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The Incorporation of Social Prescribing in General Practice: A Review of Models, Outcomes, and Scalability

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Abstract

Background: Social prescribing (SP) is a developing intervention that links patients in primary care with local non-medical services to address the social, emotional, and practical needs of patients, such as loneliness and mental health, that cannot be addressed by traditional medicine. Approximately 20% of consultations in general practice are related to social issues, making SP very relevant to practice.

Aim: This literature review evaluates the implementation of SP in general practice in terms of the implementation process, health and wellbeing outcomes, facilitators, barriers, and optimization strategies.

Methods: A systematic search of MEDLINE, Embase, CINAHL, PsycINFO, and grey literature from 2000 to October 2024 was conducted in accordance with improvements to the practice of SP in GP and other primary care contexts PRISMA 2020 guidelines, identifying 68 studies (10 systematic reviews, 33 primary studies, and 25 grey literature reports). Findings were synthesized narratively following the GRADE approach, and key themes were ascertained through thematic analysis.

Results: SP delivery varies globally. The UK model is formalized around link workers, while Canada and Australia offer considerably fewer formal connections to SP. Outcomes include improved mental health, social connectedness, and decreased food insecurity, but physical health and healthcare use outcomes were more varied. Facilitators include funding and training; barriers include gaps in the evidence base and limitations of resources.

Conclusions: SP consolidates general practice with its emphasis on social determinants, but rigorous evaluations and standardization are required. Scalability and equitable access solutions are the keys to impact.

Keywords: Social prescribing, general practice, primary care, link worker, health outcomes.

Introduction

Social prescribing (SP) is a new, whole-person approach to addressing the non-medical determinants of health in primary care. SP connects patients to community services that aim to address social, emotional, and practical issues that have a significant impact on health & wellbeing, including issues such as loneliness, social isolation, housing problems and mental health issues (1). Issues like these are non-medical determinants of health and are becoming more recognized as areas that traditional and biomedical treatment fall short of comprehensively addressing. For example, social factors have been approximated to account for approximately 20% of general practice consultations and suggest a need for an approach that operates beyond seeking clinical treatment (2). In effect, SP enables general practitioners (GPs) to refer patients onto link workers or community navigators who connect the individual to a specific community service that is appropriate for them, such as a community-based physical activity program, an arts program, financial advice, or a peer support group (3). In this

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whole-person approach, SP fits the emerging model of integrated care with a health and wellbeing perspective for the whole person.

At the heart of the plan was the commitment to introducing link workers in every Primary Care Network (PCN) by 2023/2024, aiming to make 2.5 million SP referrals to address a range of patient needs (5). Beyond the UK, countries such as Canada, Australia, and Portugal have also embraced SP, adapting it to their healthcare system and culture (6, 7).

Canada has developed SP programs for certain population groups, e.g., older adults, food insecurity, while Australia has focused on mental health, as well as isolation in community health contexts. While SP has had widespread uptake, the evidence base to support SP is still underdeveloped, where the vast majority of studies are criticized for flaws in their methodological designs, sample sizes, control groups, and term outcome measures (8). These gaps indicate the need for a comprehensive synthesis of the literature to better understand the implementation and impact of SP.

This review will systematically examine the implementation of SP in general practice via close examination of its implementation pathways, effectiveness in health and well-being outcomes, and implementation facilitators and barriers. By synthesizing international evidence, the review will gain an understanding of the ways SP can be optimized to maximize its contribution to primary care.

Methods

This literature review was conducted in a systematic and rigorous fashion to enhance transparency, reproducibility, and methodological quality (9). Due to the heterogeneity and complexity of SP interventions, we employed an adapted umbrella review approach, where both systematic reviews and primary research were able to be included in our review in order to gain an accurate and overall understanding of SP implementation in general practice (10). This allowed us to synthesize various evidence sources, such as quantitative, qualitative, and mixed-methods studies, in order to capture the implementation and impact complexities of SP.

Search Strategy

A systematic search strategy was designed to capture pertinent literature published between January 2000 and October 2024, by which SP had become an intervention in primary care. The search was carried out in six major academic databases: MEDLINE, Embase, CINAHL, PsycINFO, Web of Science, and the Cochrane Library. These were selected for their broad coverage of health, social care, and interdisciplinary studies to facilitate optimization of capture of studies. In addition to peer-reviewed literature, grey literature was sourced from repositories such as Open Grey, Google Scholar, and organizations' websites, e.g., the NHS, the Social Prescribing Network, and the Canadian Institute for Social Prescribing. This was carried out to capture policy documents, program evaluations, and other non-peer-reviewed literature to the best possible extent, as these are critical to an understanding of SP's real-world implementation (11).

The search strategy was articulated using a combination of keywords and Medical Subject Headings (MeSH) terms. Examples include (but are not limited to) "social prescribing", "general practice", "primary care", "link worker", "community referral", "non-medical intervention", or combinations of these terms and their synonyms. Boolean operators (AND / OR) were used in the search with no language limits to increase the scope to be as inclusive as possible.

Inclusion and exclusion criteria

In order to ensure relevance and specificity, explicit inclusion and exclusion criteria were established. Included studies needed to: (1) address SP interventions being delivered in general practice or primary care, to remain relevant to the scope of review, (2) include adult participant samples 18 years and older, as SP programs have primarily been developed to work with adult groups, (3) measure health (e.g., mental health, physical health), wellbeing (e.g., social connection, quality of life), or health care use (e.g., GP consultations, hospital admissions) as their outcomes, and (4) be peer-reviewed journal article, systematic review, or a grey literature report of high quality of evaluation, e.g., where data collection and analysis process were clearly described. Excluded studies were: (1) those which were non-community-based interventions, like hospital-based programs, to maintain the review's focus on primary care, (2) those that did not include any evaluation data, or did not provide enough methods description, to assure I was only including studies with reliable findings, or (3) were editorials, commentaries or protocols without any empirical findings, as these types of papers did not directly contribute to the evidence base.

Study Selection and Data Extraction

Study selection was systematic to minimize risk of bias and ensure maximum consistency. Titles and abstracts were independently screened by two reviewers using Covidence, an online tool to support systematic reviews (12). Following initial screening, full texts were accessed and assessed for eligibility against the inclusion criteria. Reviewer disagreement was addressed by discussion and if necessary, consulting a third reviewer until consensus was reached. Data extraction involved the use of a standardized form, capturing relevant details including study design (e.g., RCT, cohort study, qualitative), population (e.g., age, disease state), intervention type (e.g., link worker model, community referral-specified), outcomes measured (e.g., mental illness, healthcare use), and implementation details (e.g., referral mechanisms, working with communities). To evaluate the quality of studies to be synthesized, risk of bias was assessed using the Cochrane Risk of Bias 2 (RoB2) tool for RCTs, and the Effective Public Health Practice Project (EPHPP) tool for non-randomized studies, to help inform a critical appraisal of methodological quality (13, 14).

Search Strategy

Due to heterogeneity in study design, interventions, and outcome measurement, a meta-analysis was not possible. A narrative synthesis was used to synthesize the evidence across studies, taking guidance from the Grading of Recommendations Assessment, Development and Evaluation (GRADE) approach to assess certainty in the evidence (15).

This offered a systematic framework to the quality and strength of results, including consideration of issues like study design, risk of bias, and consistency of results. Thematic analysis was employed to identify and categorize significant themes in relation to SP implementation, health and well-being outcomes, and facilitators and barriers to integration. Themes were categorized to address the research questions, and a coherent and logical synthesis of the evidence was presented. To make the findings as useful as possible, a summary table was constructed to give an overview of key studies, their characteristics, and their contribution to knowledge of SP in general practice.

Results

The systematic search yielded 4,415 unique citations, 68 of which, representing 53 individual studies, were included following application and exclusion criteria. The studies comprised 10 systematic reviews, 33 primary studies (randomized controlled trials, cohort studies, and qualitative studies), and 25 grey literature reports, including program reports and policy reports. The geographic location of studies was weighted toward the United Kingdom (n=45), as it is leading the application of social prescribing (SP). Other countries contributed to the evidence base, including Canada (n=8), Australia (n=6), Portugal (n=4), and fewer studies from other locations (n=5), including New Zealand and Ireland. This imbalance reflects international interest in SP, although the dominance of UK research highlights the need for additional international research to clarify context-specific applications.

Implementation of Social Prescribing

SP implementation in primary care generally involves a referral process where GPs or other primary care professionals refer patients to link workers who connect patients to community-based services based on their non-medical needs (14). Implementation models vary significantly between regions, reflecting variations in healthcare systems, funding setup, and cultural contexts. Within the United Kingdom, SP is structured and formalized, with link workers being embedded in Primary Care Networks (PCNs), each with care populations between 30,000 to 50,000. The link workers, commissioned by the National Health Service (NHS) and third-sector organizations, i.e., charities, work in partnership with GPs to assess patient needs and broker access to community services (15). Canada's implementation is more population-focussed, i.e., to older people or food-insecure individuals, and programs are typically implemented through partnerships with community organizations rather than being embedded in primary care infrastructure (16). In Australia, SP is less structured, being commonly embedded within primary care infrastructure in community health centers and addressing social isolation and mental health, reflecting a more localized and less systematic approach (17).

Key aspects of the implementation of SP within general practice are referral pathways, the link worker's role, and community collaborations. Referral pathways vary from electronic health record integrations (in the UK, simplifying the complexity) to consultation or self-referral in less formalized systems (18). The link worker's role is central, featuring the co-production of individualized personalized support plans between the patient and link worker, in order to allow interventions to be tailored to personal goals and aspirations (19). Strong community partnerships are critical for effective SP interventions, with general practice collaborating with local charities, voluntary sector agencies, and public services to provide a range of referral choices, e.g., exercise classes, arts and leisure activities, or financial advisory services (20). These aspects highlight the requirement for coordination between the healthcare and community sectors to integrate SP within general practice.

Health and Well-Being Outcomes

SP interventions have been associated with a range of health and well-being outcomes, though evidence varies in quality and consistency across areas. In mental health, the trend across programs with arts-based interventions or exercise referral is uniformly enhanced anxiety, depression, and self-esteem (21, 22). An Irish 2024 RCT offered support for the effectiveness of an arts-on-prescription intervention in significantly lowering depression scores in participants and with implications for the potential of creative interventions on psychological distress (23). Physical health outcomes are also positive, with exercise referral schemes enhancing physical activity and reducing long-term illness risk factors like diabetes and cardiovascular disease (24). Participation in such schemes is an issue, though, with evidence indicating that long-term attendance is typically low, which restricts longer-term gains (25).

Social well-being outcomes are one of the strongest, with SP interventions reducing loneliness and enhancing social connectedness consistently, particularly in older populations (26). A 2024 Canadian evaluation of a new food prescribing programme demonstrated substantial reductions in food insecurity, demonstrating SP's ability to impact socioeconomic health determinants (27). For healthcare utilization, the evidence is conflicting, with some reporting reductions in GP attendances and hospitalization, particularly in chronically ill patients, and others demonstrating no effect (28, 29). Such heterogeneity is typically accounted for by methodological limitations, such as small sample sizes, lack of control groups, and short follow-up. A mapping review of 67 diverse outcomes in 13 countries included general well-being, quality of life, psychological well-being, and social connectedness, demonstrating the widespread impact of SP but also the challenge in synthesizing disparate outcomes (30).

Facilitators and Barriers

Several facilitators have been identified as key to the successful embedding of SP within general practice.

Thorough link worker training and GP education programs significantly enhance uptake by introducing healthcare professionals to SP's objectives and procedures (31). Stronger community engagement, as represented by strong ties to local organizations, enhances the diversity of referral options and enhances the capacity of SP programs to respond to heterogeneity in patient needs (32). In the UK, significant NHS investment has been a key driver of scalability, enabling link worker recruitment in PCNs and infrastructure building (33). These facilitators emphasize the significance of human and financial resources in embedding SP in primary care.

Conversely, several obstacles work against scaling up and integrating SP. Resource constraints, including limited funds and availability of trained link workers, are particularly severe in rural and underserved populations, where local resources are scarce (34). The SP evidence base remains hampered by the paucity of high-quality controlled trials, compromising confidence in effectiveness and policy support (35). Model and outcome measure heterogeneity across settings and programs interferes with evaluation and comparison, and the ability to identify best practices (36).

Equity is a priority concern, as the marginalized populations, especially ethnic minorities and those with low socioeconomic status, face barriers, whether they are geographic, cultural, or socioeconomic, to accessing SP services (37). These barriers necessitate targeted action so that SP is effective and equitable.

Optimisation Strategies

To realize SP's full potential in general practice, a number of strategies have been recommended. Standardization of measurement through tools like NHS England's Common Outcomes Framework can improve consistency of outcome measurement across studies and enable cross-study comparisons and policy (38). Additional training courses for link workers and GPs are required in order to build capacity and allow interventions to be delivered optimally (39). Equity needs to be addressed through targeted approaches to reach less well-served groups, for instance, through culturally responsive programs or mobile outreach programs (40). Finally, priority needs to be given to rigorous evaluation methods, including RCTs and longitudinal studies, to develop the evidence base and demonstrate the longer-term effect of SP (41). In combination, these strategies will overcome existing limitations and optimize SP's full potential in primary care.

Study	Country	Design	Population	Intervention	Key Outcomes	Facilitators	Barriers
Bickerdike et al. (2017)	UK	Systematic Review	Adults ≥18	Various SP programs	Mixed mental health improvements	Community partnerships	Weak evidence base
Ashe et al. (2024)	Canada	Umbrella Review	Adults ≥18	SP interventions	Improved well-being, inconsistent utilization reductions	Standardized reporting	Publication bias
Kiely et al. (2024)	Ireland	RCT	Multimorbid adults	Link worker SP	Reduced depression, no workload reduction	Trained link workers	Resource constraints
Polley et al. (2017)	UK	Review	General population	SP programs	Reduced GP visits, improved social connectedness	NHS funding	Lack of standardization
Mulligan et al. (2023)	Canada	Mixed Methods	Older adults	Community referrals	Enhanced social engagement	Local networks	Equity issues

Discussion

The integration of SP into routine practice is a healthy response to the social determinants of health, consistent with the biopsychosocial model of health, which stresses the interplay of biology, psychology, and social determinants in health outcomes (42). The UK's coordinated effort, grounded in significant NHS financing and policy support, provides a model for organized integration, in contrast to more piecemeal and local efforts in countries such as Canada and Australia (43). This comparison highlights the critical role of policy support and infrastructure in scalable SP delivery. The uniform improvement of mental health and social well-being in studies demonstrates that SP is most impactful in addressing psychosocial needs, such as loneliness and depression, common among primary care patients (44). Less conclusive evidence for physical health and health care use, however, signals challenges in measuring non-health outcomes and in maintaining intervention fidelity, particularly in programs with low levels of adherence (45).

Facilitators like thorough training and wide-ranging partnerships in the community are essential for successful SP implementation and allow practitioners to work through the various referral systems required for patients to access appropriate services (46). Although barriers still exist, like insufficient resources and lack of evidence, that challenge the scalability and sustainability of SP. Standardized models and outcome measures are lacking, rendering comparison between programs and creating a strong evidence base more difficult, an issue being addressed by initiatives such as the NHS Common Outcomes Framework (47).

Equity prioritised the issues facing poorer groups, including ethnic minorities and low-income groups, likely to face access barriers, requiring focused interventions to achieve equity and inclusion (48). Future research needs to offer high-quality research design, such as RCTs and cost-effectiveness studies, to create a further evidence base to make more authoritative statements over the long-term impact and economic sustainability of SP (49, 50). Longitudinal studies need to measure the sustainability of

outcomes over a longer period and the extent SP is able to mitigate health inequities within a reasonable time frame.

Conclusion:

Social prescribing has the potential to shift general practice to focus on the social determinants of health, which is an approach to patient care that is holistic and sits alongside conventional medical care. The evidence supports SP through improved mental health and social well-being and show the greatest gains for those disadvantaged groups, such as the elderly and socially isolated. Nevertheless, its scalability and widespread application is limited by methodological inadequacies, inconsistency of program delivery, and barriers to access and equity. SP's potential can be maximized via standardized assessment tools, longer training periods, special programs for disadvantaged groups, and strong methodological rigor with research designs. If the barriers identified could be overcome, then SP could be positioned as a novel model of primary care that may reduce health difference and inequities and improve patient outcomes on a global level.

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دمج الوصفات الطبية الاجتماعية في الممارسة العامة: مراجعة للنماذج والنتائج وقابلية التوسع

الملخص

الخلفية: الوصف الاجتماعي (Social Prescribing) هو تدخل متطور يربط المرضى في الرعاية الأولية بالخدمات المحلية غير الطبية لمعالجة الاحتياجات الاجتماعية والعاطفية والعملية للمرضى، مثل الشعور بالوحدة والصحة النفسية، والتي لا يمكن معالجتها بالطب التقليدي. حوالي 20% من الاستشارات في الممارسة العامة تتعلق بمشكلات اجتماعية، مما يجعل الوصف الاجتماعي ذا صلة كبيرة بالممارسة.

الهدف: تهدف هذه المراجعة الأدبية إلى تقييم تطبيق الوصف الاجتماعي في الممارسة العامة من حيث عملية التنفيذ، والنتائج الصحية والرفاهية، والعوامل الميسرة، والعقبات، واستراتيجيات التحسين.

الطرق: أجري بحث منهجي في قواعد بيانات MEDLINE و Embaseو CINAHL و PsycINFOبالإضافة إلى الأدبيات الرمادية من عام 2000 حتى أكتوبر 2024، وفقا لإرشادات PRISMA 2020 لتحسين ممارسة الوصف الاجتماعي في الممارسة العامة وسياقات الرعاية الأولية الأخرى. تم تحديد 68 دراسة (10 مراجعات منهجية، 33 دراسة أولية، و25 تقريرا من الأدبيات الرمادية). تم تلخيص النتائج بشكل سردي باستخدام منهجGRADE ، وتم تحديد الموضوعات الرئيسية من خلال التحليل الموضوعي.

النتائج: يختلف تقديم الوصف الاجتماعي عالميا. يعتمد النموذج البريطاني على وجود "العاملين الرابطين" بشكل رسمي، بينما تقدم كندا وأستراليا روابط أقل رسمية للوصف الاجتماعي. تشمل النتائج تحسنا في الصحة النفسية، وزيادة الترابط الاجتماعي، وتقليل انعدام الأمن الغذائي، بينما كانت النتائج المتعلقة بالصحة الجسدية واستخدام الرعاية الصحية متباينة أكثر. تشمل العوامل الميسرة التمويل والتدريب، في حين تشمل العقبات وجود فجوات في قاعدة الأدلة وقيود الموارد.

الاستنتاجات: يعزز الوصف الاجتماعي من دور الممارسة العامة من خلال تركيزه على المحددات الاجتماعية للصحة، إلا أن التقييمات الصارمة والتوحيد القياسي ضروريان. إن قابلية التوسع وضمان الوصول العادل هما المفتاح لتحقيق التأثير.

الكلمات المفتاحية: الوصف الاجتماعي، الممارسة العامة، الرعاية الأولية، العامل الرابط، النتائج الصحية.