Policy Document

Social Prescribing (2021)

Position Statement

The Australian Medical Student Association (AMSA) believes:

1. That the medical profession should aim towards a biopsychosocial model of health, centering on improving holistic patient wellbeing and disease prevention rather than a solely curative approach.
2. Social prescribing programs in Australia should be piloted and evaluated towards future integration into the primary health setting as a key facilitator of patient wellbeing.
3. The implementation of social prescribing should involve active consultation of policymakers, community service providers, representative bodies, patients and advocacy groups and researchers alike.
4. Social prescribing services must be accessible to a diverse range of populations in Australia, especially marginalised and economically disadvantaged groups.
5. Medical schools should educate and expose their students on the practice and efficacy of social prescribing.

Policy

AMSA calls upon:

1. The Federal, State and Territory Governments to:
    a. Work with the Royal Australian College of General Practitioners (RACGP), the Australian College of Rural and Remote Medicine (ACRRM) and other relevant stakeholders to develop a social prescribing system that appropriately addresses the needs of the Australian population;
    b. Organise and fund the development and implementation of widespread social prescribing pilot programmes as part of primary health care and preventative health policies, including the Australian Long Term National Health Plan and the 10-Year Primary Health Care Plan;
    c. Examine social prescribing models implemented in other countries including the link-worker program in the United Kingdom, and investigate the feasibility of such programs in Australia;
    d. Use the 2019 RACGP Social Prescribing Roundtable Report as a framework for the implementation of social prescribing in Australia;
    e. Fund research into social prescribing by engaging in evidence based screening tools and evaluation based frameworks, and ensuring there is a methodology for sufficient data collection;
    f. Consider including the development of a formal social prescribing service as a “priority areas” for Primary Health Networks (PHNs);
    g. Fund training and education about social prescribing for existing health professionals;
    h. Work with local councils to identify and expand on pre-existing programs and community services that could be incorporated into systemic social prescribing plans;
    i. Ensure social prescribing practices are inclusive of the entire Australian population and consults with culturally and linguistically diverse Australians, Aboriginal and Torres Strait Islander people, LGBTQI+ Australians and other vulnerable communities;

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j. Ensure rural, remote and regional communities have access to social prescribing plans and service structures.

2. Primary Healthcare Networks to:
    a. Commission the development of social prescribing services;
    b. Promote the use of My Community Directory and HealthPathways as the platform for the digital basis of the social prescribing network, as per the RACGP Round table guidelines;
    c. Expand the listings and promote the use of My Community Directory by healthcare providers.

3. RACGP, ACRRM , PHNs and the Consumer Health Forum (CHF) to:
    a. Advocate for the integration and formalisation of social prescribing practices;
    b. Work with Federal, State and Local Governments to suggest methods of implementation into the Australian healthcare system;
    c. Provide education and develop training programs on social prescribing to health practitioners that are readily accessible.

4. Health practitioners and allied health professionals to:
    a. Consider how social prescribing could be incorporated into their practice within the local context of their work and their patients' environment;
    b. Establish social prescribing protocols as a part of a multidisciplinary approach to health and wellbeing;
    c. Ensure patient autonomy is at the forefront of social prescribing practices, and patient wellbeing is centred in the social prescribing process;
    d. Ensure that the social prescribed interventions are culturally appropriate and equitable for all patients.

5. Medical schools to:
    a. Educate medical students and medical societies on the practice of social prescribing with up-to-date information on the latest evidence about the possible benefits and limitations of social prescribing.
    b. Educate and expose medical students to a broad range of social and allied health services as preparation for the future practice of social prescribing.

6. Local Councils, local community health organizations and providers to:
    a. Collaborate with local community initiatives, services and groups to build pre-existing community activities into those that can be used with social prescribing;
    b. Promote access to suitable and appropriate activities within the social prescribing framework for all members of the community.

7. Health and research organisations and academics to:
    a. Initiate and continue evidence-based research into the outcomes of social prescribing in order to inform the development of successful frameworks and assess the feasibility of social prescribing within the Australian healthcare setting.

Background

As the peak representative body for future medical professionals in Australia, the Australian Medical Students' Association (AMSA) advocates for the continued development of Australian health policy and practice to align with evolving standards and evidence-based healthcare. A key component of this process is the definition of good healthcare as the attainment of wellbeing, rather than the absence of disease.

Wellbeing is defined as being satisfied within oneself and one's life, and encompasses attitudes towards factors such as relationships, careers, goals, spirituality, finances and the three pillars of sleep, diet and exercise [1]. Evidence shows that improvements to the elements of wellbeing can have a positive impact on physical and mental health outcomes [2, 3, 4]. With the rise of chronic disease rates in Australia [5], wellbeing is becoming an increasingly important consideration for preventative health.

Social prescribing is an emergent tool that allows health professionals to better achieve wellbeing in patients. It involves practitioners referring patients to community services, supports and social groups. Referral end-points are based on patient needs and may include activities such as arts, gardening, volunteering or sports [5]. Social prescribing addresses the social illness (such as loneliness and isolation) that can be attributed to the social determinants of health; the influence of non-medical factors on one's health and wellbeing [6]. 1 in 5 patients attending GP services do so for social problems [7)]. Social prescribing represents a shift towards helping these patients. Existing models of social prescribing have prioritised patient autonomy by placing the individual as their own 'health champion', and therefore respecting the rights and wellbeing of the patient [8]. Centering the patient's needs and autonomy is a key feature of building trust in social prescribing [7]. The emergence of social prescribing reflects a shift towards a biopsychosocial model of healthcare, especially as a re-evaluation of, and supplement to, existing healthcare options in Australia.

Social prescribing is a recent phenomenon and its implementation has been limited by difficulties in collecting high quality qualitative data. Initial data from countries that have adopted social prescribing practices, such as the UK, Canada and Singapore, indicate promising results [9, 10]. However, due to the abstract nature of wellbeing, the consistency and accuracy of qualitative data in this area has been called into question, leading researchers to re-evaluate their strategies in order to evolve alongside emerging health trends [11, 12, 13, 14].

Social prescribing has not yet been formally implemented in Australia's healthcare funding system. However, several organisations have already emerged with the goal of facilitating and streamlining the coordination between GPs, local services, multidisciplinary teams and secondary care teams. These organisations could collaborate to formally implement a national prescribing protocol, that would standardise and optimise existing approaches to community service linkage. This could represent the best chance of becoming a tangible part of Australia's existing healthcare system by providing a cost and time efficient solution [15]. Primary Healthcare Networks (PHNs) have been established by the Australian government and function independently to oversee the organisation of a fully integrated primary healthcare system within each of their 31 regions [15, 16]. This is done through the coordination of available services, commissioning new services and providing support to improve the quality of general practice and garner their involvement in the advancement of primary care. Overall, PHNs serve to ensure a primary healthcare system that responds to community needs, improves patient accessibility and to act as a moderator for services. The Australian Governments guides the work of PHNs through the identification of "priority areas," of which there are currently seven, including mental health, Aboriginal and Torres Strait Islander health, population health and the health workforce. The Government is therefore in a position to consider adding social prescribing to this list, as social prescribing presents an opportunity to progress in priority areas such as mental and population health [16]. PHNs are

particularly well placed to work with HealthPathways and My Community Directory to expand their availability across all PHN regions and promote their use amongst health practitioners [15].

HealthPathways is a guideline targeted at health practitioners to provide collated information on recommended assessment, management and specialist referral pathways for specific medical conditions, in the context of a local district's health. The content is developed and localised by the health district that officially adopts the system. It has been implemented in 33 districts across Australia, in addition to New Zealand and the UK. [17,18]. My Community Directory provides a registration platform for health and community services, allowing anyone to see what is available in their local area [19]. Both services and their data can be utilised by health services and PHNs though a contract and membership model respectively, which are funded by PHNs, councils, hospital and health services and state health services depending on the jurisdiction [20, 21, 22, 23, 24]. Thus, these services can be utilised to facilitate a national social prescribing network.

Social prescribing is not mentioned in 'Australia's Long Term National Health Plan,' produced by the Federal Department of Health and released in 2019. This is despite the potential for social prescribing to be built upon already existing frameworks such as the aforementioned Primary Healthcare Networks (PHN), HealthPathways and My Community Directory [7, 26]. PHNs are mentioned once in the report, in the context of receiving $1.45 billion over three years in order to develop regional mental health services [26]. However, a Federal 10-Year Primary Health Care Plan is currently in development, with practicing GPs, RACGP and AMA members, nurses and representatives for both allied health and the Consumers Health Forum (CHF), amongst others, having acted as a steering group [25, 26]. In response to the 10-Year Plan, the RACGP advocated in 2020 for a shift towards wellbeing-focused care and the expansion of preventative health and non-clinical primary health care teams. This is a position shared by fellow advocacy bodies, including the Australian Medical Association [27, 28]. Social prescribing could present as an important part of this forward looking and preventative-focused plan, and should be considered as an important aspect of healthcare in Australia moving forward.

The RACGP has collaborated with the CHF to produce an extensive 2019 Social Prescribing Roundtable Report. The report makes several key recommendations to policymakers, healthcare system funders, service providers and researchers; in particular, it emphasises the need for social prescribing to be integrated into primary and preventative healthcare funding from a Federal level downward. It also emphasised the need for existing healthcare services, such as PHNs, to collaborate with a diverse cohort of community care organisations. GPs also need to be made aware and upskilled; one way to incentivise GPs to take up social prescribing is through CPD points. For example, there are a small number of webinars such as through the Black Dog Institute where 2 QI&CPD points or 2 ACRRM points can be earned [29]. Target groups recommended for social prescribing in this report include, people experiencing mental health issues, chronic physical conditions, or social isolation, as well as early childhood and old age [7].

Social Prescribing in Other Countries

Social prescribing has been adopted by the National Health Service (NHS) in the United Kingdom, and represents the largest national health system investment in social prescribing [30]. Social Prescribing in the UK involves local health agencies, including general practitioners, referring patients to a link-worker. Link-workers then spend time with the patient, focusing on the patient's needs and abilities, before connecting the patient to community groups and social services in the area [32]. The NHS England Long Term Plan will fund link-workers for newly created Primary Care Workers, with a target of one link-worker per 30,000-50,000 population [31].

Other countries that have adopted similar models include Canada [33] and The Netherlands [34], however, neither country has committed to national level social prescribing implementation at the same scale as the UK. In Germany and the Netherlands, general practitioners, assistant practitioners, physical therapists and psychologists are able to refer patients to social well-being organisations, which then link patients with a 'primary care worker' [35, 36]. New Zealand has embraced initiatives such as Green Prescribing, where health professionals provide written advice and resources to encourage families to be more active [36].

Benefits of Social Prescribing

Social prescribing can offer the opportunity to address individual and social needs through individual consultations. While there has been limited research on this topic and a lack of data collection, systematic reviews undertaken in the UK and a randomised control trial shed some light on the efficacy of social prescribing.

A 2017 systematic review revealed benefits reported by participants and referrers directly engaged in social prescribing. These include increases in psychological or mental-wellbeing, self-esteem and confidence, sense of control and empowerment and positive mood because patients were able to access appropriate help and develop their support networks [34,35]. Social prescribing has also led to improvements in physical health, lifestyle, sociability, communication skills and social connections [37]. Furthermore, findings also suggest reduction in anxiety and/or depression, negative mood, social isolation and loneliness. Overall, there were improvements in motivation and meaning in life, providing hope and optimism as well as the acquisition of new interests and skills [37]. Positive mental health and well-being is associated with social and economic benefits e.g. education, productivity, social connectivity and reduced crime rates [37].

Social prescribing can also extend boundaries of traditional general practice by bridging the gap between primary health care and the voluntary sector [39]. In doing so, it also strengthens community-professional partnerships. Primary health care practitioners also commented on the provision of a range of options to complement medical care for a more holistic approach. Moreover, studies demonstrate a reduction in visits to general practitioners, referring health professionals, and primary or secondary care services [12]. A reduction in workload allows medical professionals more capacity to focus on medical problems [40]. Approximately 20% of doctor visits are due to a social problem, therefore social prescribing could relieve pressure and thus have a protective effect on service demand [40]. This could result in cost savings and reduced rates of emergency department visits.

Social prescribing initiatives on a wider scale could be used to counter the social determinants of health inequity through offering activities that build resilience in mental and physical health, encourage social interaction and develop individual and community resources [34]. This could reduce disparities in health - particularly interventions that focus on socially disadvantaged communities where patients' medical problems are especially likely to be compounded by social difficulties [35]. By giving people a voice and to empower individuals and communities to take control of their lives, social prescribing is a potential method of combating social exclusion, especially of marginalised communities. With a focus on bolstering community care, social prescribing could fit well within Australian health policy.

Another review from the UK in 2017 calculated the usefulness of social prescribing by examining 14 papers using various data points, such as GP demand, accident and emergency service attendance and demand of secondary care services. The analysis revealed that social prescribing reduced the demand for all of these services, indicating that social prescribing can reduce dependency on healthcare systems [12]. However, the review was limited by a wide range of results across studies. Although there was a positive outcome quoted in the studies when social prescribing was put in

place, the review was limited by a wide range of results across studies [12]. This reflects on the lack of uniform research available on the topic.

Social Prescribing Concerns

Despite enthusiasm and early evidence of social prescribing from multiple countries, there remain concerns for its feasibility in Australia. Primarily, there is a lack of robust research to guide implementation.

Within the limited scope and scale of studies already conducted, many have been beset by inconsistent standardised outcome measures, magnified by a general lack of information on the social prescribing referral process and the activity or program the patient undertakes. This has made it difficult to assess who has received what services, for what duration, to what effect, and at what cost [41]. Echoing recommendations by the RACGP's 2019 Social Prescribing Roundtable, a key aim for further research is to create and fund studies that work closely with local councils and PHNs to track and review services available, as well as identify those with diverse needs who can benefit from them [16]. This research should also be evaluated by a clear and measurable framework of how social prescribing programs tangibly impact providers and patients [42].

Mirroring the development of further research, a holistic integration of social prescribing needs to be considered in the medical education realm too. One other consideration regarding social prescribing is the current lack of medical education surrounding social prescribing practices. This is likely due to social prescribing concepts being largely undefined officially within Australian healthcare, let alone within University curricula. Integrating social prescribing into medical students' learning in order to foster future advocates of holistic medical care should also be explored.

The implementation of social prescribing in Australia is limited by the lack of a centralised framework. Without a proper framework, social prescribing schemes could overly rely on a patient's abilities to maintain their connection to a community group or support service. There could also be an overreliance on a local area or network's existing funding for community programs, which can vary immensely. Furthermore, compliance with social prescribing structures may be unrealistic for patients with a decreased ability to engage with the healthcare system, such as in cases of severe mental illness and poor community health engagement. [42]. Centralised frameworks of social prescribing will allow for more accountability and standards to be upheld, and mitigate these potential issues.

Establishing both an effective and equitable social prescribing framework is a key challenge. Rural, remote and low socioeconomic communities regularly report barriers to accessing GP and specialist care, such as cost, isolation, distance and time [43, 32]. These issues have the potential to limit engagement in social prescribing practices. Therefore, the consideration that individual communities will have different needs based on their pre-existing funding and engagement should be taken into account when programs are developed.

The inclusion of social prescribing practice in Australia should also ensure marginalised groups such as the elderly, Aboriginal and Torres Strait Islanders, culturally and linguistically diverse people, refugees and asylum seekers, LGBTQI+ individuals and people with a disability receive culturally appropriate and competent interventions. Members of marginalised groups in Australia are more likely to experience social isolation due to a variety of reasons, and are therefore in a position to greatly benefit from community engagement [44]. It is consequently of great importance to work towards practices that do not threaten to further disadvantage and exclude groups from social prescribing practices as they develop.

Another concern regarding social prescribing is that its implementation may be viewed as an unsuitable response to complex social issues, such as healthcare inequality and poverty [45] or that it may be seen primarily as a way to ameliorate pressures of growing demands and the stretching of resources that currently face the health sector. With the current lack of evidence, it would be inappropriate to view social prescribing as a solution to these problems [42]. Rather, the focus should be on the patients, their individual needs and tracking their benefits from increased engagement with tailored community services. A Social Prescribing scheme within Australia should therefore not be an overly broad or a temporary fix to those with complex needs, but instead should focus on individual patient outcomes within an increasingly accepted biopsychosocial approach to treatment [33].

It is evident that many concerns related to social prescribing can be clarified by continued research and quality studies. Social prescribing has the potential to streamline and bolster efforts to include community engagement and non-medical interventions within the primary healthcare system, and awareness of this potential is beneficial to existing healthcare workers and medical students alike.

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