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Royal Australian College *of* General Practitioners

CHF Consumers Health Forum OF Australia

Social Prescribing Roundtable November 2019

Report

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Social Prescribing Roundtable, November 2019: Report

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We acknowledge the Traditional Custodians of the lands and seas on which we work and live, and pay our respects to Elders, past, present and future.

Event hosts and partner

RACGP

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Health System Sustainability
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Acknowledgements

We acknowledge the lands of the First Peoples upon which this report was written and pay our respects to Elders, past, present and future.

The roundtable was co-hosted by the Consumers Health Forum of Australia and The Royal Australian College of General Practitioners (RACGP) in partnership with the NHMRC Partnership Centre for Health System Sustainability. The hosts would like to acknowledge the support of the Australian Government Department of Health, the National Mental Health Commission and Capital Health Network, who provided funding to support the running of the roundtable and report production.

The roundtable and subsequent report are independent of this funding, and co-authored by the Consumers Health Forum of Australia, the RACGP and the NHMRC Partnership Centre for Health System Sustainability. The views and recommendations in this report represent the outcome of the group discussion and not any particular individual, organisation or government. (Some participants may have official positions that differ from that presented in this report.)

The hosts would like to thank Mr Andrew Hollo from Workwell Consulting for his assistance facilitating the roundtable and compiling the report.

Foreword

Several countries are implementing policies to integrate care for health and social services, recognising that siloed health and community and volunteer-run services and activities are inadequate to meet the increasingly complex health and social needs of patients.[1]

This report outlines the arguments for a strategic and systematic approach to incorporating social prescribing into the Australian healthcare system, starting in primary care. Social prescribing is 'a means of enabling GPs [general practitioners], nurses and other primary care professionals to refer people to a range of local, non-clinical services'.[2] Social prescribing could provide a valuable addition to the existing range of healthcare options in Australia. However, to date, the adoption of social prescribing as an organised program of support has been limited.

It is well known that socioeconomic factors in people's lives can affect their health and wellbeing and can often be the reason people reach out to healthcare services. Social prescribing can address key risk factors for poor health, including social isolation, unstable housing, multimorbidity and mental health problems. These factors are associated with low engagement in preventive activities and low levels of self-management for medical conditions.

The extent to which doctors assist patients to address socioeconomic factors linked to ill-health is variable. Seventy-four per cent of physicians in Germany and 65% in the UK said they frequently coordinated patients with social services or other community providers. In contrast, approximately 40% of physicians in Australia, the USA and Canada reported the same.[1]

Further estimates suggest that approximately 20% of patients consult their GP for what are primarily social problems.[3] These problems are not best addressed through a clinical or pharmaceutical response; however, these interactions present an opportunity to improve health outcomes if we recognise the breadth of factors that affect a person's health and wellbeing.

Characteristics of a person's physical and social environment can either facilitate or hinder their engagement with, and management of, their health and care.[4]

By recognising the trusted relationship between the patient and their health professional and taking the opportunity to address the socioeconomic determinants as part of these interactions, primary health services can facilitate engagement with community services to help address the underlying causes of poor health. The flow-on effect is a reduced reliance on health services, improved health outcomes and better value care.

The recommendations in this report have been synthesised and derived from expert discussions and reflect our shared desire to see a shift from a focus on illness to wellness in the health system.

The roundtable identified that social prescribing exists to break down silos within around medical and community services, to get closer to the root cause of the problem and therefore increase the sustained impact of treatment, or in some cases avert the need for treatment. The approach should be based on what matters to the consumer and should address non-health issues, including the social determinants of health, by providing a more holistic approach to care.

The benefits of social prescribing are wide-ranging and include health, economic, social and productivity gains, with the ultimate benefit being improved health and wellbeing for individuals and communities. Participants at the roundtable identified the potential for social prescribing to facilitate a more engaged, empowered, strengths-based approach and build capacity for people to meet their own needs.

The Australian Government is currently developing long-term plans for both primary healthcare and preventive health. This presents an opportunity to incorporate social prescribing into future health system planning and service delivery strategies. We believe doing so would help deliver more consumer-centred, integrated health and social care, while saving on health costs in the long term.

A systematic, nationally scaled and locally implemented approach to social prescribing in Australia could lead to:

- improved prevention and management of physical and mental illness
- a shift in the focus from illness to wellness
- increased consumer enablement and self-management
- a more comprehensive approach to service delivery
- decreased demand for health services
- greater value care, and greater access to care and support
- reduced siloing of health and community services
- increased wellness and decreased helplessness for both providers and patients
- decreased social isolation and loneliness
- stronger communities.

This report takes the first step in imagining social prescribing as a normal part of health and community care in Australia. We foresee a future where social prescribing supports better connections between our systems of care and better connections between people in our communities. We hope you find this report stimulating and informative.

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About this report

On 25 November 2019, the Consumers Health Forum of Australia (CHF) and The Royal Australian College of General Practitioners (RACGP) co-hosted a roundtable on social prescribing, with input from the NHMRC Partnership Centre for Health System Sustainability as the academic partner. The Social Prescribing Roundtable is part of the Consumers Shaping Health roundtable series led by CHF and will contribute ideas to the development of Australia's Long Term National Health Plan, including specific strategies on primary care and prevention that are currently under development.

Participants included people from across the health and community sectors who have been engaged in the ongoing conversations about integrated care and the need to address the social determinants of health, as well as those who have started to introduce and trial social prescribing approaches in their local communities. They included consumer advocates, clinicians, health and social care providers, academics, health economists, government and policy experts from across Australia.

The purpose of the roundtable was to harness the emerging interest in social prescribing as an approach to improving patient care outcomes, overall efficiency of delivering population level care, patient satisfaction and experience, and provider satisfaction. We formulated independent recommendations on the merits of social prescribing and how it could be supported in a more systematic way in Australia.

Participants considered the following questions:

1. ***Does social prescribing present an opportunity to improve health outcomes and increase consumer participation and engagement?***
2. ***What are the key aspects of the model that will enable social prescribing to be an effective tool to improve health outcomes?***
3. ***Is there an appetite to build systems in Australia to increase social prescribing?***
4. ***If so, how could system changes to promote social prescribing be evaluated to determine their value and contribute to a growing evidence base?***

Participants also discussed the appropriateness of the term 'social prescribing' and its varying potential applicability to different types of health professionals and healthcare settings in Australia. For the purposes of this report we will retain the term 'social prescribing', which is widely used and accepted overseas, as our work is informed by international social prescribing programs.

The roundtable considered how social prescribing could initially fit within a primary healthcare setting, though we recognise the potential for it to integrate with other parts of the health system. By 'primary healthcare', we mean those services that are usually the first point of contact in the health system, such as general practice, pharmacy, allied health, nursing, Aboriginal and Torres Strait Islander health services and a broad range of community health services. Social prescribing is about integrating the clinical aspects of primary care with the broad range of social, economic and environmental factors that affect the health and wellbeing of individuals who have specific health and social care needs.

Our approach

As the health profile of Australia's population changes and we continue to see rising rates of chronic disease, mental illness, social isolation and loneliness, we need to find new ways to support good health outcomes and ensure the sustainability of the health system. We know that social determinants such as access to safe and affordable housing, education, employment and community connectedness have a significant influence on health. Therefore, linkage with programs and services outside the health system has the potential to improve health outcomes.

We know that the attributes of high-performing primary care systems include patient enablement and a patient–team partnership, including recognising the expertise that patients, their families and carers bring to the encounter. In a high-performing primary care system, patients are not told what to do but instead are engaged in shared decision making that respects their personal goals.[5]

We also know that when patients are equipped and supported to be partners in care, better health outcomes are generally delivered. Health outcomes and quality of life can be improved for people by providing care coordination and self-management support in the community, including through information and supported access to community services.[4] This aligns closely with Standard 2: Partnering with Consumers under the *National safety and quality health service standards*, which recognises the importance of involving patients in their own care and providing clear communication to patients.[6]

This approach sits alongside an understanding that healthcare and medicine should be concerned with the broader world of the patient and that there is value in directing clinical attention to all domains of life. This is known as the 'bio-psychosocial model of healthcare' and stems from the idea that the boundaries between wellness and sickness are affected by a range of considerations, including cultural, social, psychological and environmental.[7] Both these concepts – patient enablement and the bio-psychosocial model of health – support the inclusion of social prescribing as a key feature in comprehensive primary healthcare.

In advance of the roundtable, CHF, RACGP and our colleagues at Allied Health Professionals Australia (AHPA) undertook three surveys asking consumers, GPs and allied health professionals about their views on social prescribing and how connections between health and community services could be facilitated. To our knowledge, this is the first time such data has been collected in Australia. Although the samples were not nationally representative, the results indicate the level of interest and support for social prescribing in the community.

A summary of the results presented at the roundtable is outlined in **Appendix A**. Overall there was strong agreement that referring people to community activities, groups or services can help improve health outcomes, and many GPs and allied health professionals said they sometimes or often made such referrals. However, the majority of consumers said they rarely or never discussed participating in social and community activities with their primary care provider, suggesting there is an opportunity to facilitate these linkages to better support the practice of social prescribing.

The roundtable heard from Mr James Sanderson, Director of Personalised Care at NHS England, on how social prescribing has emerged and grown in the UK. He highlighted that social prescribing is not about throwing out the medical model, but instead is about giving people choice and control over the way their care is delivered based on what matters to them as part of a holistic care plan. A key attribute from the UK is the strong commitment to, and investment in, social prescribing, with link workers seen as key enablers to support individuals with psychosocial solutions. The presentation highlighted that for some consumers there is a need to go beyond signposting or

simply providing information about local options. Consumers with complex needs may need additional facilitation to start participating in community activities. Therefore, in order to be patient sensitive and responsive to need, social prescribing should enable flexible models of support. Implementation has involved co-producing models through a collaborative process with consumers and a wide range of health professionals and community workers.

Having considered the experience in the UK, a key discussion point for the roundtable was the question of who social prescribing was for. Attendees at the roundtable considered the specific needs of different consumer cohorts, why a given cohort would be well suited to this approach and how a program could be structured to best support cohort individuals. Consumer cohorts considered in this exercise were:

- people experiencing mental health issues
- people with chronic physical conditions and multimorbidity
- people experiencing social isolation, including young people
- children in the first 1000 days of life
- older people.

Participants also considered how social prescribing could benefit carers and family members of these consumers. The above list is not exhaustive, and we recognise the potential for social prescribing to improve the health and wellbeing of many different types of consumers, with any trial or program needing to be designed in a way that reflects the needs and characteristics of the local community.

Following a session looking at the experiences of implementing social prescribing informed by the experiences of service providers who are currently delivering pilots in Victoria and Queensland, participants considered the essential elements of a social prescribing program, from the identification of consumers through to referral and evaluation.

The roundtable concluded with participants identifying key recommendations for the following audiences to support the delivery of social prescribing in Australia:

- policymakers and system managers
- funders and commissioners
- service deliverers
- academics and research organisations.

Who is social prescribing for?

People experiencing mental health issues

Why are mental health consumers well suited to a social prescribing approach?	• Often experience difficulty being part of the community due to stigma, isolation and marginalisation • Have a life expectancy gap with the general population due overwhelmingly to preventable physical conditions and often face adverse life experiences • Typically have low levels of activation leading to lower levels of social engagement • Often find their experiences and issues can be over-medicalised • Are more likely to have a better sense of identity beyond their illness or condition when connected with peers and community activities • Benefit from a recovery approach that supports people to live a full and contributing life
What are the specific needs of mental health consumers that are addressed by social prescribing?	• The right level of support provided in an early intervention paradigm is needed to facilitate engagement – social prescribing creates soft entry points to care • Programs need to be tailored and respond to the person's level of need, and recognise that needs will change across the recovery journey • Specific programs are often required to target and reach out to men as they are less likely to be engaged • Data show loneliness and mental distress is experienced across the life course, so different programs are needed for different age groups • An inclusive approach to programs and services is essential, as stigma is a barrier to participation • Many community-based services exist already but need to be integrated into existing services to make navigation simpler • Physical health needs are often ignored or are not managed well enough or early enough • Self-referrals and referrals from medical professionals are equally desirable • Programs should be consumer- and carer-focused, give a sense of purpose, and enable the person to contribute and feel a sense of belonging

People with chronic physical health conditions and multimorbidity

Why are people with chronic physical health conditions and multimorbidity well suited to a social prescribing approach?	• Are more likely to be socially isolated, particularly those with multiple conditions and other barriers to care such as lack of transport • Often have difficulty navigating the health and social care systems due to service siloing • Often have conditions that are highly medicalised – for some, overdiagnosis and overtreatment can be a common experience and risk • Can experience financial constraints due to high medical costs • Could broaden their sense of identity beyond their illness or condition and increase their self-care through engagement with peers and community activities
What are the specific needs of people with chronic physical health conditions and multimorbidity that are addressed by social prescribing?	• Early recognition and integration of community service access can see greater improvement and may decrease the need for medical intervention • Reframing the focus away from the disease or condition and onto the person and their holistic needs helps to improve experiences and quality of life • Positive framing helps people see their potential rather than their limitations • Recognise the needs of families and carers and support participation in a way that eases the burden on them • Provide help with service and system navigation and access • Provide varying levels of support and follow-up to respond to the level of need • Supports should be locally based to make access as easy as possible

People experiencing social isolation

Why are people experiencing social isolation well suited to a social prescribing approach?

- Require better connection with the community in a tailored and supported way
- Require better connection with programs in order to reduce isolation
- Often require a non-clinical response (when not a clinical condition)
- Are vulnerable because social isolation is associated with poor health

What are the specific needs of people experiencing social isolation that are addressed by social prescribing?

- This group covers a wide range of people from different age groups; therefore, approaches must reflect the varying needs of different cohorts
- Make use of the many touch points where people already have interactions (eg pharmacies)
- Facilitate engagement rather than simply suggesting or signposting to a program – likely to feel anxious about engaging without support
- Frame engagement as volunteering or joining a group rather than seeking help
- A wide range of activities is needed to reflect the range of causes of social isolation – bereavement, caring for others, poverty, sociocultural and geographical displacement (eg refugees and new immigrants), unstable housing, mental health issues, unemployment, age, transitioning through life stages (eg adolescence, having young children, retirement, old age)
- Messages around isolation should be co-designed as some people have low awareness of their own isolation
- Build on existing mechanisms (eg Neighbour Day – last Sunday in March; 2020 theme is social connection)

Children in the first 1000 days of life

Why are children in the first 1000 days of life well suited to a social prescribing approach?

- Can experience long-lasting impacts and reduce issues later in life (for the child and parents/carers)
- Can benefit from routine screening of families in relation to social determinants of health and referral to social services can improve paediatric outcomes
- Are at an age when it is important for parents to help shape thinking, change behaviours and build health literacy
- Present many opportunities for communication with families and carers
- Are at an age when a strong foundation may be established to support families through a pathway that is more enabling and less stigmatising for people who otherwise might not access services

What are the specific needs of children in the first 1000 days of life that are addressed by social prescribing?

- Provide pathways for social connection for parents/carers and families who will otherwise be isolated
- Include education, training and handover into programs to support continuation of behaviours outside the supported environment
- Ensure no disadvantage – must have a strong equity focus
- Adopt programs that address specific behaviour changes (eg in relation to smoking, nutrition, physical activity, low birth weight, parenting, attachment, child development)
- Identify and respond to potential mental health issues early, including postnatal depression
- Identify and respond to domestic and family violence issues
- Address support for housing – a common need

Older people

Why are older people well suited to a social prescribing approach?

- Often experience loneliness at this time of life, which is associated with the loss of social connections
- Often undergo significant life events (eg retirement, death of a loved one, change in lifestyle, loss of independence) that impact on health
- May experience increasing complexity and severity of chronic conditions – need for coordinated and holistic support
- Are often adjusting to changing family dynamics and new caring responsibilities

What are the specific needs of older people that are addressed by social prescribing

- Older people need support to adjust to life transitions more easily with information and/or services
- Burden on carers may be reduced via respite, self-care and social inclusion
- More external connections mean increased awareness of elder abuse and potential for it to be identified
- Transport solutions are needed to facilitate engagement in community activities/services
- Older people need assistance to address lower health and digital literacy
- It is important to provide advice as required on income, housing, transition into aged care
- Service providers should be aware of and respond to an older person's loss of identity and meaningful engagement
- Older people require services that are safe and age appropriate (eg addressing exercise, falls prevention)
- They also require services to retain or improve independence, and adjustment support when losing independence

Essential elements for delivery

Social prescribing is already happening in Australia, with small pockets of innovation and a small number of trials underway across the country. Many health practitioners already incorporate social prescribing into their daily practice, but it is not supported or recognised by the funding mechanisms and structures in the health system.

Some examples of professionals who facilitate social connections and link people to services as part of their current roles include primary care nurses, occupational therapists and National Disability Insurance Scheme (NDIS) community support workers, as just a few examples. We recognise the dedication and expertise of these people and seek to build on the work that is currently happening in a way that is informed by consumers' and health professionals' lived experience.

We'd particularly like to thank and acknowledge the following presenters who shared their experiences of implementing social prescribing in Australia at the roundtable:

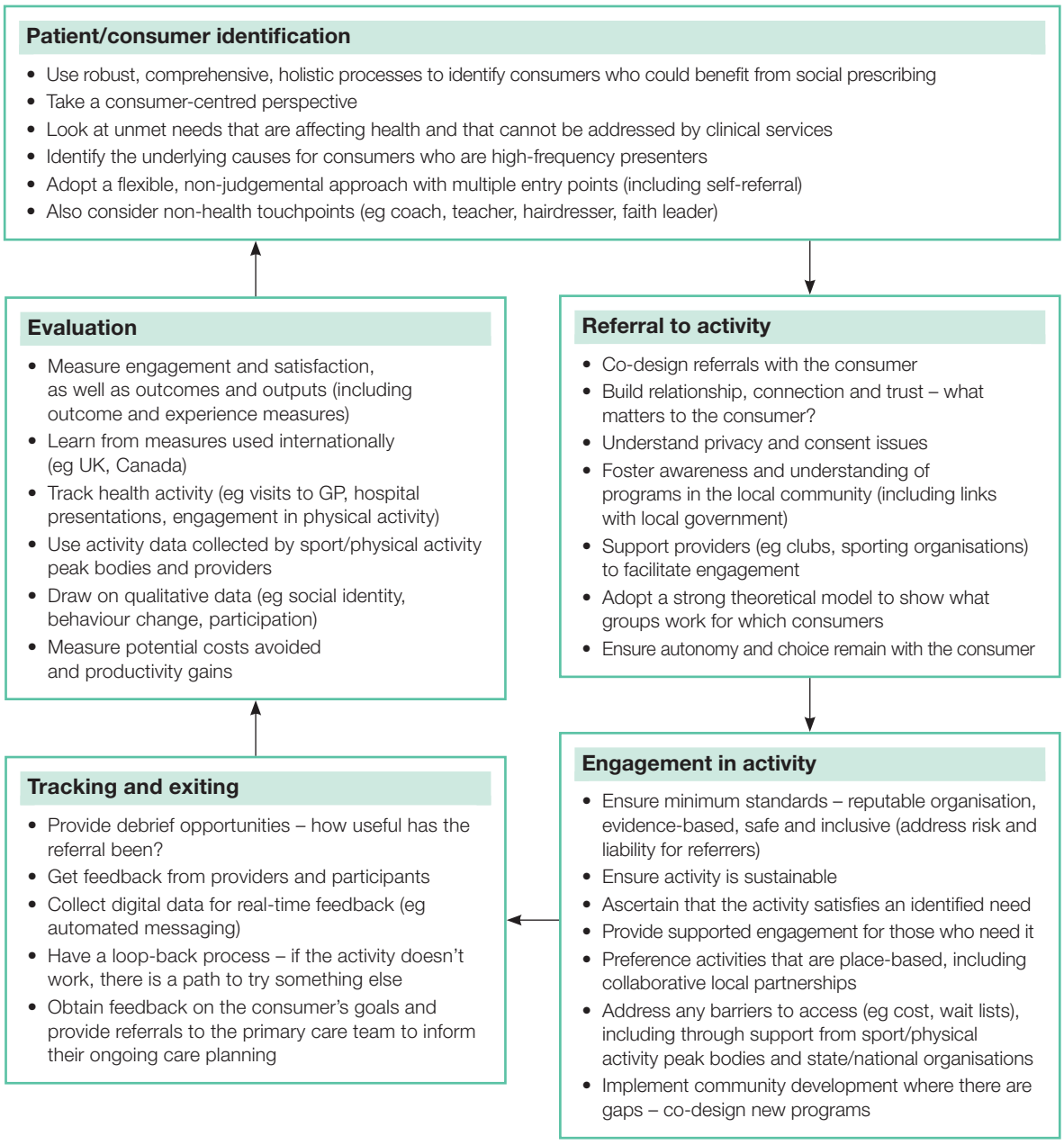
- Tracey Johnson, CEO, Inala Primary Care – 'Bridging the health and social care divide'
- Assoc Prof Genevieve Dingle, University of Queensland – 'Mt Gravatt Ways to Wellness Scheme'
- Jayne Nelson, CEO, IPC Health – 'Social prescribing in Melbourne's west'

More details about each of these initiatives is provided in the slides presented at the roundtable. A copy of these slides will be made available alongside this report.

Informed by these examples, participants identified the following essential elements for each aspect of the social prescribing pathway (Figure 1). These elements can be used to inform the development of new social prescribing schemes and support the rollout of more pilots and programs.

Implementation realities panel discussion at the Social Prescribing Roundtable: (left to right) Associate Professor Genevieve Dingle, Tracey Johnson, Catherine Cotching, Jayne Nelson, Bianca Bell

Figure 1. Essential elements of the social prescribing pathway



Recommendations

Having articulated the merits of social prescribing and the key aspects for delivery, we now turn to the recommendations identified at the roundtable that will support wide adoption and rollout of social prescribing schemes across Australia.

Recommendations for policymakers and system managers

1. Incorporate social prescribing into the Australian Government's primary healthcare and preventive health strategies, including recognition of the need for funding and implementation support to ensure a more responsive and comprehensive patient-focused health system.
2. Governments to fund and implement a Health in All Policies approach and consider adopting a wellness budget to deliver an integrated approach to social prescribing and ensure all government policies support health and wellbeing.
3. Invest in the workforce to undertake the 'link worker' role, recognising the areas where these skills already exist and building on this expertise to develop training and qualifications as needed. Ongoing funding is required for these positions to be sustainable in health services.

   To inform this work, undertake an analysis of which professions are best placed to fulfil the link worker role in Australia, adjusting for different levels of complexity.
4. Governments to work with local councils, national and state/territory peak organisations to identify community services and groups that could contribute to a social prescribing scheme. Through this network, coordinate engagement and ensure providers have the resources and capacity to deliver services or activities in a way that is sustainable and reflects the unique and diverse needs of each community.
5. Review and update existing policies and programs to support an evidence-based approach that recognises social prescribing, including updating national guidelines for nutrition and physical activity, and health and allied health workforce professional development materials.

Recommendations for health system funders and commissioners

1. Develop a mechanism to enable bundled payment arrangements between commissioners across the health and community sectors to support establishing link worker positions based in local health services.
2. Primary Health Networks (PHNs) to collaborate with local governments, Aboriginal Community Controlled Health Organisations, Councils of Social Services and local neighbourhood centres to expand and enrich the listings on the My Community Directory resource and advocate for its use as a resource for healthcare providers.
3. PHNs to expand HealthPathways to include a social prescribing pathway.
4. Federal, state and territory health funders to enable hospitals to cash out their weighted activity units for funding to deliver a social prescribing program.
5. Governments to pool funding to support the development and implementation of social prescribing pilots across the country on a scale large enough to test the concept and build the evidence base in the Australian context.

Recommendations for service deliverers

1. Clinical terminologies be implemented, and electronic medical records adapted to enable the capture of social prescribing activity.
2. Medical indemnifiers and professional bodies to promulgate supportive cultures and messaging, recognising that social prescribing reduces rather than increases exposure to litigation.
3. Universities and training providers to include social prescribing in their curricula for health professionals and community support workers in training, and include it in ongoing professional development programs.

Recommendations for academics and research organisations

1. Researchers to engage in the design of social prescribing pilots from the outset to ensure appropriate measures (including patient-reported outcome measures [PROMs] and patient-reported experience measures [PREMs], and evidence-based physical and mental health outcomes) are collected, and that there is a consistent methodology to build a critical mass of evidence.
2. Researchers to work with local councils and PHNs to undertake local-level reviews of community and government services to map what services are available, where gaps exist and what the different needs are across different communities.
3. Researchers to develop evidence-based screening tools and evaluation frameworks to be applied to social prescribing pilots and programs.

Conclusions

The roundtable concluded that:

1. Social prescribing does provide an opportunity to improve health outcomes and increase consumer participation and engagement.
2. The key aspects of a social prescribing model include building trust and relationships, co-designing solutions, having flexibility and place-based approaches, and having strong evaluation frameworks to demonstrate value (refer to Figure 1 for all the essential elements of the social prescribing pathway).
3. There is an appetite to build systems in Australia to increase social prescribing.
4. The recommendations outline a range of approaches to support system changes and promote social prescribing in Australia (including research and evaluation to contribute to the evidence base).

Where to next?

We have long known that our health is greatly impacted by a range of social factors, including access to safe and affordable housing, education, employment and community connectedness, and that by addressing these underlying social issues we can improve health outcomes. Social prescribing takes a holistic approach to healthcare by providing a mechanism to address these social determinants of health. This is particularly important today as we see rising rates of chronic illness, mental health problems, social isolation and loneliness, many of which cannot be treated effectively with a medical approach alone.

At the same time, health expenditure data shows that healthcare has increasingly shifted to expensive inpatient settings.[8] As our population ages and we see rising rates of overweight, obesity[9,10] and chronic disease, the demand for acute services will only increase if we continue on this same trajectory. We therefore need to find different, more effective ways to keep people out of acute health settings in order for our health system to remain sustainable.

Social prescribing can help shift focus back towards prevention and early intervention by integrating primary healthcare with appropriate social and community supports. It is also a way of reducing rising demand pressures on primary care by diverting some work away from clinicians to other members of the care team, leading to improved access and affordability within primary care. While some social prescribing already occurs in Australia, more resourcing and recognition is needed to implement social prescribing in a sustainable way.

The outcomes of the Social Prescribing Roundtable provide a platform to develop a more systematised approach to designing, funding and implementing social prescribing programs across Australia. We have international and local examples to learn and build from, and the opportunity to incorporate social prescribing into our long-term health system planning.

This report outlines the merits of social prescribing, the cohorts who would benefit from it, the key features of the model and a comprehensive set of recommendations to see social prescribing adopted and supported in Australia. The report recommendations can be distilled into the following 10 key elements needed to support a more integrated approach to health and social care.

- **Incorporate social prescribing into policy**
- **Develop workforce capacity and training, including link workers**
- **Connect across levels of government**
- **Map community services**
- **Use bundled payments and innovative funding models**
- **Break down silos and collaborate across sectors**
- **Support access to information on services and programs**
- **Test the concept, build the evidence base**
- **Collect data**
- **Build strong evaluation frameworks**

Thank you

CHF, the RACGP and the NHMRC Partnership Centre for Health System Sustainability are grateful for the participation of the following representatives in the roundtable discussion, and for their subsequent consultation and feedback that formed the basis of the recommendations provided in this report.

The views and recommendations in this report represent the outcomes of the roundtable discussion. The report does not necessarily reflect the specific views of roundtable participants or the organisations they represented (some of whom may have official positions that differ from that represented in the report).

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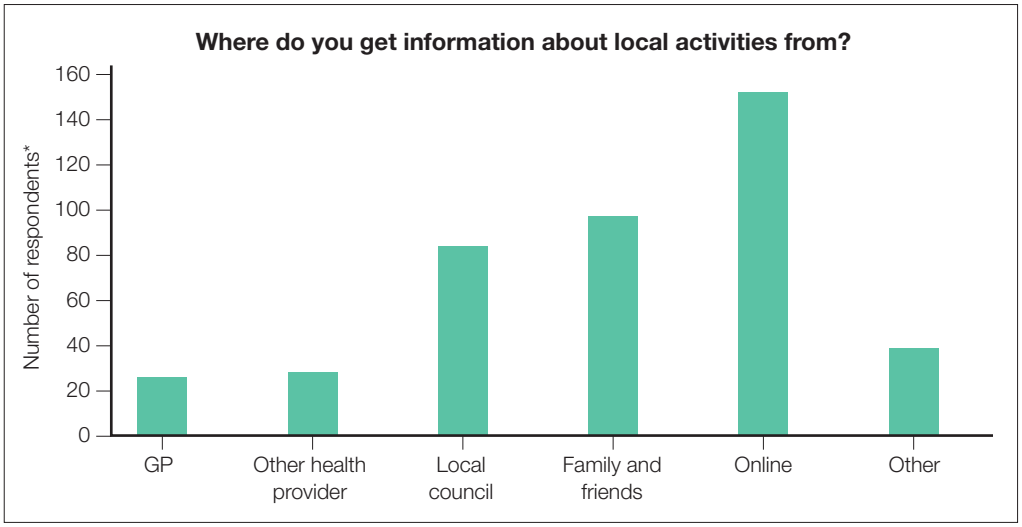
Appendix A. Summary of social prescribing survey results

Consumer survey results – Summary (218 respondents)

- **57%** said their primary care provider never discussed using community programs or services to improve their health (27% said rarely)
- **88%** agreed or strongly agreed that community programs and services can help manage health and wellbeing
- **68%** were interested in participating in community programs or services to address health and wellbeing issues
- **52%** felt knowledgeable about local community programs and services
- **44%** said they currently attend community programs or services to support their health and wellbeing

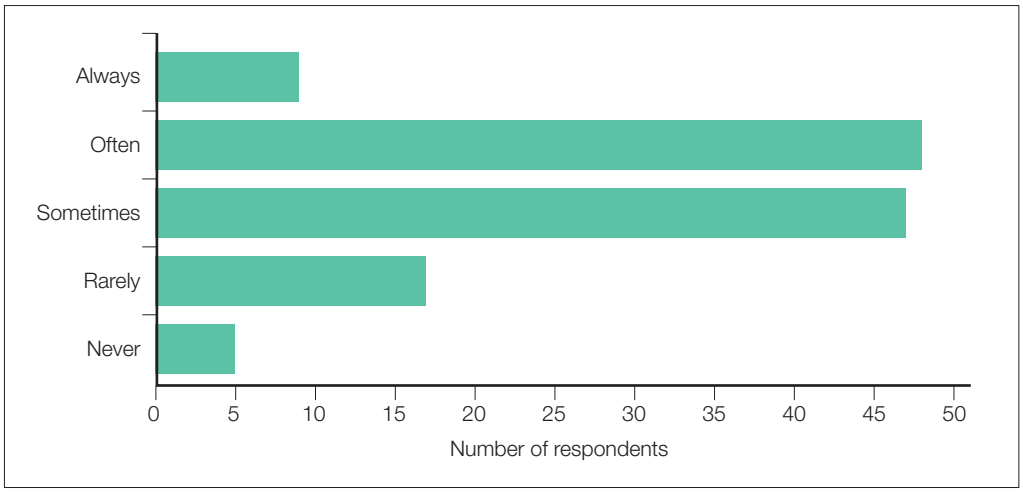


*Respondents could select multiple options.

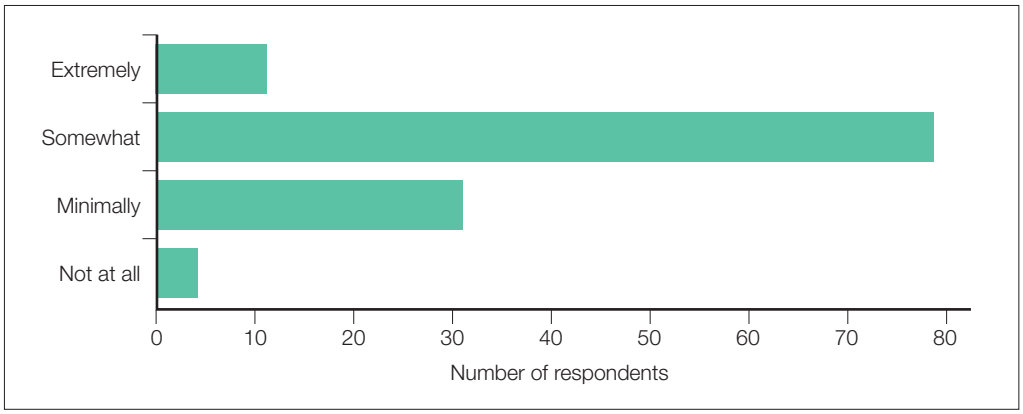
- **67%** said they would be likely to attend a community program or service if their primary care provider referred them
- **75%** said they would be likely to attend an appointment with a community support worker to discuss options for community programs if referred by their primary care provider
- **58%** said the kinds of activities they would like to attend are available in their local area
  - Reasons for not attending currently include:
    - cost
    - timing of sessions
    - transport/distance
    - not feeling comfortable
    - having caring responsibilities
- **Types of activities** suggested included disease-specific support groups, health and fitness programs, library events, book clubs, yoga, pilates, tai chi, meditation, community volunteering, men's shed, mental health support groups, community gardening, bushwalking, social sport, community choir, movie club, ballet classes

General practitioner (GP) survey results – Summary (141 respondents)

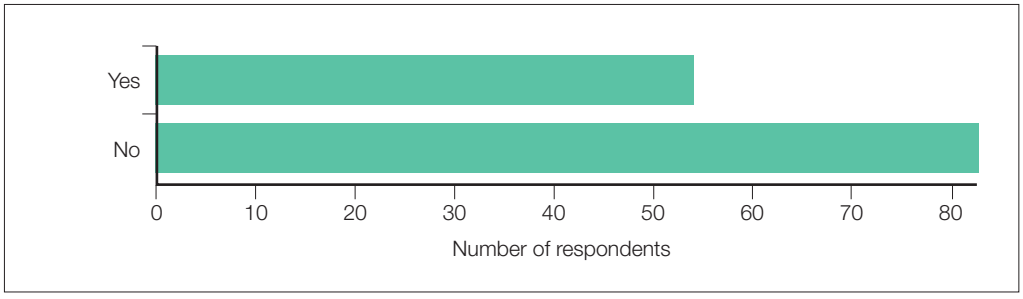
How frequently do you refer patients to non-health services in the community as part of a patient's treatment and wellbeing plan?



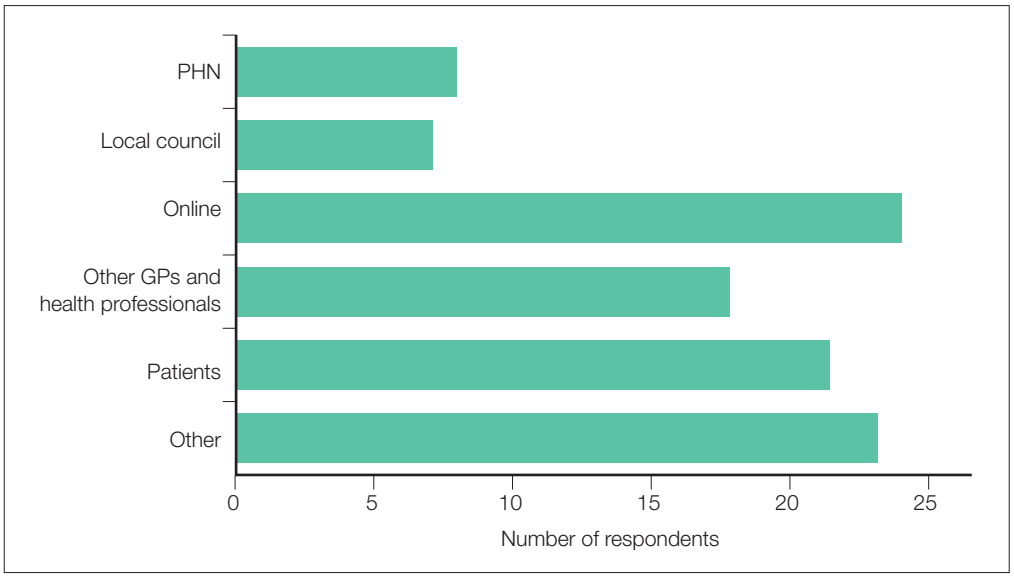
How knowledgeable are you about available local community activities, groups and services that your patients could be referred to?



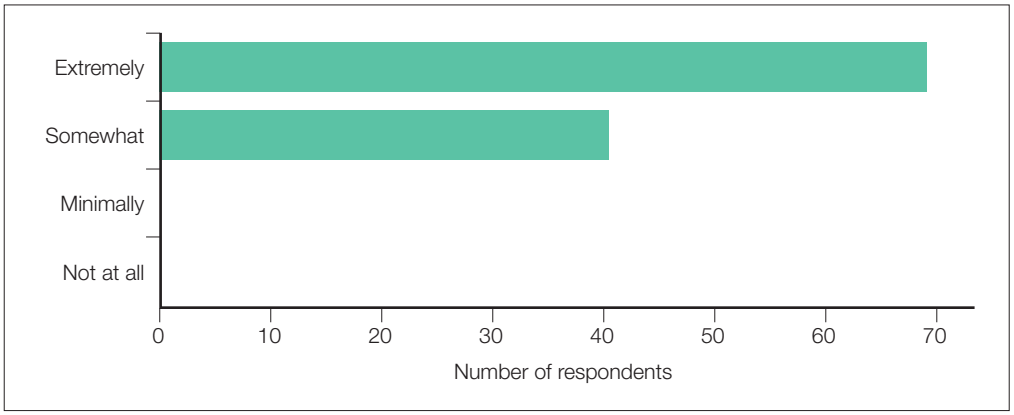
Does your practice have any established links or partnerships with local community services?



What is your primary source of information for finding out about local community activities, programs or services for your patients?



To what extent do you believe that referring patients to community activities, groups or services can help improve health outcomes for patients?

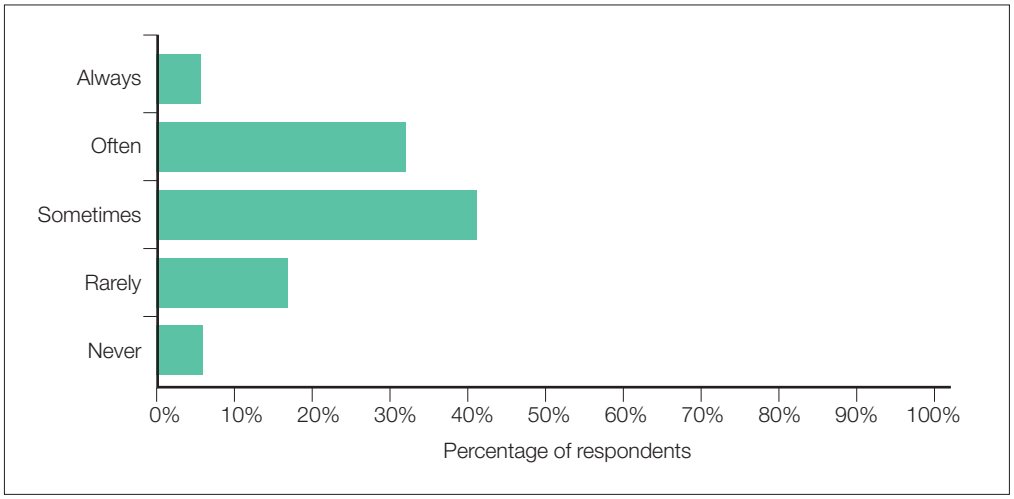


Further GP comments revealed:

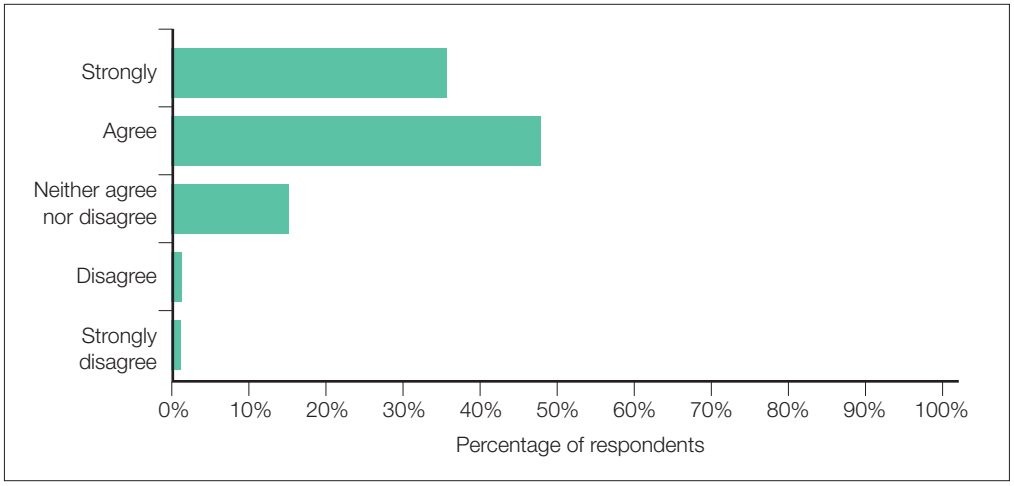
- general support for social prescribing
- a belief that social prescribing, if performed correctly, can have a positive impact on communities
- a need to consider inequities among different councils – some have funds to provide support services and groups, but poorer communities may miss out
- the need for more information about community services.

Allied health survey results – Summary (382 respondents)

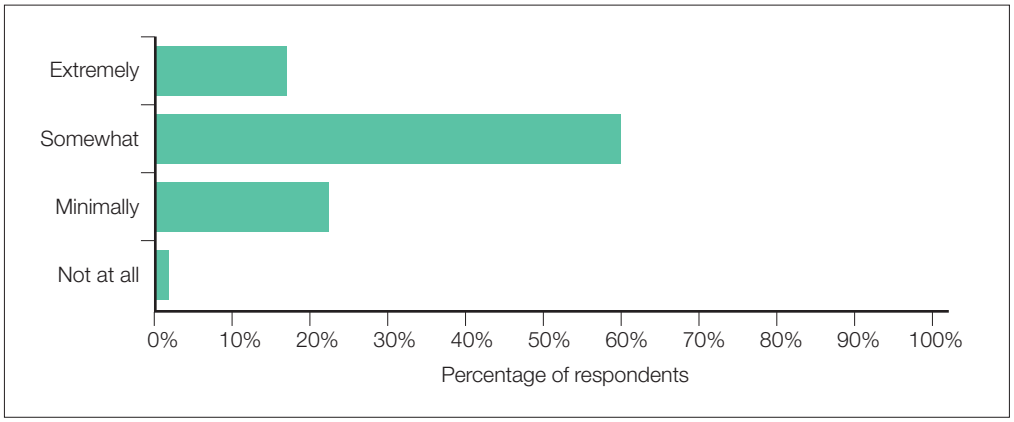
How frequently do you refer patients to non–health professional services in the community?



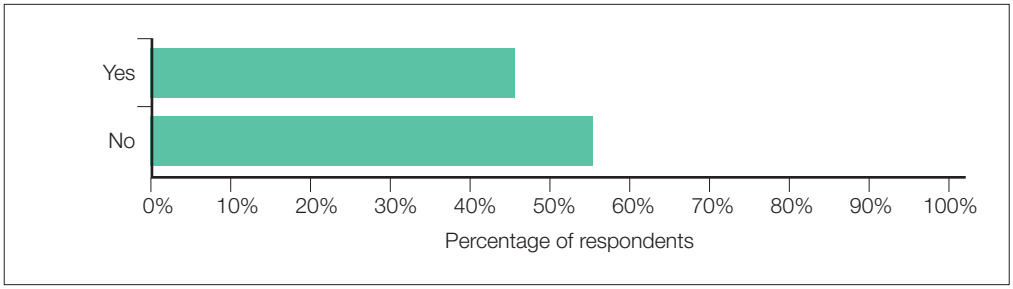
Do you believe 'social prescribing' is within your scope of practice?



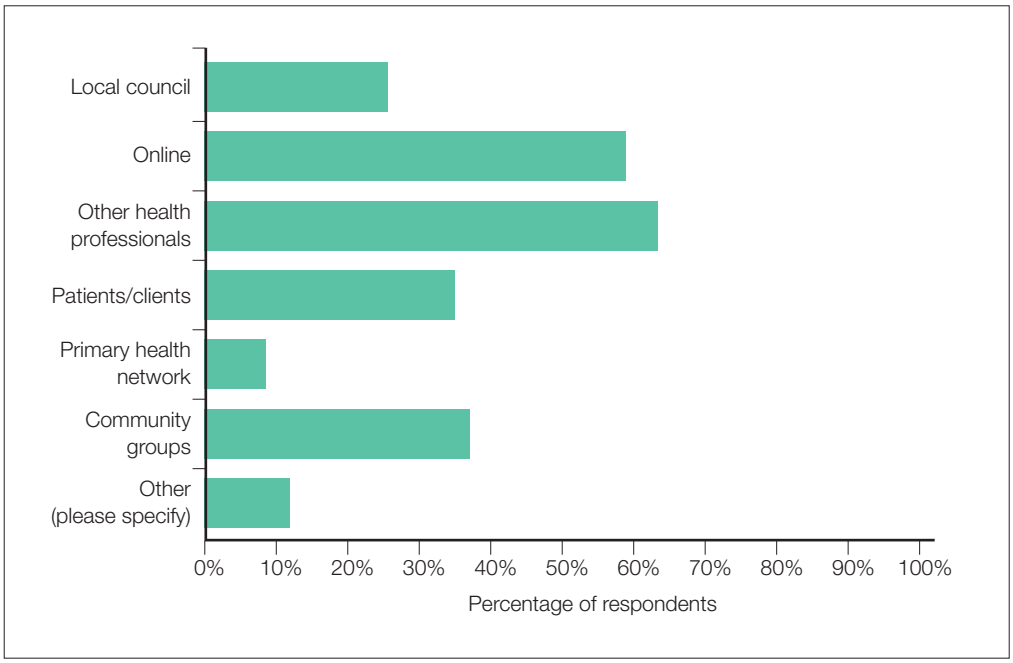
How knowledgeable are you about available local community activities, groups and services?



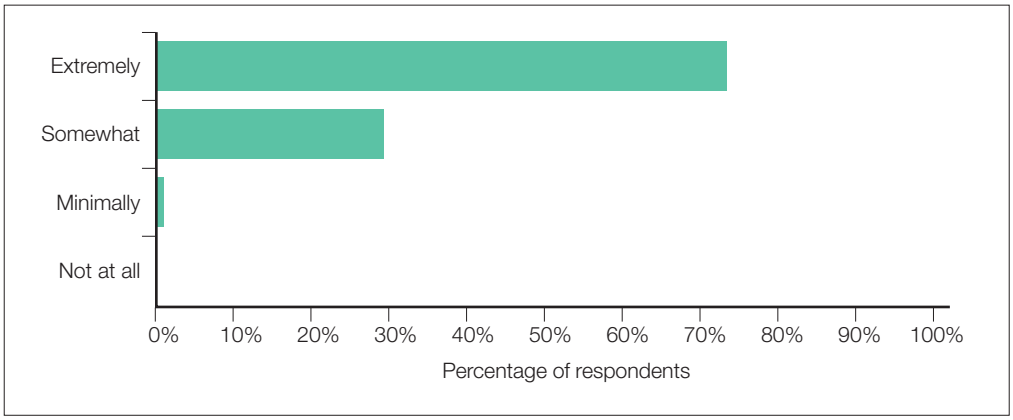
Do you, or your practice, have any established links or partnerships with local community services?



What are your primary sources of information for finding out about local community activities, programs or services?



To what extent do you believe that referring patients to community activities, groups or services can help improve health outcomes?



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