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Social Prescribing: Outcomes, Mechanisms, and Implementation Barriers

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ABSTRACT

Social prescribing has emerged as an innovative, person-centred approach to addressing the social determinants of health by linking individuals to non-clinical community resources. This paper examines the conceptual foundations, mechanisms, outcomes, and implementation challenges associated with social prescribing. It traces the evolution of the approach from welfare-oriented frameworks to its contemporary integration within health systems, particularly in primary care settings. The analysis highlights the multidimensional mechanisms through which social prescribing influences health, including behavioural change, social engagement, resource navigation, and psychological empowerment. Evidence on outcomes suggests potential benefits in physical health, mental well-being, and reduced healthcare utilization; however, findings remain mixed and are often constrained by methodological limitations and variability in intervention design. The paper further explores key implementation barriers, including funding constraints, workforce capacity, service fragmentation, and measurement challenges, alongside the critical role of link workers and community partnerships. An equity lens underscores the importance of ensuring access for vulnerable and underserved populations while addressing structural determinants of health. The study concludes that while social prescribing holds promise for improving health outcomes and promoting health equity, its effectiveness depends on robust evaluation frameworks, sustainable funding, integrated care models, and context-sensitive implementation strategies.

Keywords: Social prescribing, Social determinants of health, Health equity, Community-based interventions and Healthcare utilization.

INTRODUCTION

The World Health Organization (WHO), in the Ottawa Charter for Health Promotion published in 1986, acknowledged that the central issue as a world community is to guarantee people's basic needs [1]. Human beings' fundamental human needs, such as shelter, food, clothing, and the security of employment, had significant biological, psychological, and social meanings [2]. Social prescribing (SP) did not arise as a fashionable concept by accident in recent times but has a considerable historical background as a formal solution to the needs of poor society. The modern social care system and social prescribing practices present two key elements in the response to social need. Malaysia, like other neighbouring countries, instituted its national social welfare programme following its independence in 1963. The obligation to deliver a minimum standard of wellbeing, notably when limited resources were available, was explained in the early blueprint documents of 1966 and 1972 [1]. In fact, social prescribing has a long-standing history and development in the UK and has been mentioned officially in documents since 1964 when a specific Health and Social Services policy was outlined. This policy was much influenced by international developments and increasingly focused on preventive aspects of welfare that extended beyond sick care [2]. It particularly focused on problematic areas like deprivation related to housing, education,

and employment etc.[3]. Publicity was given to these concerns when England celebrated its 1965 Year of the Child and in a special memorandum for the 40th Anniversary of the UNICEF in 1986. During the year, policies that emphasised childhood concerns, childhood protection and childhood services were set up [2].

Conceptual Foundations of Social Prescribing

Social prescribing encompasses a range of interventions designed to address patients' social needs and improve their health [1]. A wide variety of activities falls under this umbrella, including art and gardening groups, exercise classes, befriending services, and arts-on-prescription schemes, all of which offer patients an opportunity to participate in communal activities that nevertheless differ from one another in significant ways [3]. Many of these social prescribing activities have been delivered via community-based venues, and the approach has important implications for health equity [3]. In the UK, social prescribing has been emphasized in public health policy and embedded within general practice. For example, NHS England has developed models for universal personalized care that include social prescribing as one of several key components [4]. A growing body of critical reviews examines the definition, implementation, and evidence base of social prescribing. Process evaluations and ethnographic approaches have become increasingly common as researchers seek to understand how social prescribing interventions are implemented and the ways in which they are thought to affect social and health inequalities [5]. Research in this area has highlighted the role of link workers in connecting patients to community services, the importance of person-centred care in delivering social prescriptions, and the complex ways in which social class and class practices influence health outcomes, underscoring the necessity of a nuanced understanding of social factors in health interventions [6].

Definitions and Scope

Social prescribing joins healthcare providers to community services targeting patients' social determinants of health to improve health, wellbeing, and independence especially for those with long-term, chronic conditions. Initiated in the UK in the 1990s following shifts within the National Health Service, its introduction aimed to alter treatment approaches from biomedical to biopsychosocial[5]. Proposed mechanisms include enhanced agency, wellbeing, social engagement, community support, navigation, and resource access [4]. Typical pathways involve link, navigational, referral, and signposting services related to health, social, and preventive interventions provided by the community; voluntary, charitable, and non-profit organizations; or creative, cultural, and sport-related frameworks [5]. Pathways may extend to health promotion, social integration, and digital assistance 3. Proposed targets include reduced consultation for minor ailments, service load alleviation, decreased hospital readmission, and diminished prescriptions for medically unexplained symptoms [1].

Theoretical Mechanisms Linking Social Prescribing To Health Outcomes

Many interpretations of social prescribing describe connections between health and social determinants. Systems and theories propose multiple pathways linking social prescribing to health [6]. The social determinants of health literature specify structural conditions guiding individual behaviours associated with health [5]. Healthier behaviour adoption, behavioural regulation, or overarching health capability development characterise social prescribing interventions [2]. Behavioural frameworks position knowledge and belief reformation as precursors to behaviour change [2]. Interventions enhancing social contact and support engagement posit health capacity building through broadened access to diverse capabilities [5]. Theoretically, a suite of intermediary outcomes behavioural, socio-emotional, or psychological may underpin health impact. Social engagement through network size, support quality, or community belonging fosters reassuring psychosocial conditions conducive to maintenance of health [3].

Distinction from Traditional Clinical Pathways

Between 425 and 780 million people suffer from depression worldwide, making it the most common mental disorder, and more than 2.6 billion people are at risk of developing chronic diseases (World Health Organization, 2023). The COVID-19 pandemic has exacerbated these issues, particularly among low-income and marginalized groups. In response, many countries are looking for different approaches to address social and emotional needs. The United Kingdom's NHS introduced social prescribing as a new model to tackle these challenges [3]. Social prescribing refers to the practice of linking patients with non-clinical support in the community [4]. Practitioners (also referred to as link workers, community navigators, or social prescribers) draw on a variety of community activities and services to create personalized care plans that, through social engagement, help address patients' health concerns[5]. It targets a variety of social and emotional factors: health-related stress, financial stress, lack of company, isolation, educational needs, and activities such as homework, social-care services, financial assistance programs, and parenting-school programs [6]. The practice recognizes that many patients do not require the usual clinical treatment but nevertheless experience health-related stresses or issues that non-clinical support can help mitigate. For patients whose needs are not adequately captured within the conventional biomedical model, social prescribing offers a person-focused alternative [7]. Social prescribing also differs from traditional clinical pathways in three key aspects. First, the biological, behavioral, and environmental conditions associated with

illnesses remain important; however, the emphasis lies on the behavioral and environmental factors, shifting the focus of intervention from cure to prevention. Second, existing models of care that do not fall within the established clinical pathways are nonetheless viable candidates for referral [9]. Finally, social prescribing expands the definition of wellness. Wellbeing is not simply the absence of disease; rather, it encompasses various health-related factors that, although not immediately life-threatening, can still detract from one's quality of life [4]. Social prescribing thus complements rather than displaces the traditional biomedical model, which proceeds along a secure pathway from appointment referral through targeted external treatment to clinical recovery, focusing on intervening within the established clinical-contact framework [6]. Referral practices for social prescription, however, extend beyond the appointments-prevention-recovery schema; they can preferentially target patients who already utilize health services intensely or whom the medical model alone cannot satisfy [8].

Evidence on Outcomes

Social prescribing interventions vary widely in their nature and implementation, and these differences are reflected in the health-related outcomes measured in evaluations [1]. Yet a substantial amount of evidence exists concerning the impact of social prescribing on health, across multiple studies and diverse contexts, scope of measurement, sample size, and geography [2]. Overall, the evidence base remains relatively weak in quality and certainly low to moderate in quantity, compared to other policy interventions. The balance of available data nevertheless points to positive changes across several distinct dimensions [3].

Health-Related Outcomes

Social prescribing initiatives aim to enhance social integration and tackle loneliness through personalized well-being plans providing links to local community activities, resources, and services [7]. Evidence remains mixed, however, with considerable uncertainty regarding the extent and direction of health and well-being impacts following engagement with social-prescribing interventions [8]. A systematic review 1 identified over 300 unique, supervised models across the UK, but their implementation is patchy, underscoring the widespread interest in understanding their outcomes and mechanisms [10]. Health-related outcomes include a wide array of physical health indicators. Several studies report positive changes to such indicators though the evidence base is limited, effect sizes variable, and confidence intervals wide. Outcomes studied range from general indicators like self-reported health status, through measures like body mass index, obesity prevalence, and exercise participation, to more specific biomarkers such as cholesterol, blood pressure, and glycosylated hemoglobin. Increases in walking or general physical activity levels have also been observed [2].

Mental Health and Wellbeing

Social prescribing aims to improve the health and well-being of individuals with complex social, emotional, or practical needs by linking them to community groups, activities, or resources[7]. It is particularly appropriate for people facing issues like homelessness, debt, addiction, unemployment, or social isolation [7]. In the United Kingdom, social prescribing focuses on the whole person rather than specific presenting problems, addressing the wider social determinants of health [8]. Nonetheless, engagement is often targeted at individuals with strong mental health needs, such as anxiety, stress, low mood, depression, emotional well-being, or life satisfaction.

Various metrics have been used to gauge participants' mental health and well-being [6]. For example, a study in an inner-city London borough measured clinical outcomes using scores from the Generalized Anxiety Disorder Assessment (GAD-7), the Patient Health Questionnaire (PHQ-9), and the Kessler Psychological Distress Scale 1. At eight months, no significant differences were found in overall anxiety or depression between patients referred to social prescribing and controls [5]. The same study also measured social and psychological well-being before social prescribing against a peer group, using the Warwick-Edinburgh Mental Well-Being Scale (WEMWBS), the University of Exeter Well-Being Scale (UEWBS), and the London Psychological Well-Being Scale. No significant changes emerged in these scores either [4]. Another investigation of the Life Rooms model of social prescribing recorded baseline, six-month, and twelve-month follow-up scores on validated instruments assessing anxiety, depression, stress, resilience, and life satisfaction. Statistically significant improvements between baseline and follow-up were observed across all measures, except life satisfaction at six months [7]. Between six and twelve months, resilience showed further benefit, while the impact on anxiety, stress, and life satisfaction attenuated. A survey of service-users' views on link worker social prescribing identified similar psychometric approaches to gauge improvements in mental health and well-being, although no quantitative data were reported [8]. Integrating social prescribing into local health systems creates opportunities to build such specifications and facilitate adaptive measurement. Ideally, evaluations will grapple with detangling social prescribing from justifiable resource-linked interventions addressing social determinants or root causes of deterioration [6].

Healthcare Utilization and System-Level Effects

Social prescribing can reduce healthcare utilization without negatively impacting health outcomes [5]. Five community-based interventions in England, Scotland, and Canada led to an approximately 30-40% reduction in GP visits, with no increase in emergency department use or hospital admissions [9]. Prior to social embedding,

14-61% of participants reported high health-need indicators, but these rates generally decreased post-engagement. Observed reductions stemmed from allocating time and resources to address broader community and personal issues, reducing the need for clinical consultations [10].

Equity and Social Determinants of Health

Social prescribing aims to address patients' social needs through community-based support. It involves linking individuals to non-medical services to improve health outcomes and reduce health inequalities [1]. Social determinants, including socioeconomic status, education, and environment, significantly influence health [9]. The implementation and effectiveness of social prescribing vary, and ongoing research assesses its impact and accompanying evidence [8]. Development and evaluation of complex interventions employ key frameworks. These highlight the social context and participant experiences as essential to enhancing health equity [3].

Mechanisms of Action

Enabling individuals to take greater control of their health and wellbeing, goal setting, motivation, and support in pursuing health-related behaviours features prominently in theories of behaviour change 10. It is also recognized as a pathway through which social prescribing is believed to improve health [7]. Patients are supported to identify their own health-related goals, which can include maintaining good health, meeting prescribed targets, or achieving specific indicators along counterproductive trajectories [8]. Patients report addressing a range of health-related goals through social prescribing, including long-term conditions with specified management targets [3]. These are often complemented by broader aspirations for health or wellbeing, reflecting a shift beyond the domain of health itself [6]. Goal-related support extends to safety, exercise, nutrition, and social reintegration; although diverse, such goals are not randomly associated with changes in symptoms or recovery trajectories.

Motivational factors are also intrinsic to health decision-making [5]. Surveys indicate that patients' motivation to pursue a prescribed activity, alongside alignment with their needs, is a key determinant of engagement; conversations with trusted providers or contacts typically lubricate decision-making. Added motivation arises through referrals from practitioners in trusted professional roles, especially if consultation is perceived as decisive or if a pre-existing activity is already pursued [8].

Behavioral Pathways

Social prescribing can operate through behavioral mechanisms that facilitate engagement in activities linked to well-being [1]. Engaging with the link worker typically sparks motivation to pursue such activities, and motivation is a critical precursor to goal setting within the relevant behavior change strategies [3]. Social prescribing appears to be distinct among motivational enhancement interventions; it promotes both health-related and other types of activities (e.g., physical fitness, arts, social groups), which may reach individuals not engaged through conventional health promotion initiatives [4]. Social prescribing intrinsically involves resource linking and pathway navigation, tackling challenges in accessing activities that might enhance well-being. Available cultural and therapeutic activities and social networks can be difficult to identify within communities. Access hinges not only on material resources (e.g., cost, transport) but also on the ability to navigate services. Link workers thus assist with both identification of and referral to suitable options [10]. Social prescribing may increase psychological empowerment via both intrinsic activity (conducting arts, getting fit) and extrinsic behavior (consulting a link worker)[11]. Choices made in activity selection empower individuals to manage well-being rather than passively undergo treatment. Even fears about stigma and social isolation engendered by the referral process can be alleviated when the intermediary is a non-clinical worker [9]. Evaluation studies also employ various empowerment dimensions, including control over life, confidence in health management, and enactment of healthy food choices, wherein enhanced self-efficacy for typical health-promoting behaviors seems to facilitate broader uptake of additional lifestyle adjustments [4].

Social Engagement and Social Capital

To the extent that social prescribing directs individuals to organizations that foster connections and cultivate social networks, it may target psychosocial factors more directly than alternative health promotion or wellbeing activities [16]. Such programs could potentially enhance network size or adjustment expanding contacts, advice, or emotional support or boost the perceived quality of the connections, in areas like trust and belonging [5]. All four possibilities would be consistent with established accounts of social capital, spanning conceptualizations from the structural and relational components identified by Lin 1 to the multiple types specified by Bhandari and Yasunobu[6]. Programs may also stimulate other dimensions captured within broader frameworks—such as the relational, structural, material, and cognitive axes [5]. Public health frameworks identify a wider range of psychosocial processes, describing pathways like community empowerment, the fostering of belonging and support, neurotrophins and cortisol, and social cohesion [2]. The benefits of social connections for health and wellbeing are well established, operating through multiple pathways such as diffusion of knowledge and norms, affective functions like esteem or empathy, and creating social identity and belonging[5]. Different pathways could underlie wellbeing from attendance at physical activities with others, and "cultural" activities may invoke yet

another [9]. Several models of social capital and its links to health have been articulated, largely consistent with earlier work on social networks.

Resource Linkage and Pathway Navigation

Social prescribing refers to the process by which health professionals refer patients to non-medical services to address social and lifestyle factors contributing to a range of health problems and associated health services utilization [4]. Non-medical referral processes represent an alternative model of care that draws upon resources not traditionally associated with food security or hygiene such as financial assistance, health promotion, and life skills enhancement with the aim of alleviating multi-morbidity and distress [6]. Individuals living in conditions approximating the United Nations long-term poverty metric of $3.20 are at a marked disadvantage; for instance, those under national minimum wage may need robust support to achieve work readiness and remain connected to the labour market for up to 40 years [7]. The mechanism underpinning social prescribing is resource linkage and pathway navigation; patients are referred to activities or services that meet their expressed needs, based on the assumption that fulfilling unmet needs will lead to either direct improvements in health or indirect improvements via changes in related clinical, lifestyle, or social factors[7]. Social prescribing is underpinned by direct patient referral to resources beyond the conventional health system. Typical referral pathways include home visit programs such as the Food Is Medicine Coalition, which targets the food security-related social determinant of health, and long-term income support from welfare systems or community-based, non-circuit debt assistance programs, serving as examples of services operating outside the health infrastructure [11]. These services are positioned outside third-sector service-level agreements and can effectively mitigate demand for family health services and substance-misuse support [5]. The capacity of link workers has been highlighted as an issue for both clinical life-skills enhancement and lifelong health improvement; understanding the standard for social prescribing and education on access channels to out-of-scope resources were considered valuable for increasing resource access, reinforcing timely and effective interventions to alleviate distress or impediments to recovery and addressing related lifestyle changes through the conventional health system[5].

Psychological Empowerment and Self-Efficacy

Psychological empowerment involves the instillation of enhanced agency, control, and a belief that individuals can manage their health [12]. At the heart of this process lies the concept of self-efficacy, which entails the confidence a person has in their ability to achieve goals, make healthy choices, and access necessary services. Many patients seek social prescriptions through a healthcare professional due to uncertainty regarding what they need or how to find support [7]. Link workers may play a vital role in this context by assisting individuals in articulating what activities or services they perceive will benefit them and, consequently, enabling access to those supports [13].

Individuals may also feel more confident in defining and achieving their health and well-being objectives when they receive additional support via social prescriptions [12]. The concept of self-efficacy encompasses the confidence individuals maintain in their capacity to initiate and sustain the processes sought after receiving a social prescription. In other words, service users exhibit greater commitment to actions identified as beneficial, greater resilience and determination when facing obstacles, and a heightened belief that success depends on their own efforts rather than external factors a state psychologists term an "internal locus of control [10]." The capacity to set and achieve health-related objectives is further enhanced by the activation of existing, unfulfilled aspirations [11].

Implementation Frameworks and Models

Variations in referral processes exist depending on the governance structure supporting any given social prescribing programme. In some cases, general practitioners (GPs) can refer individuals, whereas in others, this can occur only through health service providers with a designated healthcare role [7]. City government officials in Scotland "expect that in areas where access to social prescription is considered a priority, evidence of that need would be a starting point for consideration" [13]. In many cases, recipients must fulfil articulated eligibility criteria despite using LM functions, completing an LM form, or undergoing the NCGI screening process. Although less frequently, GPs may still refer individuals to NCG services when eligibility thresholds for social prescription interventions or LM have been met [14]. Variations across regions may also be observed in the extent to which community members require explicit consent before undertaking an LM referral with or without preceding recourse to an LM screening form [11]. An area, for instance, may permit wider geographical freedom in contrast to strict adherence to neighbourhood confines or charter limits, which would otherwise exclude agglomerated communities from further designated interventions or LM requirements beyond threshold fulfilment [14].

Role of Link Workers and Multidisciplinary Teams

Social prescription programmes generally designate LM as the principal function through which a NCG body issues a public invitation enabling individuals to seek LM or through which an individual affiliated with an NCG can recommend any community member, including those remaining ineligible for additional interventions or

subsequently disengaged, to receive LM support [12]. Ensemble models receiving oversight from the governing bodies of the supporting social-prescription frameworks also utilise LWs as the primary initiators of LMs. This designation may exclusively provide accompanying recommendations or solely administer LM-related referrals but retains LM workplace solicitation irrespective of the designation [13]. In contrast, regular teams dispatch a direct notification regarding membership access eligibility without necessarily issuing the public solicitation facilitating the LMs that characterises both models [13]. Interdisciplinary professional teams addressing health divisions, such as housing, welfare, and health, while possessing multi-tiered authority across NCGs and community spheres, often endorses any third-party or institutional member's communication to LMs when confirmation of pre-existing community links occurs relative to population designated levels [9]. LMs might still remain accessible contingent on enduring ties, thereby reframing, while unwittingly extending, the LM and LW characterisations articulated above [3].

Referral Processes and Eligibility

Scores indicate that 60% to 80% of individuals eligible for social prescribing were not referred. Several barriers in the referral process may contribute to this gap [13]. An initial match between the patient's social needs and the available services must first be ascertained. Although various assessments have been developed, there remains no standardized assessment tool for social prescribing [15]. The search for viable local services to refer to can frequently take weeks or even months. Furthermore, even when a suitable service can be identified, the reason for non-referral may not always be related to the service itself [11]. Strategies employed to address this issue mostly involve enhancing workflow integration. The primary objective is to make social prescribing more visible and easier to implement so that prescribers quickly notice it as an option during routine patient consultations. Research suggests that many professionals are unaware of community resources such as social prescribing, while others, although aware, prefer not to refer patients [3]. Failure to recognize the scope of social prescribing leads to missed opportunities.

Role of Link Workers and Multidisciplinary Teams

Link workers serve as crucial facilitators in the social prescribing process. Their functions include supporting patients in identifying social needs, providing information about community services, and assisting with access to resources and onboarding processes [9]. They also help patients delineate social challenges affecting their health, support them in decision-making, and promote active engagement in self-care [16]. However, the absence of a universally stated definition of the link worker role and competencies has resulted in diverse implementations across settings [12]. Link workers (often called community connectors, community navigators, or Champions) come from various disciplinary backgrounds, including social work, public health, and community organizing, reflecting community-based approaches to health promotion, chronic disease management, and mental health support [13].

Partnerships with Community Services

Promoting social prescribing requires collaboration with VCSE organizations and other community resources. At the outset of a social prescribing initiative, governance partners should map the services and assets available within the community and articulate how the program will connect individuals with these options [2]. Alignment among stakeholders on a shared vision helps build partnerships for the initiative's design, implementation, and scale, and for monitoring progress and effectiveness over time [3]. Community services should also help shape the social prescribing model to ensure it is relevant and that their support whether access to a particular service, provision of information or other assistance is optimized [1]. Co-production with stakeholders and partnership development remain foundational practices throughout a social prescribing initiative, responsive to the evolving local context [5].

Monitoring, Evaluation, and Data Integration

The objectives for monitoring and evaluation include assessing reach, coordination, and link-worker use, alongside indirect social-prescribing measures of social capital [5]. Selection of social-prescribing performance indicators has emphasised five aspects: staff/service availability, light-touch interventions, activities related to health-driving social determinants, attendance monitoring, and care re-engagement [6]. Evaluation literature calls for developing a national outcome set to standardise social-prescribing impact and align evaluation with the benchmarking of other primary-care services [17]. The current absence of well-documented monitoring and evaluation in any specific social-prescribing service model limits insights that might otherwise guide adaptation, scaling, or further exploration [1]. Building integrated social-prescribing data systems is viewed as essential. Well-constructed data systems facilitate monitoring, produce useful feedback loops, and instil overall service-confidence. Interoperability, spreading monitoring practices widely, and integrating individual-level outcomes across health-care and community systems, are highlighted as early priorities [12,13].

Barriers to Implementation

Implementing social prescribing remains challenging despite its potential to improve health and well–being, enhance access, and mitigate inequities [13]. Systematic reviews have identified myriad facilitators and barriers shaping the implementation and integration of social prescribing in primary care and community settings 18. Resource-related obstacles top the list of barriers, with constraints on funding, budgets, staff, infrastructure, time, evidence bases, maintenance, and skills all reported as difficulties for its implementation. A related barrier concerns the nature of resources themselves uncertainty about the fit between context, pathway, and available interventions hampers social prescribing engagement [14]. Greater clarity on the term remains elusive, compounded by varied nomenclature. Fur thermore, the articulation of its potential benefits health/personal, systemic/economic, individual/societal, immediate/longer-term alongside evidence that grounds these in realistic appraisals, remains insufficient [15]. An absence of critical formative evaluation, supplemented by effective knowledge–management strategies, further constrains appropriate audience targeting, formal or informal, across care settings [16]. Delivery of social prescribing schemes frequently ceases after a short initiation phase due to competing prior ities, funding withdrawal, or the pursuit of alternative innovations; interim evaluation of such schemes and their connection to subsequent establishment, termination, or reconfiguration might help address this challenge [17]. Uncertainty arises whether it constitutes formal, informal, or neither differentiation from existing health pathway, care model, or service remains underexplored, inhibiting awareness of historic precedents and impending decisions. Guidance for exit-planning is scanty, yet evaluation undertaken across an early development and subsequent implementation phase would enhance comprehension of longer-term support requirements; meanwhile, a new model offering continuity and expanded reach might concurrently be developed [16].

Resource Constraints and Funding

Social prescribing is a relatively new approach to providing social, emotional and practical support for people with non-clinical needs [3]. The goal is to help people improve their health and wellbeing by connecting them with community services and resources. In England, social prescribing has been officially promoted by the NHS since 2019, and early evidence suggests that it can lead to meaningful improvements in health-related quality of life and social circumstances. However, funding and sustainability continue to be a challenge [6]. Implementation studies highlight resource-related barriers to social prescribing. A primary concern is uncertainty over the sustainability of secure funding; many stakeholders regard social-prescribing services as being under threat and lacking commitment beyond pilot status [3]. Without a robust business case, the health impact of social prescribing remains unclear. Additional resource-related challenges include insufficient capacity to scope how best to deliver social prescribing, and uncertainty regarding the availability of cost-effectiveness evidence to inform that scoping [7].

Workforce Training and Scalability

Social prescribing often involves link workers referring people to community groups, charitable services (the voluntary, community, and social enterprise [VCSE] sector), local socio-environmental services and networks, and community assets [7]. Individuals may be supported with confidence, skills, knowledge, transport, and practical help to access desired services. Reflecting the multi-disciplinary nature of social prescribing teams, these roles may include health, social, and care provision [5]. The link worker role is pivotal to success and vulnerable without resource and understanding [4]. Link workers need training in ethics, safeguarding, and the relevant systemic landscape of organisations, groups, and services. Many appointed link workers move into roles elsewhere, and under-funding leads to un-resourced turnover among supervisory, managerial, and coordinating roles [16 , 3].

Service Fragmentation and Coordination Challenges

Social prescribing links patients with local, non-clinical activities; effective implementation requires coordination with existing services [8]. Many services operate in silos; information and access are negotiable across providers but vary greatly [7, 9]. Governance structures and power dynamics influence interactions inside and outside health and care systems; alignment occurs in shared commitment to social determinants of health and behaviour change yet remains fragile. Social-prescribing systems attached to primary care conversely face risks [6]. Embedding in integrated care systems clarifies purpose and enables collaboration but does not guarantee strategic alignment [3].

Measurement Challenges and Attribution

Social prescribing services need to consider how to measure and attribute their impact on the health and wellbeing of patients served and system-level indicators such as healthcare utilization and cost [2]. Questions on measurement include which outcomes to select, how to assess them, and the duration of follow-up. Attribution is complicated further by uncertainty regarding the causal contribution of social prescribing to the desired effects [15]. Compared to the various social determinants of health, social prescribing is not the only intervention contributing to change [17].

Equity and Access Considerations

Social determinants of health shape the distribution of health so fair distribution is a matter of social justice. Equity means particular consideration for the disadvantaged [5]. Individuals deprived of basic social goods such as adequate housing, safe neighbourhoods, a living income, or support for social connectedness may benefit from social prescribing [6]. However, these needs are not explicit in most social-prescribing interventions. Other social-prescribing interventions acknowledge and seek to address these problems. Moreover, socioeconomically disadvantaged groups tend to display lower levels of social engagement, impacting their capacity to benefit from participation in social networks that such interventions provide [3]. North Americans of different ethnic backgrounds exhibit uneven distribution of social resources, including social capital, civic engagement, participation in social-service programs, and educational attainment; Indigenous, Black, and LatinX groups generally have worse resource access and the gap with majority white populations is broadest for the most vulnerable families[7].

Methodological Considerations in Evaluating Social Prescribing

Approaches such as randomized controlled trials (RCTs), quasi-experimental designs, and evaluative mixed-methods are commonly employed to assess social prescribing and demonstrate its rationale and impact on health and well-being systems [1]. Given mixed or limited evidence of social prescribing effects, platform pseudonymization in longitudinal studies introduces potential for bias through unanticipated intercept effects and moderating elements [17]. Any predefined framework cannot fully capture emergent mechanisms, social processes, or system-specific determinants pertaining to multifaceted phenomena such as social prescribing.

Selection of appropriate, coherent health-care outcome measures remains a significant challenge for social-prescribing evaluations [2]. Clinical, psychosocial, equity, and utilization-related metrics, individualised to specific systems and community needs, are thus strongly recommended to gauge framework impact within wider systems. Media-reported population health and social-associated issues, aligned with determinants of health exerted throughout the transformative framework, have observable societal consequences largely unnoticed thus far in the literature [4]. Community activity, health-care demand, support exchanged between, within, and across frameworks, and any widening access gaps are visualisable spill-over effects offering potential to demonstrate, communicate, and advocate causal, long-term benefits[3].

Study Designs and Evidence Quality

Evidence on the effects of social prescribing is growing, but considerable uncertainty remains regarding its impacts, pathways, and implementation [4]. The predominant study designs are uncontrolled before–after studies of limited methodological robustness. Rigorous evaluations based on controlled study designs, such as randomized controlled trials or mixed-methods approaches, are limited and involve important contextual factors influencing outcomes [5]. Existing evidence therefore primarily supports the plausibility of hypothesized effects and mechanisms rather than establishing certainty about them [3]. Adequate evaluations of social prescribing require study designs reflecting the role of context in determining outcomes [19]. Recognizing the limitations of observations at provider and individual levels, controlled and quasi-experimental designs permit assessments of community-based interventions while tracing the links to social prescribing. Greater emphasis on understanding the implementation of social prescribing at both levels would enhance research relevance; however, studies increasingly concentrate on contextual factors influencing observed effects, without specifying the active components underpinning those effects [6].

Outcome Measures and Indicators

Most evaluations use the Patient Health Questionnaire to measure anxiety and/or depression in the context of social prescribing [8]. Other questionnaires used for this purpose include the Generalized Anxiety Disorder 7-item scale (GAD-7), the Warwick-Edinburgh Mental Well-being Scale, short-form of the World Health Organization Five Well-being Index, the Brief Resilience Scale, the Perceived Stress Scale, and the Short Form Quality of Life Questionnaire (SF-12) [1]. Most studies classify the identified effects either as "statistically significant" or "not significant." However, it might be more informative to supplement the p-value with the confidence interval of the estimated effect [17].

Societal and Long-Term Impacts

Integrated community engagement through the provision of link worker support enables people to receive the resolution of service-related barriers [3]. However, link workers often report the difficulty of accessing certain services, particularly for groups who do not meet eligibility criteria or when weekly sessions are impossible due to waiting lists [3]. This underlines that social prescribing may not sufficiently address the root causes of inequalities if there are wider systemic issues that the community sector is unable to resolve. Social prescribing can reduce health-related inequities and contribute to public health policy goals by facilitating the connection of individual needs to services that alleviate socioeconomic barriers or enable services that promote healthy lifestyle

changes [5]. The COVID-19 pandemic exposed vulnerabilities among people with long-term conditions and accentuated the challenge of distance-based disruption.

Policy Implications and Best Practices

Systematic social prescribing enjoys robust support across clinical, policy, and public domains. Health interventions for the social and emotional wellness of patients can promote better health and wellbeing. Accessible community activities that develop community connections have positive influences on health determinants such as housing, financial stability, and social interaction [10]. Yet implementation of social prescribing systems that concentrate on vulnerable communities, including public transportation access and delivery of resources, knowledge, and skills tends to lag [1]. To promote equitable and effective implementation, integrated delivery that mentors, moderates, and monitors social programs can guide multidisciplinary health teams and local regulations. Collaboration with local organizations, strong stakeholder engagement, incentives for sustainable community partnerships, and governance in national guideline development can streamline the design of equitable arrangements [7]. The application of social prescriptions is associated with numerous supportive mechanisms promoting health equity[2]. Yet measures of social prescribing still omit many equity indicators and fail to encompass health-oriented and community-representative actions [8]. Although population-level and program-oriented strategies are accessible, individuals, organizations, and localities still grapple with statewide initiatives that acknowledge unique community determinants of vulnerable and health-improving populations[9]. A priority agenda further distinguishes the various determinants of health across different economic strata, by linking governmental efforts that endorse regional or localized variation at a resource scale with interventions that maintain maintain national principles of equity and governance [9].

Equity-Focused Implementation

Implementation efforts for social-prescribing initiatives must consciously adopt an equity lens, targeting communities and individuals with the greatest needs and designing programmes that accommodate diverse backgrounds [3]. The provision of services and resources should actively address prevailing social determinants of health to promote an inclusive environment that fosters individual potential [11]. Monitoring and evaluation frameworks should measure distributive impacts across demographic and geographic dimensions to identify groups that remain underserved and inform appropriate adjustments [10].

Integrated Care Models

Integrating social prescribing with primary care, social care, and community services represents an opportunity to reinforce existing preventive approaches and the principles of collaborative care set out in the 2019 NHS Long-Term Plan for England, the 2020 NHS Mental Health Implementation Plan, and the 2021 NHS Operational Planning Guidance [11]. These approaches encompassed early access and personalized, holistic, and community-centred care that improved health outcomes for vulnerable populations. Aligning with wider integrated care efforts also helps to embed such approaches in existing systems, mitigating the risk of them being viewed as separate from mainstream care and increasing the potential for them to contribute to wider integrated care objectives [3]. Consistent with these intentions, social-prescribing service specifications developed by NHS England promote the establishment of Primary Care Networks as the principal delivery structure for social prescribing in the community [12]. In this approach, the link-worker role is intended to incorporate community-centered, asset-based, and person-centred elements [13]. Delivery by and through the voluntary, community, and social-enterprise sector remains vital; whilst this sector is a key partner in social-prescribing services in many places, determining effective governance arrangements between the National Health Service and local community services represents a central challenge and requires further exploration. Feeder services identifying and referring patients into social-prescribing services from integrated neighbourhood teams, health visitors, and maternity services are also a frequent part of service development [18].

Stakeholder Engagement and Governance

Wider policies intended to mitigate or in some cases, exploit transitions to social prescribing include the involvement of citizens and patients themselves, as well as community organizations on the design, implementation, and evaluation of initiatives [13]. Stakeholder engagement has been identified as a major factor in the success of social-prescribing initiatives, and a common requirement among local authorities and health and well-being boards 20. Prospective clients report that a provision of clear information about the scheme is crucial for their engagement; furthermore, the scope available to them to provide input into planning was seen as markedly variable. With a view to unifying these approaches, stakeholders and clients have stressed local flexibility, highlighting the need to generate a balance between the specificity required to attract initial investment and the room to customize practice [15]. The nature of the involvement of independent community organizations including charities, housing associations, and other providers and health services is also highly variable. Sufficient attention and resources should be invested into capacity building and co-operation [15]. Evaluation of existing

pilot projects identified the development of a service-mapping tool as an instructive component that support other local networks in identifying available community provision [21].

Future Directions and Research Priorities

The social prescribing evidence base remains limited and requires further exploration. Feasibility and effectiveness studies should be conducted in primary care [16]. Realist evaluations could illuminate mechanisms and contextual factors influencing health outcomes, extent of community service and network engagement, and link workers' contributions [17]. Research on approaches to enhance client enrolment and commitment would provide insight on these critical design issues, as would examination of social prescribing's potential to exacerbate or mitigate health inequalities for particular groups [18]. Nevertheless, important avenues for inquiry have emerged. Understanding how nudges can promote health-related behaviour changes linked to social prescribing holds promise for improving population health [17]. The prospective impact of such prescriptions on individuals with long-term conditions warrants additional investigation, as does the relationship between social prescribing and well-being. The need for evidence-based guidance on integrating social prescribing into primary care to combat health inequalities and bolster patient support systems remains urgent [18]. The sociomedical crisis sparked by the pandemic has underscored the critical importance of addressing social needs and advancing the health equity agenda through policy reform, improved services, and evidence generation [19]. Social prescribing has gained traction in many highly industrialized economies as a strategy for ensuring universal access to the necessary non-clinical resources to promote health and eliminate the rooted factors of social inequity [20]. Its emergence as a key focus illustrates the need to monitor and evaluate both the development of services reflective of a social-prescribing approach and the policies being advanced to curtail the capability to address social openness and vulnerability [21].

CONCLUSION

Social prescribing represents a significant shift from traditional biomedical models toward a more holistic, biopsychosocial approach to health and well-being. By addressing the social, emotional, and practical needs of individuals, it offers a promising pathway for improving health outcomes, enhancing patient autonomy, and reducing pressure on healthcare systems. The evidence indicates that social prescribing can contribute to improved mental health, increased social connectedness, and reduced healthcare utilization, although the strength and consistency of these outcomes vary. The mechanisms underpinning social prescribing including behavioural change, social engagement, resource linkage, and psychological empowerment, highlight its capacity to address complex and interrelated determinants of health. However, these mechanisms are highly context-dependent, requiring careful adaptation to local needs and resources. The success of social prescribing initiatives is closely tied to the effectiveness of link workers, the availability of community assets, and the strength of partnerships across sectors. Despite its potential, the implementation of social prescribing faces substantial challenges. Resource constraints, lack of standardized evaluation frameworks, workforce limitations, and fragmented service delivery systems hinder scalability and sustainability. Additionally, persistent gaps in evidence quality and difficulties in attributing outcomes complicate efforts to build a robust case for long-term investment. Equity considerations remain central to the future of social prescribing. Without deliberate efforts to target disadvantaged populations and address structural barriers, there is a risk that such interventions may inadvertently reinforce existing inequalities. Therefore, embedding equity-focused strategies, improving access, and ensuring inclusive programme design are essential. In conclusion, social prescribing holds considerable promise as a tool for advancing public health and addressing health inequalities. Realizing this potential requires sustained policy commitment, interdisciplinary collaboration, rigorous research, and the integration of social prescribing into broader health and social care systems.

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