide for a whole-of-system establishment of and support for services.
 PERSON-CENTRED	• This would rely on individual programs to embed person-centred care as core to their service. This requirement should be built into grant guidelines. • The parallel development of a National Centre would promote and support services to be person-centred through activities and resources.
 TRUSTED PARTNERSHIP	• At the individual level this would rely on individual programs to embed a focus on relationships as core to their service. This requirement should be built into grant guidelines. • The parallel development of a National Centre would promote and support services to develop trusted partnerships through activities and resources
 ACCESSIBILE & INCLUSIVE	• General practices and other primary healthcare services will have variable capacity, depending on their scale and resources, to participate in a grants application process, potentially leading to inequitable development of link worker capacity across Australia. Provision of initial funding for proposal design and funding application for practices and services would offset this. • Program inclusivity relies on the individual program definition of its target population. The grants program should provide adequate funding for services to have capacity to be accessible and inclusive for all people.
 CULTURALLY SAFE	• This would rely on individual programs to embed cultural safety as core to their service. The grants program should provide adequate funding for services to have the capacity to be culturally safe for people accessing the services. • The parallel development of a National Centre would promote and support services to prioritise cultural safety through activities and resources.
 FLEXIBLE & LOCALLY TAILORED	• The parallel development of a National Centre would promote and support services to be tailored to local context through activities and resources.
 NO WRONG DOORS	• A lack of existing support services in Australia can make the 'no-wrong-doors' principle difficult to achieve. It is often what leads to social prescribing services becoming overwhelmed as they become the only available or visible pathway to primary care providers for people with complex needs. • The grants program should provide adequate funding for practices to provide for 'no wrong doors' for people accessing the services.
 SUPPORTED COMMUNITIES	• Community sector capacity would be variable and potentially inadequate without specific additional funding and support for community development. • Parallel establishment of a National Centre would provide support to communities and the community sector by working with established and future social prescribing programs to gather evidence on effective design, implementation and operation.

Embedded link workers in primary care settings and the operational components

Link workers placed within general practice and other primary care settings would establish social prescribing networks in their communities. The program's design and funding requirements should ensure these services incorporate relevant operational components.

This approach would primarily develop standard (i.e. non-specialist) link worker roles. Without provision for a specialist link worker role within this program, this could potentially limit options for individuals with complex non-clinical needs.

Establishing a National Centre for Social Prescribing in parallel to this grants program would significantly enhance the quality and consistency of the link worker role. However, this option does not directly boost the capacity for general practice, though this could be addressed through specific program design or additional funds for practice development. Additionally, this option does not directly support community sector development nor does it address the potential increased demand on community services.

The development and implementation of social prescribing link workers in primary care settings could vary widely across Australia, reflecting the differing interest and capacity of individual general practices and other primary healthcare services. This variability risks worsening existing inequities in healthcare access and benefits for some communities.

Strengths and limitations

Strengths

Direct integration: This option directly integrates social prescribing as an embedded component of general practice and other primary healthcare services. Primary healthcare settings are particularly relevant for reaching individuals most likely to benefit from social prescribing.

Embeds capacity to address non-clinical needs in primary care: Link workers embedded in primary care settings create capacity to address non-clinical needs through connections to community supports, mirroring practices within ACCHSs and aligning with recommendations from the *Review of General Practice Incentives*[112].

This option also complements or augments existing social prescribing initiatives.

Limitations

Risk of 'postcode lottery' and inequitable service provision: There is likely to be variable uptake and inequitable service delivery as this option relies on engagement by general practices and primary healthcare services in an optional grants program. Organisational capacity and workforce distribution may also affect uptake.

Link worker capacity: Link workers embedded in primary healthcare settings will require capacity to establish direct connections with community organisations and services to enable referrals. As this option does not provide for specialist link worker support, there is a risk that link worker capacity will be overwhelmed by individuals with complex needs.

No direct support for community resources and services: This option does not include direct support for community service capacity to respond to increased demand through referrals from link workers.

Administrative burden: Funding and accountability requirements would need to consider the administrative burden on service providers, both in general practices and other primary healthcare settings.

5
Conclusion

5. Conclusion

This report has presented the outcomes of a feasibility study commissioned by the Australian Government Department of Health and Aged Care (now the Department of Health, Disability and Ageing) on the potential to implement social prescribing as an adjunct to Australian primary healthcare. It draws together the best available Australian and international evidence, along with the findings from an extensive national program of stakeholder consultations.

The commissioning of this feasibility study illustrates the growing recognition of non-clinical factors is important determinants of health wellbeing, and the potential role for social prescribing in addressing these factors. A national social prescribing program would improve health and wellbeing across Australia, particularly for communities and individuals with limited resources and social supports.

The advancement of social prescribing in Australia to date is a direct outcome of the sustained efforts and innovation of the Australian social prescribing sector. While efforts to date are commendable, it is evident that further advancement will require ongoing leadership, collaboration and advocacy by social prescribing advocates and key stakeholders.

Following submission of the initial government-commissioned feasibility study report to the then Department of Health and Aged Care in 2024, this public report has been developed as a resource for the Australian social prescribing sector, and health and community sectors more broadly.

Of the four implementation options presented in this report, the optimal model would best enable comprehensive, systematic and equitable implementation of social prescribing across Australia. The optimal model proposes a national social prescribing program with the following elements:

National Social Prescribing Framework	PHN-led co-commissioning of localised social prescribing services	National Centre for Social Prescribing	Implementation enablers and national infrastructure

The three other options are not as comprehensive as the optimal model and allow for implementation at different levels of scale and impact. All three would nevertheless advance social prescribing in Australia and each could be considered a ‘stepping stone’ towards implementation of the optimal model.

The three alternative options are to:

- Establish a National Centre for Social Prescribing as a standalone initiative.
- Establish a grants program for PHNs and/or community consortia to implement localised link worker services, and a National Centre for Social Prescribing.
- Establish a grants program for general practices and other health service providers to embed link workers within existing primary care settings, and a National Centre for Social Prescribing.

Whilst this report outlines the potential for a federally coordinated and funded national social prescribing scheme to enable the implementation of mostly new localised social prescribing services, it also provides a resource to existing services, current and future funders and other stakeholders to inform and strengthen future initiatives. It is grounded in what is feasible, starting with primary care today, and recognises that longer-term coordination of health and social care services and supports are both achievable and essential for a truly integrated system.

6
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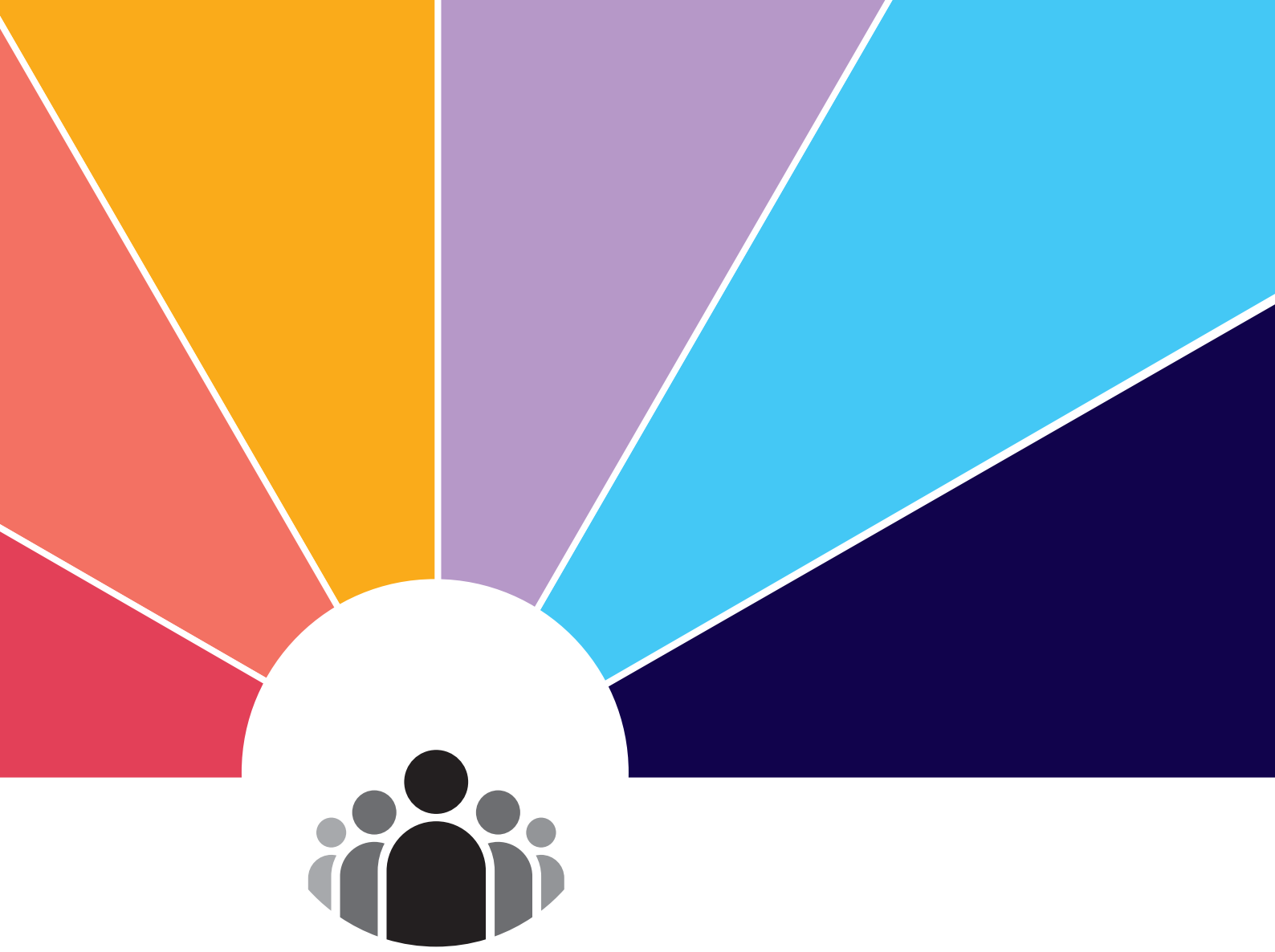

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