More than Medicine:
Exploring Social Prescribing in Australia

2021

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Executive Summary

We are pleased to present the Friends for Good research report *More than Medicine: Exploring Social Prescribing in Australia.*

This report explores the perspectives and attitudes of people from across Australia about social prescribing and how they think it would impact their lives.

Using a representative sample of 1004 Australian adults some of the key findings include:

1. 14% of people had experienced social prescribing previously. Of those, 84% followed through on what was prescribed and 91% found it helpful.
2. Majority of people (83%) would be comfortable or very comfortable with a GP or health professional prescribing social activities.
3. When asked about how social prescribing might impact peoples lives, most (84.9%) felt it would either positively or very positively impact them.
4. Most people felt GPs were the best placed to undertake social prescribing in the community.
5. There wasn't a significant difference in the level of comfort or positivity towards social prescribing based on age, gender or location.
6. Key themes from the qualitative data analysis included the possibility of social prescribing decreasing feelings of loneliness and improving mental health and overall wellbeing.

I would like to thank all of the participants who provided their insight and ideas as well as the team at Friends for Good for their ongoing support and suggestions. I hope this research will continue the conversation about social prescribing in Australia and inspire the implementation of new services for those who are experiencing loneliness.

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Background

What is social prescribing?

Social prescribing (also known as community referral or non-medical prescribing) is defined as a method to allow general practitioners (GPs) and other primary care workers to link clients to community support services[1].

That is, to 'prescribe' non-medical treatments to assist patients. The assumption underlying social prescribing is that it is important to address social and psychological aspects of treatment alongside biomedical issues[2]. It extends the range of tools that are available to practitioners, by allowing them to provide non-medical referral options that can be an alternative to medications.

The basis of social prescribing comes from a person-centred approach to care, looking at the needs and wider social network of each individual and determining what form of care would be best for them. The aim is also to empower individuals and decrease their reliance on medical support. This holistic form of care may also have the ability to address underlying or causal issues and ultimately lead to better outcomes long-term[3].

[1] *Bickerdike, Booth, Wilson, Farley & Wright, 2017*

[2] *Drinkwater, Wildman & Moffatt, 2019*

[3] *Brandling & House, 2009*

Why is it important?

We now know that physical and mental health are intrinsically entwined.

Non-medical and social factors have a large impact on overall health and wellbeing[4]. Loneliness and social isolation have been linked to a number of physical health issues, such as heart disease, sleep difficulties and immune issues[5]. In order to understand and treat both physical and mental health, a holistic approach is required. Social prescribing is an important strategy in which health practitioners from various fields can offer those experiencing loneliness access to interventions and support. In a recent roundtable discussion by the Royal Australian College of General Practitioners in partnership with the Consumers Health Forum of Australia[6] it was noted, "social prescribing could provide a valuable addition to the existing range of healthcare options in Australia", with people experiencing loneliness and isolation identified as a key cohort that may benefit from such a service.

There is also evidence to suggest higher rates of loneliness and social isolation are linked with an increase in GP visits. For example, one Australian study found low social group connectedness was associated with higher frequency of primary care attendance[7]. GPs or primary care workers may therefore be ideally placed to identify those at risk of loneliness, and prescribe social activities to support these people. Social prescribing programs have been shown to reduce the number of both hospital admissions and GP visits[8][9], indicating a long-term economic benefit and a decrease in reliance on the health system.

[4] *World Health Organization, n.d.*

[5] *Luo, Hawkley, Waite & Cacioppo, 2012*

[6] *Royal Australian College of General Practitioners & Consumer Health Forum of Australia, 2019*

[7] *Cruwys, Wakefield, Sani, Dingle & Jetten, 2018*

[8] *Kimerlee, Ward, Jones & Powell, 2014*

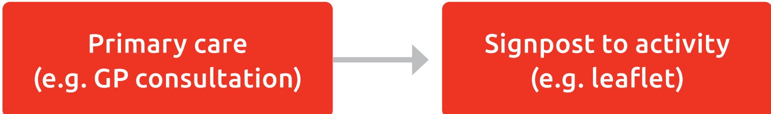
[9] *Rogers et al., 2008*

Models of social prescribing

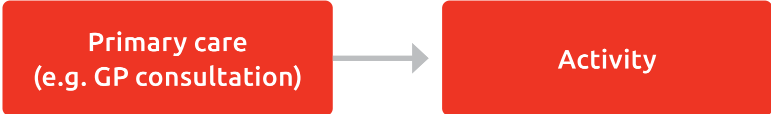
Social prescribing can take many forms in terms of the settings, targeted groups, and method.

The process can be informal (e.g. GPs handing out a pamphlet about a local service) or follow a formalised protocol. Husk and colleagues[10] suggest a number of pathways for access to social prescribing information as can be seen in Figure 1.

1: SIGNPOSTING



2: DIRECT REFERRAL FROM PRIMARY CARE



3: LINK WORKER

3+: HOLISTIC

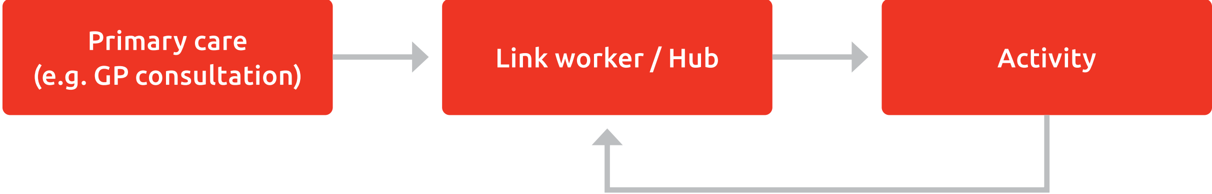


Figure 1. Pathways of social prescribing by Husk et al., 2020

Central to all of these is the role of the primary care workers (e.g. GPs) spending time to discuss and identify the social needs of the individuals and then making suggestions or referrals. Qualitative research indicates that GPs understand the importance of social prescribing, but may lack training and capacity to undertake it[11].

[10] *Husk et al., 2020*

[11] *Aughterson, Baxter & Fancourt, 2020*

Evidence for the effectiveness of social prescribing

Some empirical studies in the UK support the effectiveness of social prescribing to decrease loneliness[12], indicating this is a promising approach to investigate in the Australian context.

For example, a program in Northern England that was assessed, used Wellbeing Coordinators as link workers between GPs and individuals[13]. Using both qualitative and quantitative measures, the study reported an increase in wellbeing and social connectedness as well as a reduction in anxiety for participants in the program. Meta-analyses (that look at the overall effectiveness of this approach for a range of issues) also show some promise[14]. However, it is difficult to get a quantitative measure of the overall effectiveness, as much of the research is based on small pilot studies and standardised outcomes measures are not always used[15] [16].

Overall, the evidence base is still emerging, and more research is needed in this area to inform practice.

[12] *Kellizi et al., 2019*

[13] *Woodard et al., 2018*

[14] *Bickerdike et al., 2017*

[15] *Pitini, Adamo, Gray & Jani, 2020*

[16] *Drinkwater, Wildman & Moffatt, 2019*

Case Study 1

A pilot study for participants with a diagnosis of a mental health illness[17] has been implemented and evaluated in Sydney.

Participants were referred by their GP and the program involved a link worker assessing the needs of the individual and discussing available services. All participants also attended a weekly arts and crafts group. The results of the evaluation of the program indicated a significant improvement in measures of quality of life, health satisfaction and self-perceived health status. Although not a significant difference, there was also a trend towards participants experiencing less loneliness over the course of the program. This pilot study shows promising results for the implementation of social prescribing programs in the Australian context.

Case Study 2

In the UK the Bromley-By-Bow Centre has been delivering a social prescribing program for over 20 years using link workers and has also worked to scale-up this program across the country.

This centre "…champions social prescribing"[18] and includes GPs as well as a range of social and community services (such as spaces for therapeutic horticulture, welfare advice, adult learning etc.) in the one complex. Individuals who visit the centre to see a GP can be directly referred to an appropriate service within the centre itself, creating a welcoming and cohesive space to address a wide range of issues.

The program was also adapted in 2020 to provide crisis social prescribing during the pandemic. The Bromley by Bow Centre's social prescribing program has been evaluated extensively for the past four years. The results from the evaluations indicate that services provide a clinically significant increase in overall wellbeing and there is very positive feedback from service users.

[17] *Aggar et al., 2021*

[18] *Davis-Hall, 2018*

The Present Study

"Many inspirational and hard-working professionals have all come to the same conclusion – that we can do better for the person who stands before us"[19].

Social prescribing may be a crucial way we can connect those in need with direct assistance and social connection. However, there has been limited research into the use of social prescribing in Australia. Friends for Good aims to look at a wide range of interventions and strategies to improve the health and wellbeing of Australians. Models of social prescribing that have the potential to reduce social isolation and loneliness are therefore an important consideration for our research.

The aim of this research was to determine the level of awareness and openness to social prescribing in the general population, while gaining important insights to inform potential implementation of social prescribing programs in Australia.

Method

An online survey was created that included demographic questions as well as a series of multiple choice and short answer questions to explore opinions on social prescribing.

A representative sample of Australians was obtained using an online polling company. Overall, there were 1004 participants (456 males, 545 females and 3 who preferred to self-describe), aged 18- 85 years (mean age was 42). The sample was also representative based on geographic location, with respondents from both regional and metropolitan areas. A breakdown of the sample demographics can be found in Appendix 1.

[19] *Polley, Fleming, Anfilogoff & Carpenter, 2017, p.8*

Results and Discussion

Awareness of social prescribing

In our sample, 18.3% of people had previously heard of social prescribing. Majority (67.3%) had not, while 14.3% were unsure.

This result suggests a lack of overall awareness of social prescribing in the general population, which might be caused by it being called by different names or it being implemented in different forms.

Past experiences of social prescribing

In our sample, only 14% of respondents had ever experienced social prescribing firsthand. Some examples were GPs suggesting yoga, community groups, Men's Sheds, exercise, and volunteer work. Of those who had experienced social prescribing, most (84%) followed through with what was prescribed and 91% found it was helpful.

> "It helped me get through hard times"
>
> – Female, 22, NSW

Although social prescribing doesn't appear to be a common practice yet, preliminary evidence suggests there are beneficial effects for those that have experienced it.

Formats for social prescribing

When participants were asked about who was best placed to undertake social prescribing in the community; most answered GPs, followed by social workers and community nurses. Given there is evidence suggesting people who experience loneliness may visit GP clinics more often[20], this would be an excellent avenue for social prescribing work.

We also asked what format people would prefer to receive social prescribing in. Face-to-face was the most popular choice (60.7%), followed by online (28.2%) and telephone-based (9.6%).

[20] *Cruwys, Wakefield, Sani, Dingle & Jetten, 2018*

Openness to social prescribing

We aimed to learn if people are open to social prescribing. As Figure 1 shows, majority of people (83%) would be comfortable or very comfortable with a health professional 'prescribing' social activities.

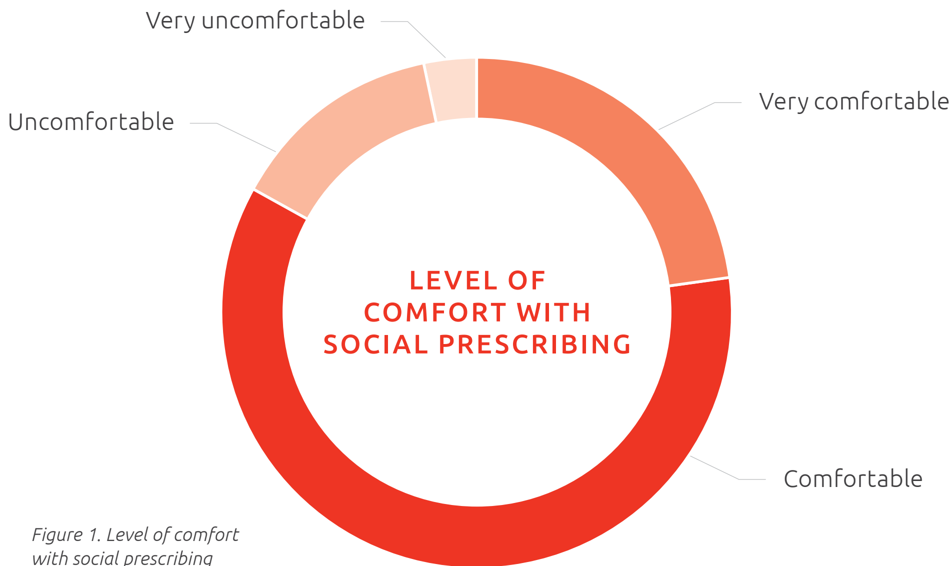


Figure 1. Level of comfort with social prescribing

When asked about how people felt social prescribing might impact their lives, most (84.9%) felt it would either positively or very positively impact them (Figure 2).

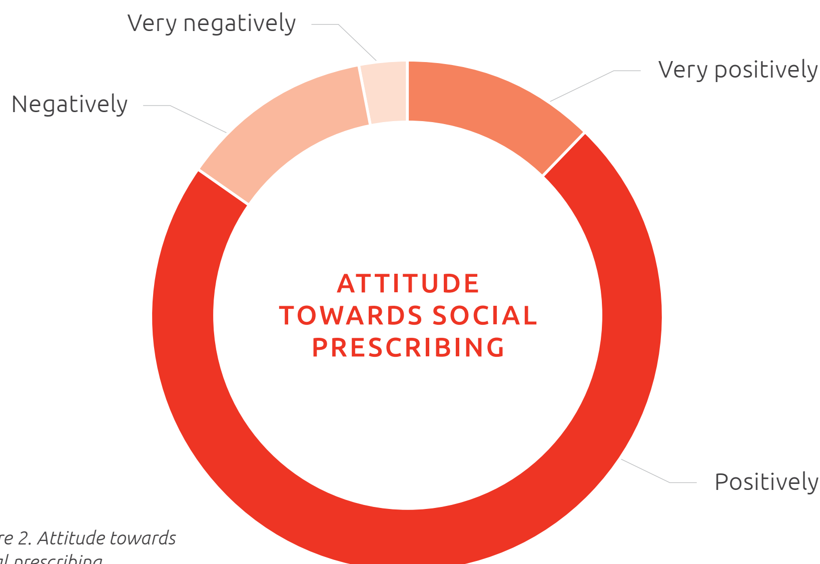


Figure 2. Attitude towards social prescribing

These responses were also analysed in terms of different demographic characteristics, including age, gender and location to determine whether there were significant differences in the level of comfort and positivity people felt towards social prescribing. Overall, in all of the demographic groups, majority of people felt comfortable with the idea of social prescribing and were positive towards it. Details of the scores for each of the groups are provided in Appendix 2.

This preliminary, yet very promising result indicates that the general population would be open to social prescribing and they believe that it will positively impact their lives.

Social prescribing and loneliness

Loneliness was measured using the UCLA Loneliness Scale[21]. This is an empirically tested scale and is widely used as a measure of subjective loneliness[22]. The scale includes 20 questions (e.g. "How often do you feel part of a group of friends?") which are answered on a scale from 1 (never) to 4 (always)[23].

In this sample the total scores on the scale ranged from 20 to 80, with an average score of 46.05 (*SD* = 11.39).

Using a standard published cut-off score[24], approximately 57% of our sample would be considered to be experiencing high levels of loneliness. Using a more conservative estimate[25], approximately 14% would be considered to be experiencing high levels of loneliness. These results are very similar to our previous research[26], which also used a representative sample (66.3% and 15% respectively). These findings are interesting given that the COVID-19 pandemic occurred between the data collection for each study. This could indicate that people were experiencing the same level of loneliness throughout this time period or there may have been an even greater increase during the pandemic. More research is needed to determine the direct impact of the pandemic on experiences of loneliness.

Responses to the survey questions were analysed to determine whether people who scored highly on the loneliness measure were more or less receptive to the idea of social prescribing. Overall, there was no significant difference in the response to social prescribing related to the level of loneliness experienced by respondents. Given that some of our sample indicated an experience of loneliness at the time of taking the survey, the significantly positive support for social prescribing indicates the potential for this as a tool for tackling loneliness.

[21] *Russell, 1996*

[22] *Goossens, Klimstra, Luyckx, Valhalst & Teppers, 2014*

[23] *The UCLA-LS is presented in Appendix 3*

[24] *A score of above 44 as suggested by Cacioppo & Patrick, 2008*

[25] *Those scoring more than 1 standard deviation above the mean*

[26] *Friends for Good, 2019*

Qualitative responses

As a follow up to the question "How do you think social prescribing would affect your life?" we asked participants to "Please describe why". This question was intended to produce qualitative responses which would allow a deeper understanding about the opinions and concerns of the general public.

Following a thematic analysis of the responses to this question, a number of key themes emerged. These are listed below along with examples of responses.

THEME 1: SOCIAL PRESCRIBING WOULD HELP WITH LONELINESS

Many responses included a reference to social prescribing as a tool to alleviate social isolation or loneliness. Also, responses reflected the idea that social prescribing would increase connection and social engagement.

"Encourages healthy connection and helps with loneliness"

"Make you feel less alone"

THEME 2: SOCIAL PRESCRIBING WOULD IMPROVE WELLBEING AND MENTAL HEALTH OUTCOMES

As shown in the example responses, social prescribing was seen by many as a way to increase overall health and wellbeing and to access services when experiencing mental ill health.

"Sometimes you need advice about how you can improve your mental health and when you aren't feeling mentally well you can't reach out and make those decisions"

"I have severe anxiety and panic attacks when I am around crowds this would be something that I definitely am interested in to help me"

"When I get depression I am not capable of finding these services myself"

THEME 3: UNSURE ABOUT THE IDEA OF SOCIAL PRESCRIBING

Many people were unsure of the meaning of social prescribing and were unclear about the potential benefits.

"I don't know enough about it to have much of an opinion"

"Unsure. I would have to consider what it was for and how it might work"

THEME 4: ANY HELP WOULD BE BENEFICIAL

A key theme was the idea that offering any additional help to people would be beneficial in some way.

"Offering options is always better then doing nothing"	"To gain help that is beneficial is always a good positive outcome"

THEME 5: GPS WOULD BE A TRUSTED SOURCE OF INFORMATION

GPs or other medical health professionals were seen as experts and a trusted source of information. As such, many people noted that social prescribing would be well received if information was given by a trusted professional.

"I'd like to think that recommendations from a trusted source will be beneficial for my life, if they believe it will help me"	"If it is something a GP recommended I believe it would help as I trust GPs"

THEME 6: SOCIAL PRESCRIBING WOULD BE HELPFUL/ BENEFICIAL

A final recurring theme in responses was the idea that social prescribing would be helpful and beneficial. The most common key word used across the 1004 responses was "help" and the idea that social prescribing would provide help to people was strong throughout.

"Sometimes you would not know where to start - so having some suggestions is great"

"Because it would help me as a person"	"Help when and where you needed it"

Summary

Previous research suggests that social prescribing may be an important tool for people experiencing loneliness or social isolation to access supports and services in their area.

Our data indicates that people are open and positive about receiving social prescribing, and those who have experienced it found it beneficial. This research provides some preliminary, yet encouraging data, that supports the implementation of social prescribing in Australia.

One potential drawback for the implementation of social prescribing is the limited amount of time GPs or other health professionals may have, and the additional costs involved to undertake this work. Associated with this for some practitioners is the need for significant resources and information about where to make referrals. It is beyond the scope of this report to delve more fully into service delivery possibilities and limitations, however, it does seem that we should work to overcome these barriers, given the considerable support in the community for the idea of social prescribing. Previous research shows that people experiencing loneliness visit GPs more often. The introduction of social prescribing may have the additional benefit of reducing the number of visits to GPs solely for social contact. Furthermore, a cost benefit analysis would potentially show long-term benefits through better health outcomes.

We are aware that there are a number of projects being undertaken in Australia that seek to use the linkage model and these are not yet complete or evaluated. To our knowledge there has not been widespread introduction of social prescribing by GPs and this is what the majority of people surveyed by Friends for Good would welcome.

> Social prescribing in the Australian context may be a powerful preventative strategy that could allay the development of more serious mental health problems for many people.

If implemented successfully, it would potentially save significant amounts of money spent within the Australian health system, in addition to the improvement in wellbeing for individuals. We hope that this research will inspire more discussion, awareness and implementation of social prescribing programs in Australia.

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Appendices

Appendix 1: Sample demographics

DEMOGRAPHICS	*n*	% OF SAMPLE
Gender		
Male	456	45.4%
Female	545	54.3%
Prefer not to self-describe	3	0.3%
Location		
Victoria	255	25.4%
New South Wales	256	25.5%
Queensland	214	21.3%
Northern Territory	6	0.6%
Australian Capital Territory	20	2%
Tasmania	47	4.7%
Western Australia	104	10.4%
South Australia	102	10.2%
Age		
18–25	139	13.8%
26–40	362	36.1%
41–55	308	30.7%
56–70	166	16.5%
70+	29	2.9%

DEMOGRAPHICS	*n*	% OF SAMPLE
Language spoken		
English only	849	84.6%
Arabic	9	0.9%
Cantonese	12	1.2%
Greek	7	0.7%
Mandarin	13	1.3%
Vietnamese	12	1.2%
Hindi	13	1.3%
Other	89	8.9%
Employment status		
Employed full time (35+ hours per week)	422	42%
Employed part time (<35 hours per week)	208	20.7%
Student (full time)	41	4.1%
Student (part time)	8	0.8%
Not employed and not looking for work	37	3.7%
Unemployed, looking for work	83	8.3%
Home duties	91	9.1%
Retired	90	9%
Other	24	2.4%
Education		
Postgraduate degree or higher	150	14.9%
Undergraduate degree	252	25.1%
TAFE or certificate course	284	28.3%
High school completed (VCE or equivalent)	202	20.1%
Some high school, no diploma	107	10.7%
No schooling completed	5	0.5%
Prefer not to say	4	0.4%

Appendix 2: Key questions by demographics

LEVEL OF COMFORT BY GENDER

	n	Very comfortable	Comfortable	Uncomfortable	Very Uncomfortable
Female	545	21.8% (119)	**60.9% (332)**	14.3% (78)	2.9% (16)
Male	456	24.3% (111)	**59.2% (270)**	13.2% (60)	3.3% (15)
Prefer not to self-describe	3	33.3% (1)	33.3% (1)	33.3% (1)	0

LEVEL OF COMFORT BY STATE

	n	Very comfortable	Comfortable	Uncomfortable	Very Uncomfortable
Victoria	255	25.1% (64)	**59.6% (152)**	11.4% (29)	3.9% (10)
ACT	20	20% (4)	**65% (13)**	15% (3)	0
New South Wales	256	28.5% (73)	**57.8% (148)**	11.7% (30)	2% (5)
Queensland	214	21% (45)	**59.3% (127)**	16.4% (35)	3.3% (7)
Western Australia	104	20.2% (21)	**56.7% (59)**	16.3% (17)	6.7% (7)
South Australia	102	11.8% (12)	**70.6% (72)**	16.7% (17)	1% (1)
Northern Territory	6	**50% (3)**	33.3% (2)	16.7% (1)	0
Tasmania	47	19.1% (9)	**63.8% (30)**	14.9% (7)	2.1% (1)

LEVEL OF COMFORT BY AGE

	n	Very comfortable	Comfortable	Uncomfortable	Very Uncomfortable
18-25	139	24.5% (34)	**62.6% (87)**	12.9% (18)	-
26-40	362	23.5% (85)	**63.5% (230)**	10.5% (38)	2.5% (9)
41-55	308	22.7% (70)	**57.8% (178)**	14.6% (45)	4.9% (15)
56-70	166	21.1% (35)	**54.8% (91)**	20.5% (34)	3.6% (6)
70+	29	24.1% (7)	**58.6% (17)**	13.8% (4)	3.4% (1)

ATTITUDE BY GENDER

	n	Very positively	Positively	Negatively	Very negatively
Female	545	13.6% (74)	**72.7% (396)**	11.4% (62)	2.4% (13)
Male	456	10.7% (49)	**72.6% (331)**	13.4% (61)	3.3% (15)
Prefer not to self-describe	3	33.3% (1)	**66.7% (2)**	0	0

ATTITUDE BY STATE

	n	Very positively	Positively	Negatively	Very negatively
Victoria	255	11.8% (30)	**71.8% (183)**	13.7% (35)	2.7% (7)
ACT	20	15% (3)	**80% (16)**	5% (1)	0
New South Wales	256	17.6% (45)	**69.9% (179)**	8.6% (22)	3.9% (10)
Queensland	214	11.7% (25)	**72.9% (156)**	13.1% (28)	2.3% (5)
Western Australia	104	7.7% (8)	**77.9% (81)**	9.6% (10)	4.8% (5)
South Australia	102	6.9% (7)	**76.5% (78)**	15.7% (16)	1% (1)
Northern Territory	6	0	3 (50%)	3 (50%)	0
Tasmania	47	12.8% (6)	**70.2% (33)**	17% (8)	0

ATTITUDE BY AGE

	n	Very positively	Positively	Negatively	Very negatively
18-25	139	12.9% (18)	**66.9% (93)**	17.3% (24)	2.9% (4)
26-40	362	13.5% (49)	**76.5% (277)**	8.3% (30)	1.6% (6)
41-55	308	12.3% (38)	**73.7% (227)**	10.7% (33)	3.2% (10)
56-70	166	9.6% (16)	**68.7% (114)**	17.5% (29)	4.2% (7)
70+	29	10.3% (3)	**62.1% (18)**	24.1% (7)	3.4% (1)

Appendix 3: UCLA-Loneliness Scale

LONELINESS SCALE	SCORING			
Statement	**Never**	**Rarely**	**Sometimes**	**Always**
1. How often do you feel that you are "in tune" with the people around you?	4	3	2	1
2. How often do you feel that you lack companionship?	1	2	3	4
3. How often do you feel that there is no one you can turn to?	1	2	3	4
4. How often do you feel alone?	1	2	3	4
5. How often do you feel part of a group of friends?	4	3	2	1
6. How often do you feel that you have a lot in common with the people around you?	4	3	2	1
7. How often do you feel that you are no longer close to anyone?	1	2	3	4
8. How often do you feel that your interests and ideas are not shared by those around you?	1	2	3	4
9. How often do you feel outgoing and friendly?	4	3	2	1
10. How often do you feel close to people?	4	3	2	1
11. How often do you feel left out?	1	2	3	4
12. How often do you feel that your relationships with others are not meaningful?	1	2	3	4
13. How often do you feel that no one really knows you well?	1	2	3	4
14. How often do you feel isolated from others?	1	2	3	4
15. How often do you feel you can find companionship when you want it?	4	3	2	1
16. How often do you feel that there are people who really understand you?	4	3	2	1
17. How often do you feel shy?	1	2	3	4
18. How often do you feel that people are around you but not with you?	1	2	3	4
19. How often do you feel that there are people you can talk to?	4	3	2	1
20. How often do you feel that there are people you can turn to?	4	3	2	1

Source: Russell, D. (1996). UCLA Loneliness Scale (Version 3): Reliability, validity, and factor structure. Journal of Personality Assessment, 66, 20-40.

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