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Co-Designing Social Prescribing for the Barossa

Candice Oster, Ashleigh Powell, Claire Hutchins, Deb Anderson, Bill Gransbury, Martin Walton, Jenny O'Brien, Susan Raven & Svetlana Bogomolova

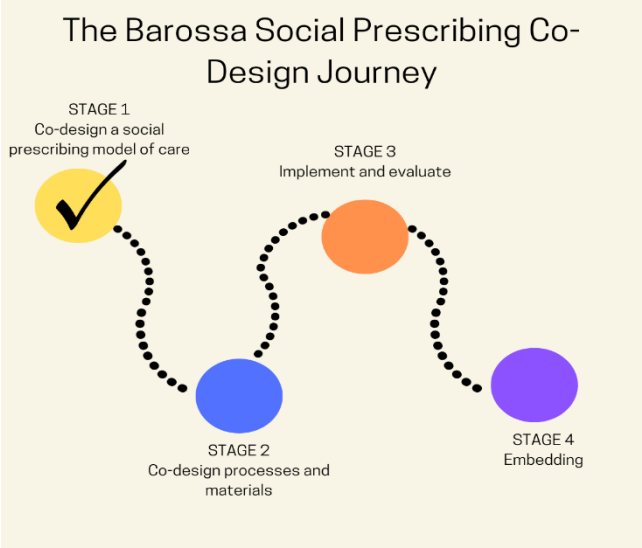
Flinders University

Contents

Key Messages

The context

Many things affect our health and wellbeing, such as loneliness, poor housing, or financial pressures. These issues cannot be fixed by our health system. Social prescribing connects people to supports and services, such as a community group or financial counselling, to address these 'non-medical' issues. This is often done through health settings, involving people called 'link workers' to identify people's needs and refer them to the appropriate service or support.



Social prescribing is widely used in the UK and US but is only in its initial stages in Australia. It is important that we co-design social prescribing to fit Australia's unique systems and communities. In 2023, Barossa Council partnered with Flinders University to co-design a model of social prescribing for the Barossa region.

This project is Stage 1 of the Barossa Social Prescribing co-design journey, involving co-design workshops with key stakeholders from health, social care, and the community to design a social prescribing model of care.

Key outcomes

The co-designed model of care is a holistic model that goes beyond simply connecting people with services, with link workers also providing additional support such as motivation and goal setting. While social prescribing is commonly delivered via general practice, participants saw the need for multiple referral pathways, including through broader health settings (e.g., allied health), through community, and via self-referral. Participants furthermore identified the importance of including existing programs that support people with their non-medical needs (e.g., Community Connections Program, Care Finder, Local Area Coordinator, among others) in the model of care to avoid service duplication and support sustainability. Technology was identified as an important enabler of social prescribing, in addition to an updated and maintained directory of services. The need for community awareness raising of the concept of social prescribing to support uptake and engagement due to the novelty of the terminology and concept in Australia was also identified.

Recommendations

Further work is needed in Stage 2 to address key questions identified through co-design, which are as follows:

1. How could awareness raising (for community and health providers) of the concept and importance of social prescribing be done in the region?
2. How could screening tools be used for a) identifying participants for social prescribing, and b) needs assessment?
3. How could triaging be done for a) determining which link worker/program to refer to and b) for link workers to determine urgency of need?
4. How can a directory of social and community services and supports be sustainably developed and maintained?

Executive summary

Introduction

Non-medical (social) issues such as housing, employment, food, income, and social isolation have a negative effect on health and wellbeing (Hood et al. 2016). Many Australians struggle to access social and community support services due to a lack of information and referral pathways, instead reaching out to their trusted health professionals, in particular GPs, with their social needs (RACGP 2022). However, health professionals are not equipped to support patients with non-medical issues.

Social prescribing has been implemented internationally to address this problem. Social prescribing involves the referral of individuals to social activities and social services to address social needs. Social prescribing is often delivered through health settings and can also be delivered in the community. Social prescribing commonly involves people called 'link workers' to identify people's needs and refer them to the appropriate service or support (see Figure 1).

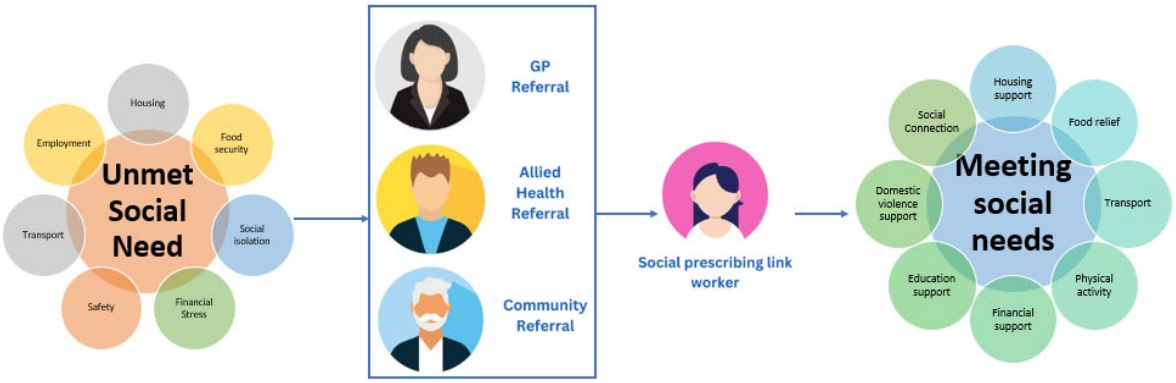


Figure 1. The concept of social prescribing

There are many different models of social prescribing internationally, which vary in the delivery context, staffing, population of focus, non-medical needs they address, and referral processes (Oster et al. 2023). Given variability in the design and delivery of social prescribing, it is important that social prescribing programs are co-designed with key stakeholders to ensure fit and relevance to the implementation context. In 2023 a project was undertaken in partnership between Barossa Council and Flinders University to co-design a social prescribing model for the Barossa region.

Aim

To co-design a model of social prescribing for the Barossa region with key stakeholders from health, social care, and community settings.

Methods

Co-design workshops were conducted, following Trischeler et al.'s (2019) seven step co-design process of resourcing, planning, recruiting, sensitising, facilitation, reflecting, and building for change, described in Box 1.

All the data were captured (via photos of the created idea 'mud maps'/butcher papers, completed workbooks, journey maps, and facilitators' notes). Data were analysed descriptively to identify a social prescribing model of care for the Barossa.

Box 1. The seven-step co-design process

Step	Description
1) Resourcing	Gaining an initial understanding of the problem/task to be addressed through a) a scoping review of international models of social prescribing and b) undertaking community needs assessment to explore non-medical needs experienced by the community.
2) Planning	Regular steering committee meetings to determine the design task (goals and outcomes) and plan the next stages of co-design.
3) Recruiting	Key stakeholder mapping was undertaken by the steering committee to determine who to invite to each workshop.
4) Sensitising	Preparing participants for the design task and triggering reflections on the topic was done through presentations on the concept of social prescribing.
5) Facilitation	Co-design tools (workbooks, butcher paper activities, journey mapping) were used to foster creativity.
6) Reflecting	Reflecting on the co-design outcomes occurred through steering committee meetings.
7) Building for change	Open dialogue with key stakeholders to assess feasibility and realisation of the ideas generated in the workshop(s) are planned for 2024.

Results

Four co-design workshops were conducted between July and November 2023. This included two workshops with health and social service providers (n=19 in Workshop 1, n=16 in Workshop 2). A further two co-design workshops were run with community members. The first community member workshop involved participants recruited through a retirement village and aged care facility (n=13). Participants in the second community member workshop were recruited via flyers, advertisements, and social media (n=24).

Data from the four workshops were brought together into a social prescribing model of care, including six main elements, as follows (see page 8 for the full model of care):

Community Awareness Raising

Raising awareness about social prescribing was identified as an important starting point for the implementation of a model of care in the Barossa, due to the novelty of the terminology and concept.

Multiple Link Worker Roles: At the centre of the social prescribing model is the link worker role. A key element of the co-designed model for the Barossa is the inclusion of multiple Link Worker roles, recognising that there are several programs already running in the region for referral for social needs. There is also a role for volunteers in the social prescribing model, working across low and high-level needs to support the link workers (e.g., by attending services with the person).

No Wrong Door: There is a clear preference that access to social prescribing in the Barossa be a ‘no wrong door’ approach, including self/community referral as well as health provider referral.

A Triage & Referral Process: The integration with existing link worker programs necessitates the addition of a triage process in the health provider referral pathway.

Directory of Services: It is important to have a centralised ‘source of truth’ documenting relevant services for social prescribing. This needs to be maintained and accessible to community, health and social services, and link workers.

Social Prescribing Technology: Relevant to both triage and referral process, and an accessible and searchable directory of services, technology is an important element of the social prescribing model of care.

Conclusion

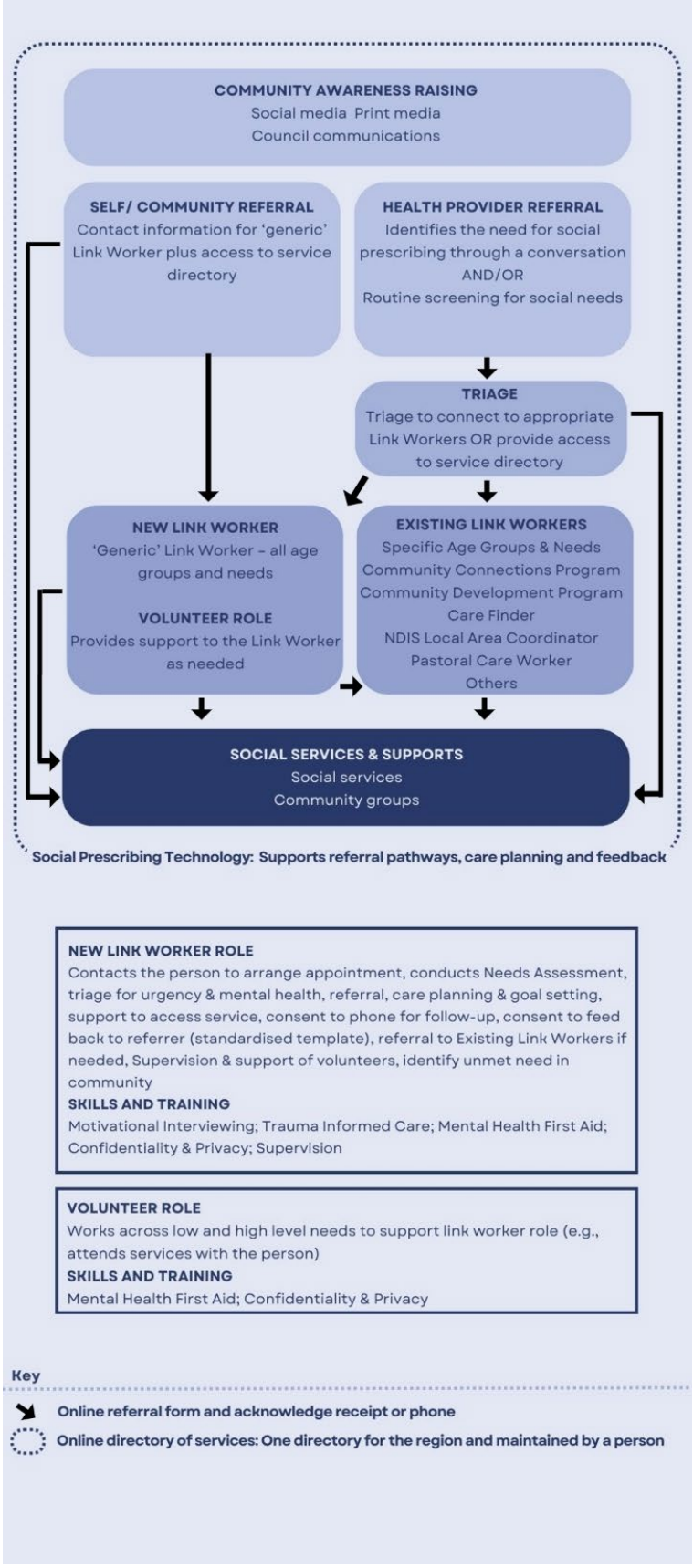
There was strong engagement across the participant groups throughout the workshops. A comprehensive social prescribing model of care for the Barossa was successfully co-designed by key stakeholders. Further work is needed to:

1. Raise awareness of social prescribing for community and health providers
2. Determine processes for identifying participants for social prescribing and conducting a needs assessment
3. Determine processes for triaging participants into the appropriate link worker program
4. Resolve the long-standing issue of how to develop and maintain an up-to-date directory of social and community services and supports

The following projects are underway to continue the process of social prescribing co-design in the Barossa:

1. Co-design workshops with service providers to design a decision tool and referral process for triaging patients to access currently available services to address their social needs
2. A photovoice project to explore community members' views and experiences of community connection and support to help us understand the community context of social prescribing

The co-designed social prescribing model of care



Introduction

Non-medical (social) issues such as housing, employment, food, income, and social isolation have a negative effect on health and wellbeing (Hood et al. 2016). Many Australians struggle to access social and community support services due to lack of information and referral pathways, instead reaching out to their trusted health professionals, in particular GPs, with their social needs. In fact, up to 36% of GP visits are for the effects of social issues on health (RACGP 2022). Addressing non-medical needs is complex and time-consuming, and health professionals often lack capacity to address these issues (Andermann 2018), which has been linked to clinician burnout (Kung et al. 2019).

Social prescribing offers a potential solution to this problem. Social prescribing involves the referral of individuals to social activities and social services to address non-medical issues (Morse et al. 2022; Muhl et al. 2023). Social prescribing is often delivered through health settings and can also be delivered in the community.

There are many different models of social prescribing, with variability in the delivery context, staffing, population of focus, non-medical needs they address, and referral processes. Models can be as simple as providing information to individuals about services that are available (termed 'signposting') to more wholistic models (see Figure 2). Holistic models involve a Link Worker/ Community Connector meeting with the person to identify their non-medical needs, actively supporting them to access services (e.g., by attending services with them), providing care planning, motivation, and goal setting interventions, and providing follow-up over weeks or months (Oster et al. 2023).

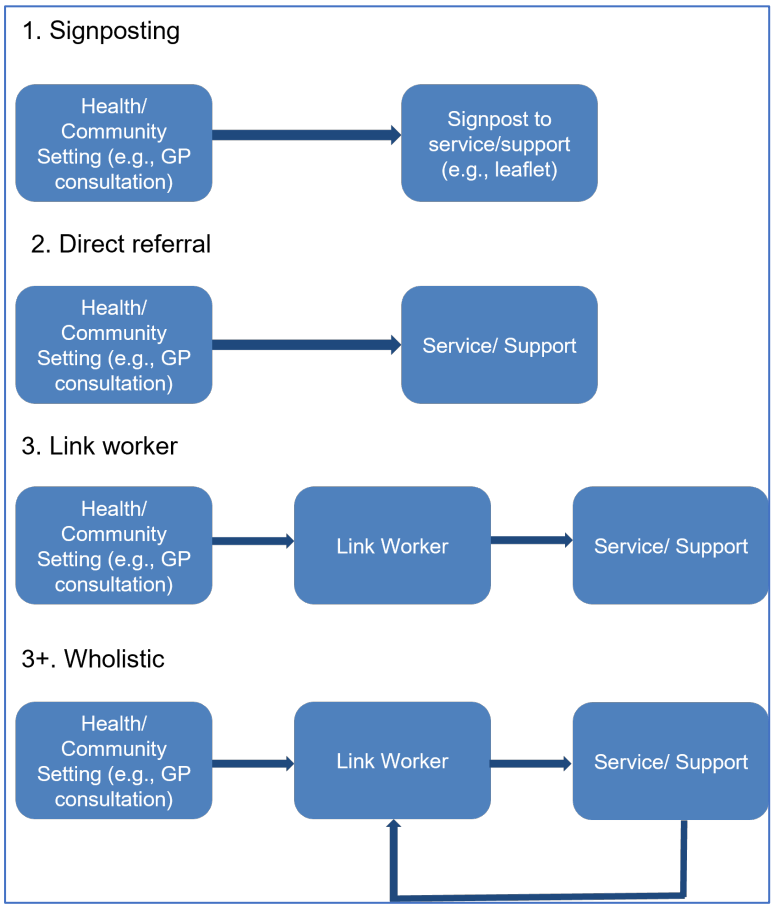


Figure 2. Models of social prescribing (adapted from Husk et al. 2020)

Social prescribing is widely used internationally (Oster et al. 2023). There is also increasing recognition of the need to implement social prescribing in the Australian context, particularly in response to the ongoing effects of the COVID-19 pandemic and rising cost of living. Given variability in the design and delivery of social prescribing, it is important that social prescribing programs are co-designed with key stakeholders to ensure fit and relevance to the implementation context. In 2023 a project was undertaken in partnership between Barossa Council and Flinders University to co-design a social prescribing model for the Barossa region.

Aim

To co-design a model of social prescribing for the Barossa region with key stakeholders from health, social care, and community settings.

Method

Ethics Approval

The project was granted approval by the Flinders University Human Research Ethics Committee (Project Number 4868).

Steering committee

A Steering committee was formed comprising representative from Barossa Council and Flinders University and representatives from health care, social care, and community services.

Co-Design Workshops

We followed Trischeler et al.'s (2019) seven step co-design process of resourcing, planning, recruiting, sensitising, facilitation, reflecting, and building for change, described in Table 1.

Table 1. The seven-step co-design process

Step	Description
1) Resourcing	Gain an initial understanding of the problem/task to be addressed (e.g., through literature reviews, interviews, surveys)
2) Planning	Work with key stakeholders to determine the design task (goals and outcomes) and plan the next stages of co-design
3) Recruiting	Systematically identify, screen, and recruit suitable participants
4) Sensitising	Prepare participants for the design task and trigger reflections on the topic through activities such as presentations and thought-provoking questions
5) Facilitation	Using co-design tools to foster creativity in individual activities and group discussion (e.g., card sorting)
6) Reflecting	Reflecting on the co-design outcomes
7) Building for change	Open dialogue with key stakeholders to assess feasibility and realisation of the ideas generated in the workshop(s)

Step 1: Resourcing

Resourcing involved a) undertaking a scoping review of components and models of social prescribing in the international literature (Oster et al. 2023) and b) undertaking community needs assessment to explore the non-medical needs experienced by the community.

Step 2: Planning

Planning was undertaken through regular steering committee meetings. Early meetings involved developing the Theory Change and Project Logic (see Appendix 1) and planning the workshop format. The format involved commencing with two workshops with service providers to develop a draft social prescribing model followed by two workshops for community members to input into what they would like to happen at each stage of the model. Community members could also discard aspects of the model and propose new ones. Regular steering committee meetings were held to reflect on each workshop and plan for the next.

Step 3: Recruiting

Key stakeholder mapping was undertaken by the steering committee to determine who to invite to each workshop. This occurred during steering committee meetings prior to each workshop, where committee members discussed the service types and communities for whom social prescribing would have relevance. Committee members explored personal/professional connections and potential avenues for snowball sampling to ensure involvement of relevant key stakeholders in each workshop.

Steps 4-6: Sensitising, Facilitating, and Reflecting

There were different approaches to sensitising, facilitation, and reflecting for the workshops, described below. This was an iterative process where outcomes of Service Provider Workshop 1 informed the process for Service Provider Workshop 2. Outcomes of Service Provider workshops then informed the process for the Community Member workshops (see Figure 3). Co-design materials used in the workshops are presented in Appendix 1.

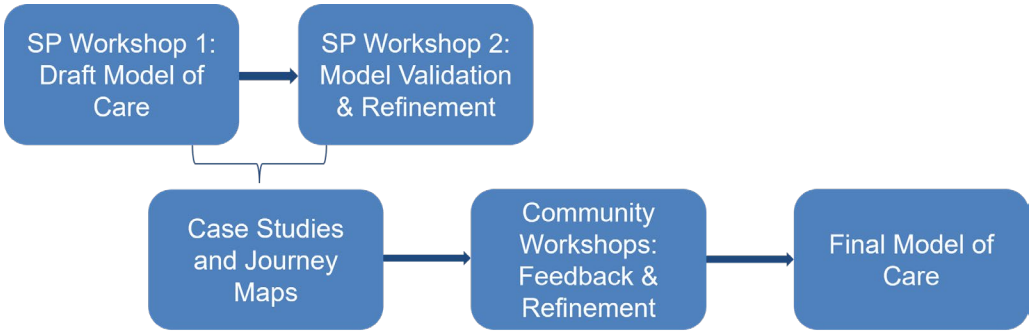


Figure 3. Iterative workshop processes

Service Provider Workshop 1: Co-designing a draft social prescribing model of care

Sensitising for Service Provider Workshop 1 involved a PowerPoint presentation explaining the concept of social prescribing, presenting the results of the scoping review and needs analysis, and explaining the co-design process. Participants then individually completed an Ideas Workbook, indicating their likes/ dislikes of the various components of social prescribing.

Participants were then divided into groups of 3-5 people to develop their own ideas for a social prescribing model of care using butcher paper, coloured pens, and sticky notes. Each group was facilitated by a member of the steering committee who helped the group stay on task and ensured each participant had a voice in the development of the model. Facilitators took notes of each group's discussion. Groups then presented their ideas to the larger group for further discussion, with facilitators again taking notes.

All the data were captured (via photos of the created idea 'mud maps'/butcher papers, completed booklets, and facilitators' notes). Data were analysed descriptively to identify a draft model of care, which was presented to the steering committee for reflection and refinement.

Service Provider Workshop 2: Validating the draft model of care and further refinement

The purpose of Service Provider Workshop 2 was to present the draft model and check if any critical elements were missing, and then to workshop practical implementation of all the proposed steps of the model. Sensitising involved presenting a PowerPoint showing the results from Workshop 1 activities and the draft model of care, and to explain the co-design process.

Workshop participants were asked to individually provide written responses to the following statements “Social prescribing would help me by …”, “Social prescribing would help my clients by …”, and “Social prescribing would help my community by …”. They were then asked to anonymously vote on the proposed draft model of care using a QR code linked to a question asking them to indicate whether they liked, disliked, or felt neutral about the draft model.

Following these individual activities, participants were divided into groups of 3-5 people, each group focusing on one stage of the model. Groups were provided with questions and examples of each stage in the model of care from other programs (e.g., examples of needs analysis surveys, directories of services, care planning tools, social prescribing technology) and asked to explore what they think should happen their stage of the model. Groups presented their ideas to the larger group for discussion. Each group was facilitated by a member of the steering committee who took notes on the discussions. Data in the form of butcher paper images and facilitator notes were analysed to inform the final social prescribing model of care.

Data from both Service Provider workshops were used to develop five case studies of people in the region who have experienced non-medical needs. The draft model of care was used to develop journey maps for community workshops, each based on a case study depicting typical circumstances and associated needs.

Community Member Workshops 1 and 2: Feedback and refinement of the draft model of care

Sensitising for community members involved a PowerPoint presentation describing the concept of social prescribing, presenting two of the case studies as examples of when social prescribing might be needed, presenting the draft model of care, and explaining the co-design process. Participants were invited to discuss the case studies as well as their own experiences of social needs or those of others they knew or had heard about in groups of 3-5 to aid reflection on what social prescribing might mean for their community.

Each group was then provided with a case study, journey map (printed in A1 size), sticky notes, and facilitator guide with ideas for each stage of the journey. Participants were guided through the task of filling in the social prescribing journey map for each case study by a member of the steering committee, describing what they would like to happen at each stage of the journeys. Data in the form of butcher paper images and facilitator notes were analysed to inform the final social prescribing model of care.

Step 7: Building for Change

Building for change will involve presentation of the co-design results to local council and key players in the development and delivery of health and social care (Local Health Network, Primary Health Network, Department of Human Services, etc.) to assess feasibility and realisation of the ideas generated in the workshop(s).

Results

The four co-design workshops were conducted between July and November 2023. The workshops were held across the region, typically in a hotel function room-type space, and lasted for approximately 90 minutes. A two-course meal was provided to health and social service providers and community organisations; community members were provided food and beverages and a $50 gift voucher.

Workshop Participants

Two co-design workshops were run with health and social service providers (n=19 in Workshop 1, n=16 in Workshop 2). Of this sample, 75% (n=12), attended both workshops (one GP, seven allied health providers, and four social service providers). Recruitment was conducted via snowball sampling, using steering committee member networks.

Two co-design workshops were run with community members. The first community member workshop involved participants recruited through a retirement village and aged care facility (n=13). Participants in the second community member workshop were recruited via flyers, advertisements, and social media (n=24).

Participant demographics are presented in Tables 2 and 3.

Table 2. Service provider workshop participant demographics

Demographic		**Workshop 1 (n=19)***	**Workshop 2 (n=16)***
Profession	Allied Health	8	7
	GP	2	2
	Social Service Provider	9	7
Year in Profession	1 year or less	2	0
	2-5 years	4	4
	>5 years	12	11
Gender	Male	1	3
	Female	17	11
Age	Under 25yo	0	0
	26-35yo	4	2
	36-45yo	4	3
	46-55yo	7	5
	56-64yo	1	3
	65+yo	2	2

*Some participants did not provide full demographic data

Table 3. Community member workshop participant demographics

Demographic		**Workshop 1 (n=13)**	**Workshop 2 (n=24)**
Gender	Male	5	6
	Female	8	18
Age	Under 25yo	0	0
	26-35yo	0	0
	36-45yo	0	4
	46-55yo	0	3
	56-64yo	0	9
	65+yo	13	8
Time living in the region	1 year or less	1	1
	2-5 years	3	4
	>5 years	8	19

Service Provider Workshop 1 results

Four themes were identified in the analysis of workbook data and co-design discussions in the first Service Provider workshop.

1) A health system in crisis

Health and social care professionals reflected that the health care system is in crisis and that social prescribing is needed to take the pressure of the health system, in particular, general practitioners

(GPs). Health services and practitioners were identified as experiencing a high burden of patients with non-medical (social) needs and lacking the capacity to address these needs. Participants furthermore identified that those most in need had the shortest appointments with GPs, further reducing the capacity to address social needs:

"The people who need social needs support the most have the shortest bulk-billed GP appointments, so we don't get much time to explore what their needs really are." (GP)

Participants discussed the negative effect that this has on health professionals in the form of clinician burnout, vicarious trauma, and compassion fatigue:

"There's no one we can easily refer to as a linking person. How do I tell you I'm worried about this person? And when? My evenings? Weekends? This is how we get clinical burnout and vicarious trauma." (Allied health)

"Most of my clinic is made up of young practitioners. Mentoring to help them to deal with this (social needs) is the biggest part of the job – and the compassion fatigue that comes with it." (Allied health)

2) The need for a system to support social prescribing

With the high number of patients entering the health system with social needs, participants identified that health professionals are already undertaking social prescribing (i.e., supporting and referring patients with social needs). However, they identified an urgent need for a system to be put in place so that social prescribing can be done more easily and efficiently to reduce the burden on health practitioners and improve outcomes for patients:

"We do this (social prescribing) already – would be great to actually have a structure." (Allied health)

3) A social not a medical model

Workshop participants noted that the development of social prescribing should "move away from a medical model" (Quote from butcher paper), underpinned by a prevention approach and noting the important role of community in addressing social needs:

"A community not a health responsibility." (Quote from Butcher paper)

4) Raising the profile of social prescribing

Finally, participants identified the need to raise the profile of social prescribing for this to be successful. Overall, the concept of social prescribing was seen as something new in the Australian landscape. While some providers were familiar with the term, others stated they were not familiar with the term prior to the workshop:

"First time I've come across social prescribing – the term/word." (Social service)

Participants discussed the importance of marketing to help familiarise the community with the concept of social prescribing, including having a unique brand and visual identity for the program. Participants also discussed participating services displaying the logo/brand to symbolise their support for social prescribing.

There was also some discussion about the appropriateness of the term social prescribing itself. Some felt it had medical connotations and risked 'medicalising' social needs. Others noted the role of health

providers, particularly GPs, in legitimising accessing support for social needs, which is helped by the term ‘social prescribing’.

Draft social prescribing model

Four elements of the draft social prescribing model were identified in the analysis of Service Provider Workshop 1 data.

1) No wrong door

The preferred social prescribing model identified by Service Providers is one in which the program is available to anyone in the community experiencing non-medical needs, rather than focusing on specific at-risk populations:

> *I think that every single individual could benefit from social prescribing, and targeting specific groups is potentially problematic in creating something that is too narrow, when this has so much potential to do so much good for so many in our community. (GP)*

Participants valued a “no wrong door” (Allied health) approach with multiple entry pathways into the social prescribing program, including through general practice, allied health, community, and self-referral.

2) Link worker is key

The link worker role was identified as fundamental to the program to engage with the person over time, provide care planning, and actively support them to connect with services and community. Participants discussed the possibility for multiple ‘specialised’ link worker roles, possibly addressing different needs/populations, and supported by volunteers. Importantly, participants noted that the link worker role should be properly funded and a “viable position” (Quote from Butcher paper) to ensure the link workers have relevant expertise, support, and capacity.

3) Feedback loops

Participants furthermore noted the need for feedback loops to those referring into the program. Health providers stated that they have a “duty of care” (GP) to their patients and a need for information about whether and how the person they referred is being supported by the link worker.

4) Supported by technology

The final element identified in the first Service Provider workshop is that the social prescribing model should be supported by technology (e.g., an App), including an online care planning tool and maintained directory of social and community services.

These elements were brought together into a draft social prescribing model for discussion and refinement in Service Provider Workshop 2 (see Figure 4).

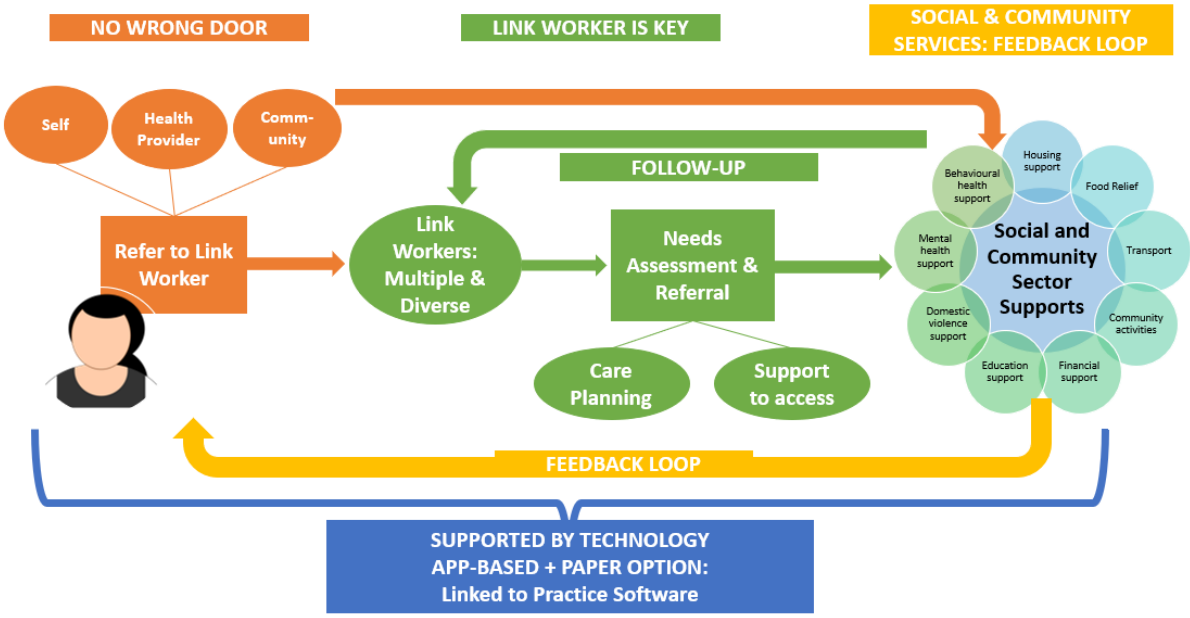


Figure 4. Draft social prescribing model for exploring in subsequent workshops

Service Provider Workshop 2 results

The benefits of social prescribing

Service Provider Workshop 2 participants described numerous benefits of social prescribing for themselves, their clients, and their communities. Healthcare providers identified that social prescribing would help them by reduced the clinical burden of social needs and freeing up their time to work within their scope of practice:

> *"Allowing me to focus on my area of expertise, knowing that my duty of care to the client (with other issues outside my scope of practice) has been upheld." (Allied health)*

> *"Reducing the number of non "medical" patients through my door as a GP" (GP)*

They also valued having a "single referral point" (Allied health) for social needs and an updated service directory:

> *"Providing a clear pathway to referral for vulnerable patients and a clear directory of available services." (Allied health)*

> *"Providing a single referral point for multiple client needs, particularly when I work with clients outside of my usual area, or with specific needs that are less familiar to me." (Allied health)*

Social service providers identified that social prescribing would help them by providing "local knowledge of services and supports" and improving their ability to meet clients' needs:

> *"Giving support to me as I care for the needs of the community."*

Health and social service participants together identified a range of potential benefits of social prescribing to their clients, including:

- Improved health and wellbeing: “Improve outcomes for health, mental health, social connection” (GP)
- Building resilience and capacity: “Building social capacity to deal with crises/logistical needs” (Allied health)
- Improved access to services and supports: “Provision of referral pathways and options” (Social services)

Health and social service participants together identified a range of potential benefits of social prescribing to their communities, including:

- Improved support for those experiencing vulnerability: “Supporting people who are struggling to achieve better outcomes for health, childcare, education” (GP)
- Improved community health and wellbeing (including reduced crime): “Increased wellness of community” (GP)
- Increased awareness of and access to services and supports: “Increased awareness of community programs” (Allied health); “Ease of access to service options” (Allied health)
- Increased service integration: “Creating/enhancing agency connections” (Allied health); “Hopefully fewer people would ‘fall through the cracks’” (Allied health)
- Reduced pressure on the health system: “Decreased hospital admissions for ‘social reasons’ – lack of carer, homelessness, depression” (GP)
- Increased community capacity: “Supporting the development of new services to meet their needs” (Social services)

Voting on the draft model

There was a positive response to the draft social prescribing model from Workshop 1, with 94% (n=15) voting that they liked the model and one participant voting ‘neutral’.

Key themes from co-design discussions

Five themes were identified from co-design discussions:

1) The person is at the centre

Participants identified the need for a person-centred, strengths-based approach to social prescribing. While participants noted that much of the current narrative is around introducing social prescribing to reduce burden on the healthcare system, they felt it was important to keep those who will receive the intervention at the forefront of planning and development of social prescribing.

2) Normalising help for social needs

Participants discussed the need to raise community awareness of social prescribing. This includes normalising seeking help for social needs and building confidence in service providers and the community regarding the effectiveness and value of social prescribing:

“The confidence that the community has in this will be such an important part of it working well.” (Social services)

Participants furthermore identified that health professionals would benefit from training to better understand the effect of social needs on health and wellbeing as well as training in social prescribing itself.

3) Augmenting what is there rather than creating something new

Participants raised concerns that developing a new program to address social needs in the community would lead to duplication of existing services. In fact, several programs were identified that could be described as 'link worker models', where individuals with social needs are referred to a link worker who identifies social needs and refers to relevant services and supports. Examples include:

- Community Connections Program (for adults aged 18-24, funded by Department of Human Services)
- Local Area Coordinators (for people with a disability, funding by the National Disability Insurance Scheme)
- Care Finder (for vulnerable older people who need intensive support to access aged care and other local services, funded by the Commonwealth Government and delivered through Primary Health Networks)
- Community Development Coordinators (for families, funded by Department of Human Services)
- Pastoral care workers (Non-government organisation (NGO) sector)

While these services exist in the Barossa, they are not widely known, nor are there established referral mechanisms into and between programs:

> *"Social prescribing is happening in the Barossa; we just need to coordinate better." (Health provider).*

In addition, there was strong support for the development of a new link worker role to address any gaps in existing services. Participants also discussed the potential role of practice nurses in general practice and leveraging Medical Benefit Scheme items such as the Chronic Condition Management Plan, Mental Health Plan, and the health assessment for people aged 75 and over, as a way of identifying patients for social prescribing.

4) Skills and capacity of link workers (including potential role of volunteers)

There was significant discussion about the importance of link workers having the necessary skills and capacity to work with people with complex health and social needs. There was strong support for social workers and other health professionals with a similar skill-base to undertake the role, supported by sufficient funding to attract the necessary staff. Participants were strongly against the idea of having students or volunteers as link workers, due to the need for a developed skill-base and appropriately funded role. However, they did identify the value of volunteers in supporting roles, working alongside and with the oversight of link workers. A key issue was the need to define the scope of practice of link workers and ensure they are sufficiently trained to undertake this role (the necessary components of training are discussed below in the final model of care).

5) Community development should be part of social prescribing

The final theme identified from Service Provider Workshop 2 data is the importance of ensuring that community development is part of social prescribing. Participants discussed the need to ensure sufficient and appropriate community assets are available to support social prescribing. Mapping of community assets and gaps to inform future community development was identified as a critical element of social prescribing.

Service Provider Workshop 2 data relating to the social prescribing model and its components have been merged with Community Workshop data, discussed below in the description of the final model of care.

Results of Community Member Workshops

Three main themes were identified in the analysis of Community Workshop Data.

1) Community needs and assets

Participants identified many situations of people in the community experiencing social needs, such as food insecurity, housing insecurity, financial insecurity, transport issues, and loneliness and social isolation. They also discussed the many and varied community assets available to meet these needs, such as community kitchens, Men's Shed, community groups, and supports provided by churches (e.g., Christmas lunch) and council (e.g., library). While there are community assets available to support social needs, participants identified a lack of knowledge of services and supports on the part of community members and health and social service providers.

2) Stigma and legitimising social needs

Despite the recognition that social needs are affecting the community, workshop participants identified that there is perceived stigma attached to experiencing social needs. Participants furthermore noted that people often downplayed their own issues, leading to them not reaching out to available supports:

> *"People have issues and concerns their issue is not as 'big' as others." (Consumer Workshop 1)*

Both perceived stigma and downplaying social needs was identified as resulting in people not reaching out to available supports. Participants identified the need to legitimise social needs and validate that it is ok to reach out for help when needed.

3) Social Prescribing: A person-centred approach

The importance of person-centred care and communication was highlighted throughout the Community Workshops, with an emphasis on building rapport and trust between the person and link worker. Participants discussed that people need to be given autonomy and the ability to express their needs, boundaries, and preferences in a non-judgmental environment. Ideally, people should be encouraged to help themselves rather than a clinician predicting or deciding what they need.

Community participants' discussion of the journey maps and what should happen at each stage of the social prescribing journey were integrated with results from Service Provider workshops to develop final model of care and its components.

Barriers and Enablers to Social Prescribing

Several barriers and enablers to implementing social prescribing in the Barossa were discussed across the four workshops.

Barriers

Barriers were identified at the community and program levels, as follows.

Community-level barriers

Lack of awareness of the concept of social prescribing: The term 'social prescribing' was new to many participants, particularly those in the community workshops. Lack of community awareness of the concept was identified as a barrier to uptake of, and engagement in, social prescribing.

Stigma: As discussed above, community participants identified stigma around social needs and seeking support for these needs. This is a potential barrier to engagement in social prescribing.

Health provider capacity to refer to social prescribing: A further barrier relates to the capacity of health providers, and particularly GPs, to refer patients to a social prescribing program. An issue related to general practice is prohibitive costs around accessing GPs in the region and the issue of those most in need of social prescribing having the shortest appointments.

Capacity to accept social prescriptions: The potential lack of capacity to accept social prescriptions was identified as a barrier to social prescribing. Social services and community groups need to be available in the region and have capacity to accept social prescriptions. Social groups

need to be open to accepting and welcoming new members who have come to them via a social prescribing program.

Program-level barriers

Developing and maintaining a service database: A core element of social prescribing is knowledge of available services and supports for referral. There is a clear need for an updated and maintained database of available services for social prescribing to succeed in the Barossa; however, this is a costly exercise and there is lack of clarity around financial mechanisms and which organisation(s) should be responsible for this.

Funding: Lack of clarity around how link workers (including administrative support for their role) could be funded was a further program-level barrier.

Integration with existing technology: Participants in service provider workshops were strongly in favour of the development of technology to support social prescribing. However, a potential barrier identified by participants was variation in the technology used across health services and how new technology could be integrated.

Enablers

Enablers were identified at the community and program levels, as follows.

Community-level enablers

Awareness raising: Participants identified raising community awareness of social prescribing as an enabler to the introduction of social prescribing in the region, including legitimising support for social needs to address stigma.

Enhancing general practice capacity: Enablers for general practice to engage in social prescribing include utilising existing MBS items providing longer appointments times (e.g., Chronic Condition Management Plan; Mental Health Plan: Over 75 Health Assessment) and utilising practice nurse and administrative staff to support social prescribing. A further enabler to enhance the capacity of general practice to support social prescribing was the provision of funding to general practice for uptake of social prescribing (akin to current funding to uptake My Health Record).

Funds for community: An enabler to enhancing the capacity of community to take up referrals was the use of vouchers provided to patients to access community groups.

Program-level enablers

Maintained service database: A key enabler of social prescribing identified by participants is the availability of a maintained database of services, including the ability of community groups to input and update the ever-evolving landscape of groups and social connection opportunities.

Technology: The ability for social prescribing technology to sit alongside existing practice software was identified as an enabler through to reducing administrative burden.

Funding: Federal and state government funding of social prescribing were identified as enablers. Other potential funders included private health funds and large organisations.

Final Model of Care and its Components

Results of the four workshops have been brought together into a proposed social prescribing model of care for the Barossa. The co-designed model is presented in Figure 5 and described below.

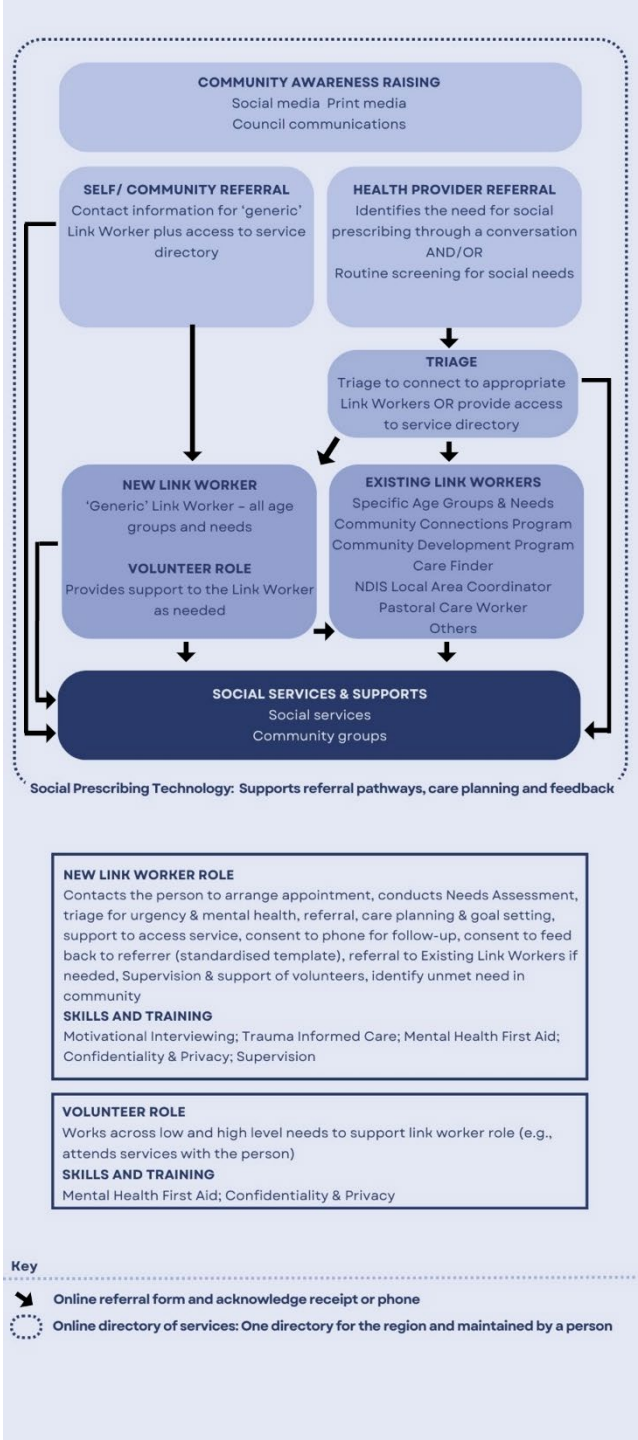


Figure 5. Co-designed social prescribing model for the Barossa

Community Awareness Raising

Raising community awareness about the concept of social prescribing was identified as an important starting point for the implementation of social prescribing in the Barossa. Workshop participants indicated a range of ways a person can learn more about social prescribing. These included both in person such as through church groups, schools, health providers, local council, and the library, and online (e.g., social media such as Facebook). It was noted that communications that may be perceived as 'junk mail' may not be an appropriate means of finding out more about social prescribing as many people do not receive or accept it.

Multiple Link Worker Roles: At the centre of the social prescribing is the link worker role, identifying social needs, referring to services, and providing additional support as needed. A key element of the co-designed model for the Barossa is the inclusion of multiple link worker roles, recognising that there are several programs already running in the region for referral for social needs. The proposal is that the Barossa model will integrate with existing programs with the addition of a new link worker role to fill any gaps in existing services and provide co-ordination of the overarching program. The new link worker should be located in the community (e.g., Community Hub) to support accessibility and to avoid medicalisation of social needs.

The new link worker will receive referrals from community members and health providers (see below) and contact the person to arrange an appointment. They will conduct a needs assessment, triage for urgency and mental health, and either refer the person to one of the existing link worker services or to relevant services to meet their social needs. The link worker will undertake care planning and goal setting and provide support to access services if needed. They will follow up with the person with their consent.

There was consensus across workshops that the new link worker role should be a paid position and that the appointee needs to be supported and part of a team. There is also a role for volunteers in the social prescribing model, who can work across low and high-level needs to support the link workers (e.g., by attending services with the person). Volunteers require training in mental health first aid and confidentiality and privacy.

Link workers should have a range of interpersonal and practical skills to be able to engage with individuals from all walks of life and diverse backgrounds. Interpersonal skills include warm referral to services and supports through phone calls and attending with the person (if needed), being an active listener and non-judgmental, having flexibility in their approach, and adapting language/terminology based on the person's needs. Practical skills may include trauma informed practice and the relevant qualifications for this, experience with motivational interviewing, identifying existing and potential barriers, and conflict resolution and negotiation. It was also noted that the link worker and clinician should "walk alongside" the client and seek feedback. There was some concern around the appropriateness of link workers and social prescribing for culturally and linguistically diverse groups; however, this needs to be explored further.

Additional roles of the new link worker include supervision and support of volunteers and identifying unmet needs in the community. The link worker can also identify new services for inclusion in the service directory (see below).

No Wrong Door: There is a clear preference that access to social prescribing in the Barossa be a 'no wrong door' approach. Two pathways were identified for referral into social prescribing:

1. Self and community referral, which involves either referral to the new link worker role or referral directly to social services and supports (i.e., using a 'signposting' approach via a directory of services, described below).
2. Health provider referral, which involves a triage process for referral to either existing or new link worker roles, with signposting directly to services and supports also available.

The process for self- and community-referral will depend on the availability/development of technology to support social prescribing. If technology is used, the model suggests the need for a public facing element of the technology to facilitate referral where individuals can fill in a referral form and be contacted by the link worker. A non-digital referral process is also needed for those not digitally literate or who do not have access to a computer.

The process for health provider referral includes identifying that a patient would benefit from social prescribing, either through a conversation and/or routine screening for social needs. This is followed by a triage and referral process, described next.

A Triage & Referral Process: The integration with existing link worker programs necessitates the addition of a triage process in the health provider referral pathway. Further workshops are planned in 2024 to co-design this process. The focus will be on developing a decision-tree with relevant eligibility

criteria and referral processes for each service. This will allow health providers to determine the most appropriate link worker service for the patient and how to undertake referral.

Directory of Services: It is important to have a centralised ‘source of truth’ documenting relevant services for social prescribing. This needs to be maintained and accessible to community, health and social services, and link workers. The directory should be online with the option to print. The directory should be searchable and provide details such as services offered, cost, eligibility, wait times/urgent appointments, accessibility, cultural safety, and client feedback ratings.

Social Prescribing Technology: Social prescribing technology is an important element of the social prescribing model. This needs to be a separate system and not part of an existing health practice management system but with integration capability. Important aspects of the technology include:

- Accessibility to clients, health providers, and link workers
- Housing the service directory
- Facilitating referral using online forms
- Facilitating feedback to health providers who refer their clients (e.g., system generated update that the client has been received and serviced)
- Supporting link workers to work collaboratively with the client to co-design a social prescription, set goals, and provide support and follow-up.

It is important that the technology incorporates the ability for non-digital referral (telephone and paper-based) to meet the varied digital capability and comfort of clients.

Discussion

This report describes the process of co-designing a social prescribing model of care for the Barossa. Key stakeholders from health and social services and community members took part in workshops to co-design the model. The workshops were characterised by liveliness and dynamism, and participants expressed satisfaction in having their perceptions, experiences, and suggestions genuinely acknowledged. The significant number of repeat participants among service providers attests to their enjoyment of the process and appreciation of the outcomes. There was a strong interest in continuing collaboration to refine and implement the final social prescribing model. The use of co-design tools such as Ideas Workbooks, case studies, and journey maps effectively encouraged creativity and engagement among stakeholders.

Participants identified the need for a holistic social prescribing model with key elements including link worker support (augmented by volunteers), 'no wrong door' entry, and feedback loops to those referring into the program. Technology was identified as an important enabler of social prescribing, in addition to an updated and maintained directory of services.

A novel element that emerged through co-design was the importance of including existing programs that support people with their non-medical needs (e.g., Community Connections Program, Care Finder, and the National Disability Insurance Scheme Local Area Coordinator) in the model of care and triaging people into the relevant program. Triaging people into existing programs, in addition to a new link worker role to support those not eligible for these programs, was identified as important to avoid service duplication and support sustainability. Participants furthermore identified the need for community awareness raising of the concept of social prescribing to support uptake and engagement due to the novelty of the terminology and concept in Australia. Finally, while social prescribing is commonly delivered via general practice, participants identified the need for multiple referral pathways including those beyond general practice and through community and self-referral.

Further work is needed to address key issues identified in through co-design, as follows:

5. How could awareness raising (for community and health providers) of the concept and importance of social prescribing be done in the region?
6. How could screening tools be used for a) identifying participants for social prescribing, and b) needs assessment?
7. How could triaging be done for a) determining which link worker/program to refer to and b) for link workers to determine urgency of need?
8. Service directory – how can a service directory be sustainably developed and maintained (including who has oversight, funding mechanisms, and the potential role of Artificial Intelligence)?

Next steps

The following projects are underway to continue the process of social prescribing co-design in the Barossa:

3. Co-design workshops with service providers to design a decision tool and referral process for triaging patients to access currently available services to address their social needs.
4. A photovoice project to explore community members' views and experiences of community connection and support to help us understand the community context of social prescribing.

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Appendix 1. Co-design materials

Contents

SOCIAL PRESCRIBING CO-DESIGN
PROJECT LOGIC & THEORY OF CHANGE

Objective: To co-design a model of social prescribing with health professionals, service providers and community members in the region.

Needs statement

Residents are experiencing unprecedented financial stress, homelessness, food insecurity, and loneliness/social isolation. Social prescribing provides non-clinical referral pathways for residents to access support for social needs. It is important for social prescribing to be co-designed by key stakeholders, including health professionals, service providers and community members.

Inputs	Activities	Outputs	Short-term outcomes	Medium-term outcomes	Long-term outcomes
Funding from SA Healthy Towns Project. Project committee: • Led by Local Government • Cross-sectoral representation • University Strong networks across the region. Knowledge & expertise in co-design. Knowledge of components and models of social prescribing.	Project committee workshop Co-design service workshop 1: health and social service providers (draft model). Co-design workshop 2: health and social service providers (model refinement). 2 x Co-design workshops with community (model feedback and input). Information session with service providers not engaged in the co-design process.	Co-designed social prescribing model. Initial development of a directory of social and recreational supports that can be utilised as part of the model.	Health Professionals and Service Providers: • Understanding the effects of social determinants on health and wellbeing. • Knowledge of components and models of social prescribing. • Having a voice in program design. Community: • Understanding the effects of social determinants on health and wellbeing. • Awareness of social prescribing.	Health Professionals and Service Providers: • Strengthened cross-sectoral collaboration to address social determinants of health. • Increased knowledge of available community and social assets. • Commitment from service providers to support the model of social prescribing in roles that are relevant to their organisation.	Implementation and evaluation of the social prescribing model of care. Community: Improved health and wellbeing as a result of “filling social prescriptions”.

Qualitative and quantitative data from needs assessment.			• Having a voice in program design.		

Theory of change statement

Australians are facing unprecedented financial stress, homelessness, food insecurity, and loneliness/social isolation. This crisis is exacerbated by the combined effects of the COVID-19 pandemic and the current cost of living, disproportionately affecting the most vulnerable Australians[1]. Social needs are best addressed by social and community support services. However, 6-36% of General Practice consultations are for social needs[2] while social and community services experience difficulties connecting those at greatest disadvantage to their services[3]. There is a clear need for referral pathways between health services and the social and community service sectors to better support people experiencing social needs. This can be done through social prescribing, a systematic approach to screening people for social needs and referring them to social and community services[4]. Social prescribing is in its infancy in Australia relative to the UK and USA but is gaining momentum in practice and policy[5]. With the evidence-base for social prescribing coming from the UK and USA, co-design with key stakeholders is needed to ensure adequate fit with Australia's health and social care systems and to ensure models of social prescribing meet the needs of Australian communities[6].

This project will co-design a model of social prescribing with key stakeholders in the region. Co-design workshops will be conducted, two with health professionals and social service providers and two with community members. Assumptions of the project are that participation in co-design workshops will improve participants' understanding of the effects of social determinants on health and wellbeing and their knowledge and awareness of social prescribing and provide them with a voice in co-design. It also assumes that participation in workshops will strengthen cross-sectoral collaboration to address social determinants of health and that service providers will understand and commit to their role in the social prescribing model. The outcome of the project will be a co-designed model of social prescribing for implementation and evaluation in a future project, followed by a long-term outcome of improved health and wellbeing for community members as a result of "filling social prescriptions".

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5. Australian Government (2021). National Preventive Health Strategy 2021-2030. Australian Government, Canberra.
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SOCIAL PRESCRIBING CO-DESIGN
SERVICE PROVIDER WORKSHOP 1
INDIVIDUAL TASKS

Note: Images are stock images from Microsoft Word.

Social Prescribing Co-Design

BOOKLET OF IDEAS

Instructions: please review each page by yourself, answering any questions and noting your thoughts and comments on the margins.

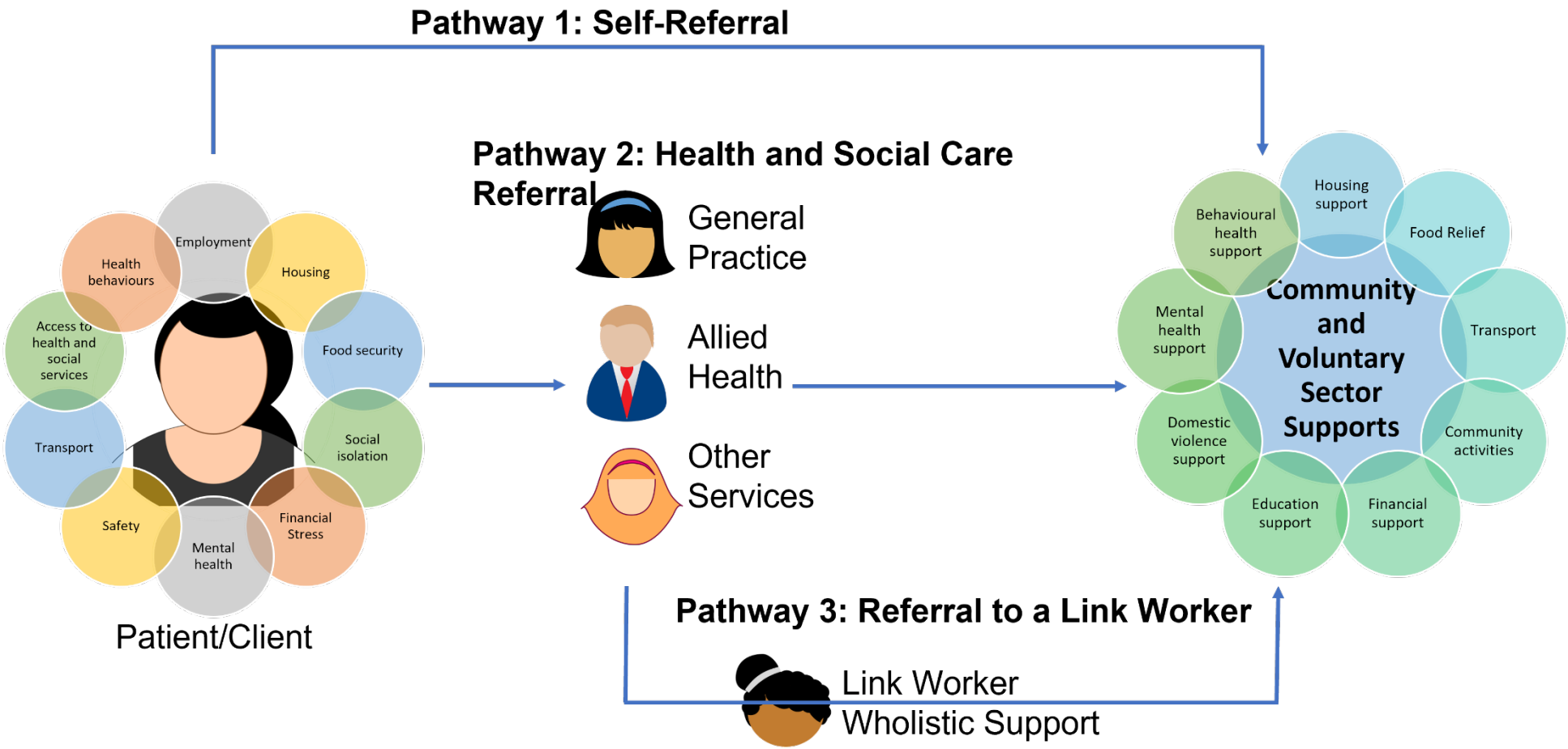
(Print in colour)

Instructions: On the next few pages, please indicate your liking or disliking of each component of social prescribing shown in pictures (by circling the ‘faces’).

Feel free to add any other comments on the margins.

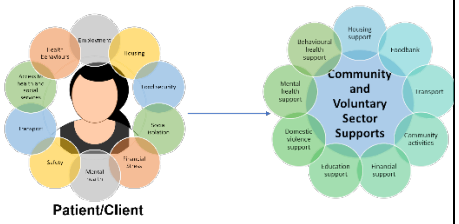
Start thinking which components you would like to see in a social prescribing programme.

SOCIAL PRESCRIBING PATHWAYS

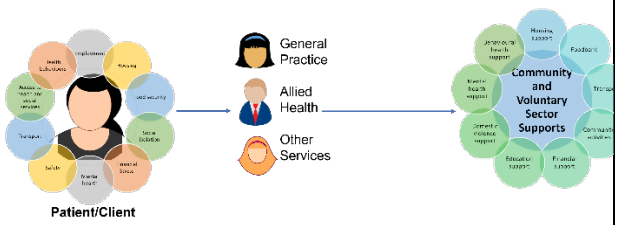


WHICH SOCIAL PRESCRIBING PATHWAY?

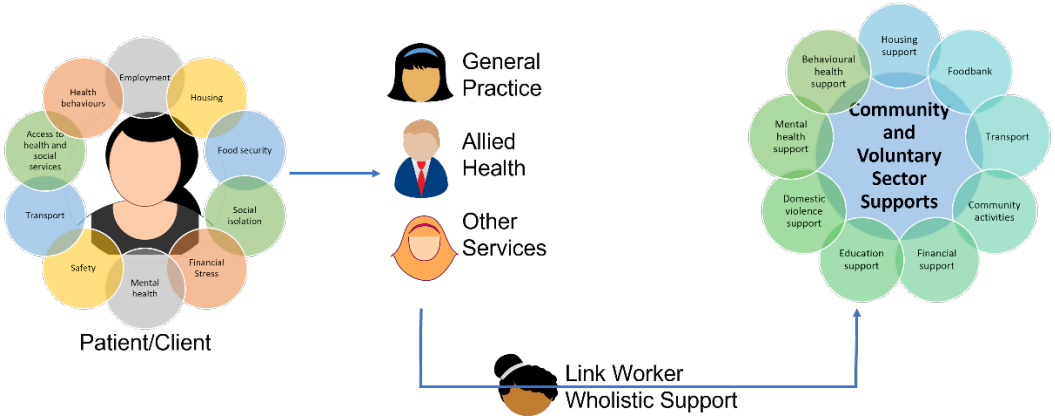
(can be one, two, or all three)



Pathway 1: Self- Referral



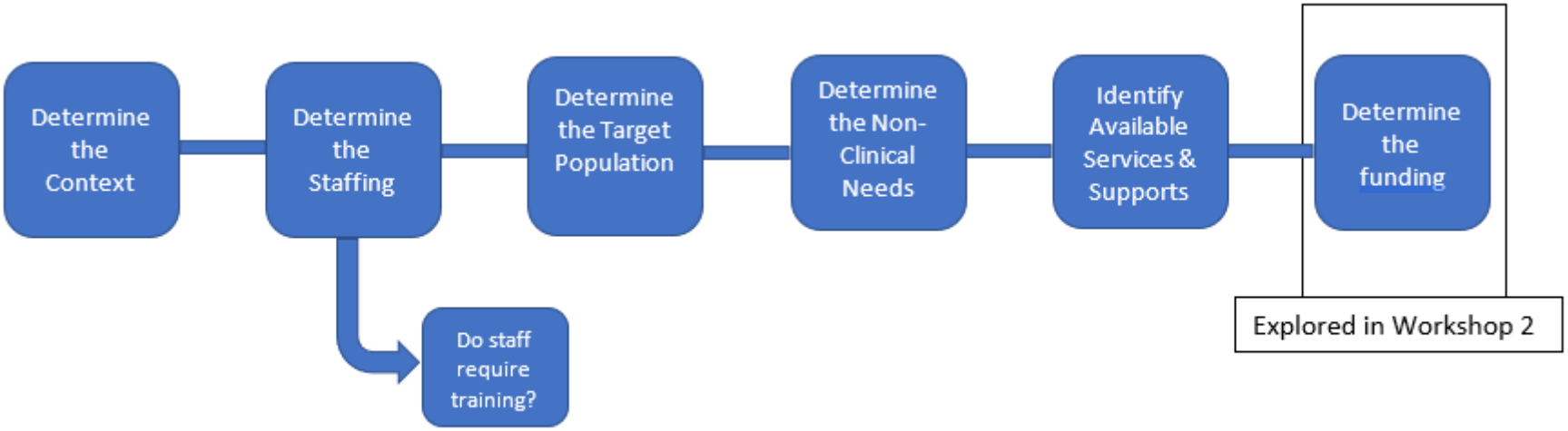
Pathway 2: Health and social care referral



Pathway 3: Health and social care referral to a Link Worker

1. Planning stages and decision-making

[Note: Identifying available services and supports will be discussed towards the end of the workshop]



WHERE DO WE WANT SOCIAL PRESCRIBING TO HAPPEN?

☹ 😐 ☺	 **In General Practice**	☹ 😐 ☺	 **In Allied Health Practices**
☹ 😐 ☺	 **In Community Settings** (E.g., Library, online)	☹ 😐 ☺	 **In Social Service Settings** (E.g., Centrelink)

STAFFING THE SOCIAL PRESCRIBING MODEL?

(What staff are needed)

	**Existing staff** (GP or allied health during routine consultation)		**Nominated internal Link Worker** (E.g., practice nurse)
	**New Link Worker role** (E.g., funded position/volunteer)		**Existing Link worker role** (Community Connections Program link workers)

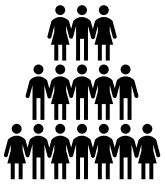
STAFF TRAINING?

	 **Training in the effects social determinants of health**		 **Training of staff in the model of social prescribing** (Processes and procedures)

	 **Training of Link Workers** (E.g., Motivational Interviewing; goal setting; mental health first aid)

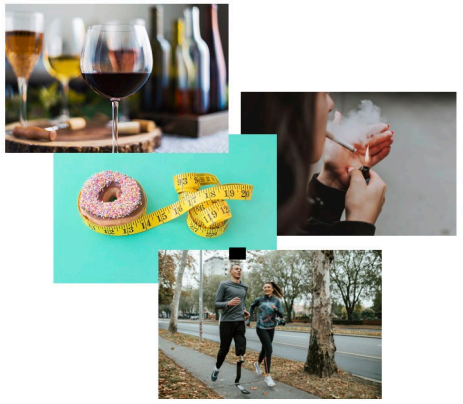
TARGET POPULATION

(Who will take part in the programme?)

	 **General Population**		 **Specific At-Risk Groups** (E.g., People with long-term conditions; older people; people with mental health issues; etc.)

NON-CLINICAL NEEDS TO BE ADDRESSED?

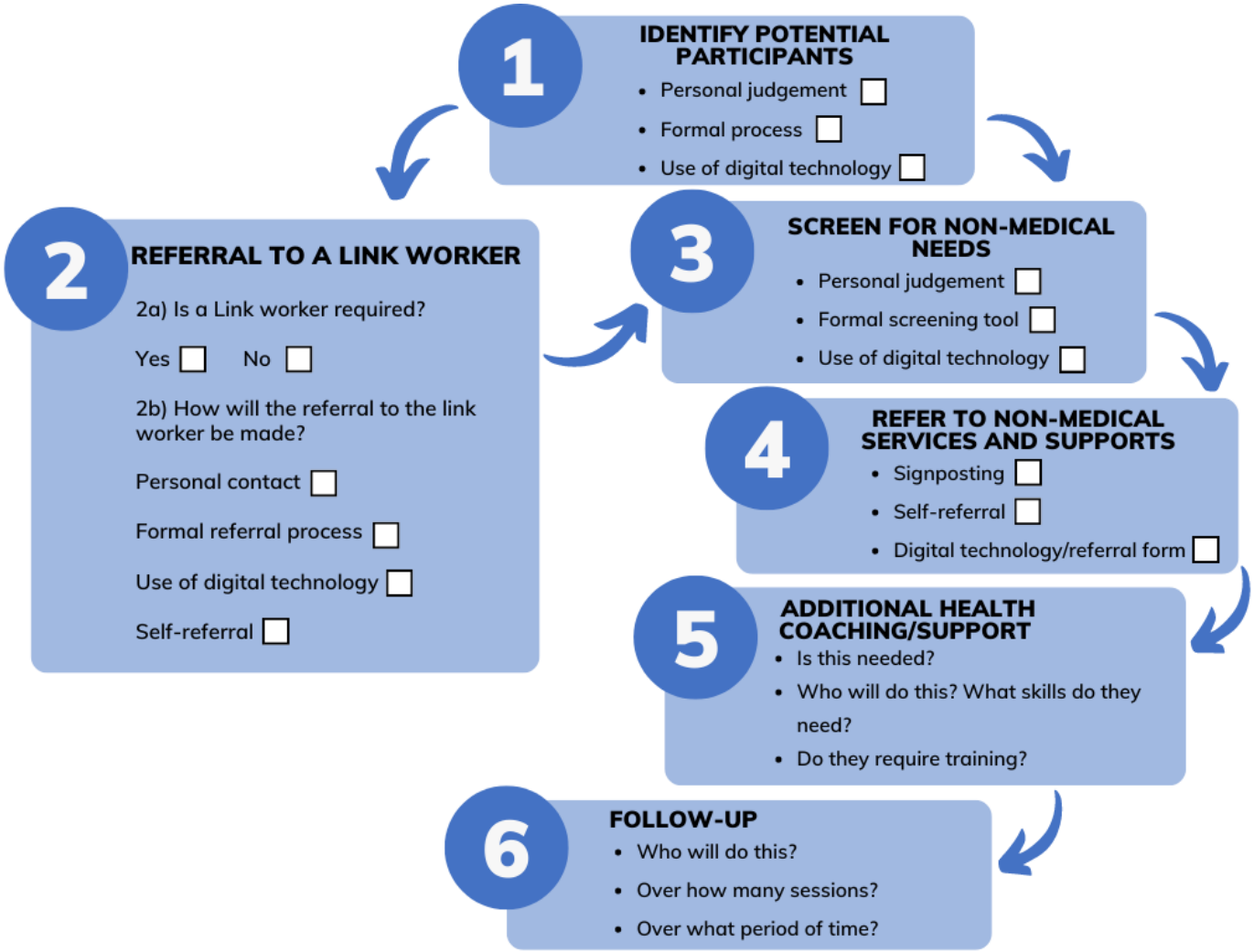
Social Determinants of Health



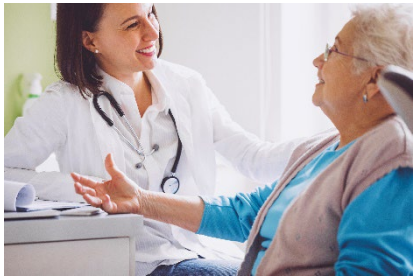
Health Behaviours

(E.g., smoking, exercise, diet)

2. Process stages and decision-making


1
IDENTIFY POTENTIAL PARTICIPANTS
Personal judgement
Formal process
Use of digital technology
2
REFERRAL TO A LINK WORKER
2a) Is a Link worker required?
Yes
No
2b) How will the referral to the link worker be made?
Personal contact
Formal referral process
Use of digital technology
Self-referral
3
SCREEN FOR NON-MEDICAL NEEDS
Personal judgement
Formal screening tool
Use of digital technology
4
REFER TO NON-MEDICAL SERVICES AND SUPPORTS
Signposting
Self-referral
Digital technology/referral form
5
ADDITIONAL HEALTH COACHING/SUPPORT
Is this needed?
Who will do this? What skills do they need?
Do they require training?
6
FOLLOW-UP
Who will do this?
Over how many sessions?
Over what period of time?

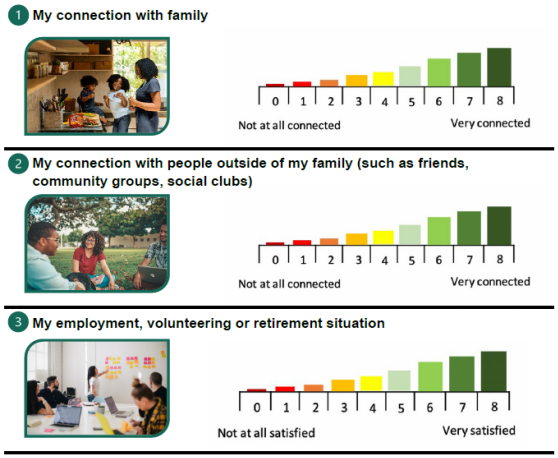
HOW WILL PEOPLE BE IDENTIFIED FOR PARTICIPATION IN THE SOCIAL PRESCRIBING PROGRAM?

☹ 😐 🙂	 **Professional judgement** (E.g., during a medical/allied health consultation)	☹ 😐 🙂	 **Routine screening** (E.g., in waiting room)

HOW WILL THE PERSON'S NON-CLINICAL NEEDS BE IDENFIFIED FOR REFERRAL?

Professional judgement

(E.g., identify specific needs during consultation)



Use of a screening questionnaire

Self-identification

IF THERE IS A LINK WORKER: REFERRAL PROCESS?

	 **Warm Referral** (Contacting the link worker for or with the client)		 **Referral pad** (Client takes the referral to the link worker)
	**Self-referral** (E.g., providing information about a link worker service)		

REFERRAL PROCESS: REFERRAL TO SOCIAL/COMMUNITY SERVICES?

Warm Referral

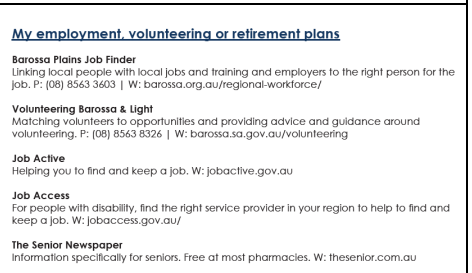
(Contacting a service for or with the client)

Referral pad

(Client takes the referral to the service)

Computer

(E.g., tick-box and download a list of relevant services and contact information)



Self-referral

(E.g., providing a booklet of services / online link to a service directory)

FOLLOW-UP?

	 **No follow-up**		 **Follow-up** (E.g., reminder in the client information system)

TECHNOLOGY?

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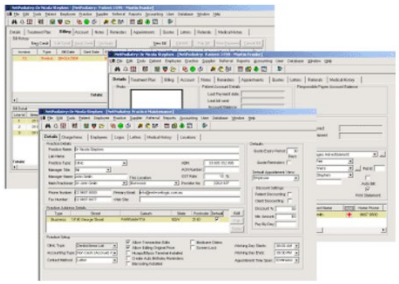
<td> 

Including social prescribing in existing patient management software</td>
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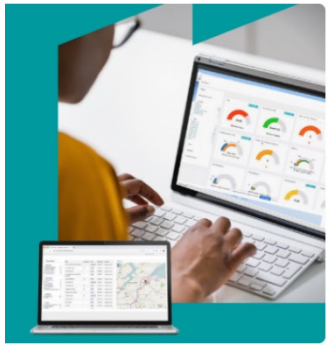
<td> 

New software for social prescribing</td>
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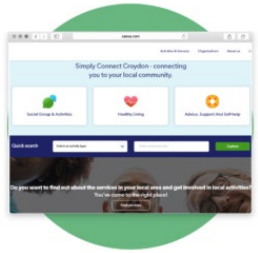
<td colspan="3"> 

Public Facing Social Prescribing Referral Platform
(E.g., Social needs screening survey
linked to a service directory; downloadable referral form)</td>
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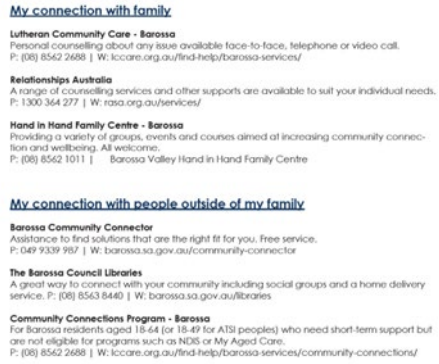
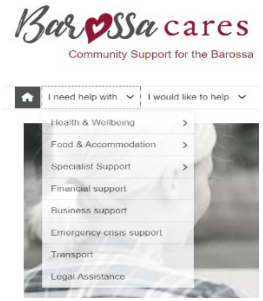
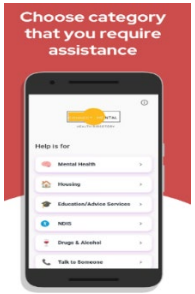
</table>

3. Developing and maintaining service database

☹ 😐 ☺	 **Personal knowledge** (E.g., of health/social care provider or link worker)	☹ 😐 ☺	 **Local service mapping and Booklet of services**
☹ 😐 ☺	 **Local service mapping and Online database**	☹ 😐 ☺	 **Postcode Searchable Community Directory App/Website**

SHORT QUESTIONS

(For statistical purposes only. Please write response or circle appropriate answer)

1. What is your profession?
2. About how long have you worked in your profession? A. 1 year or less B. 2-5 years C. >5 years
3. What is your gender? A. Male B. Female C. Non-binary D. Prefer not to answer
4. Which age group do you belong to?

   A. Under 25yo B. 26-35yo C.36-45yo D.46-55yo E.56-65yo F.65+yo G. Prefer not to answer

Thank you for completing these questions. We will shortly return to the group discussion.

SOCIAL PRESCRIBING CO-DESIGN
SERVICE PROVIDER WORKSHOP 2
INDIVIDUAL TASKS

SOCIAL PRESCRIBING CO-DESIGN
SERVICE PROVIDER WORKSHOP 2
INDIVIDUAL TASKS

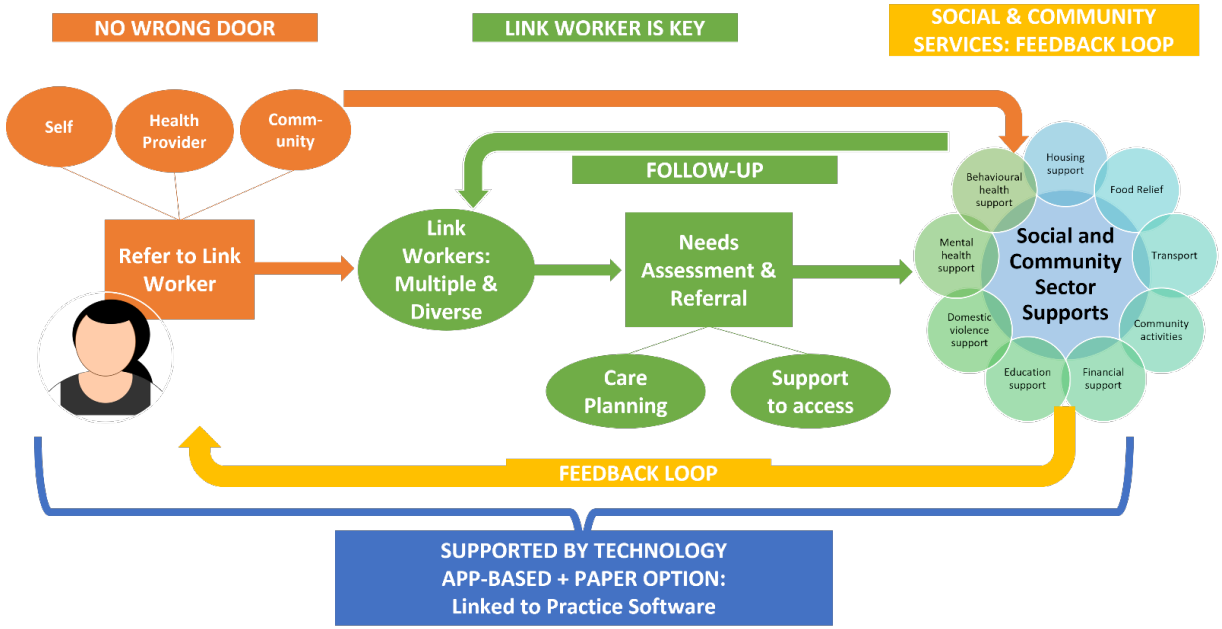
TASK 1: FINISH THE SENTENCES

Instructions: Complete the unfinished sentences below with whatever ideas first come to mind.

START	**FINISH THE SENTENCE (WRITE DOWN)**
Social prescribing would help me by …	
Social prescribing would help my clients by …	
Social prescribing would help my community by …	

TASK 2: VOTING

Scan QR code, or go to XXX to vote on the draft social prescribing model



QR CODE HERE

TASK 3: DEMOGRAPHICS

(For statistical purposes only. Please write response or circle appropriate answer)

5. What is your profession?
6. About how long have you worked in your profession? A. 1 year or less B. 2-5 years C. >5 years
7. What is your gender? A. Male B. Female C. Non-binary D. Prefer not to answer
8. Which age group do you belong to?

   B. Under 25yo B. 26-35yo C.36-45yo D.46-55yo E.56-65yo F.65+yo G. Prefer not to answer

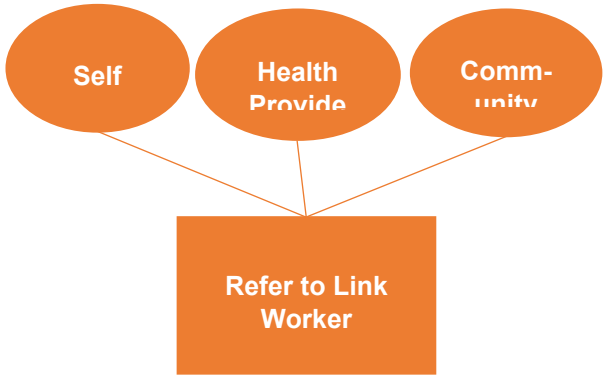
Thank you for completing these questions. We will shortly return to the group discussion.

SOCIAL PRESCRIBING CO-DESIGN
SERVICE PROVIDER WORKSHOP 2
SMALL GROUP ACTIVITY

NO WRONG DOOR

Anyone can refer to a Link Worker

(Health Provider, Self-referral, Community referral)



THINK ABOUT:

PROGRAM ENTRY

How do service providers determine who might benefit from social prescribing? (e.g., professional judgement, routine screening)

How do individuals and community find out about social prescribing? (e.g., print/social media advertising, flyers in health and community settings)

LINK WORKER REFERRAL

How do service providers refer individuals to a Link Worker? (e.g., warm referral, referral pad, online)

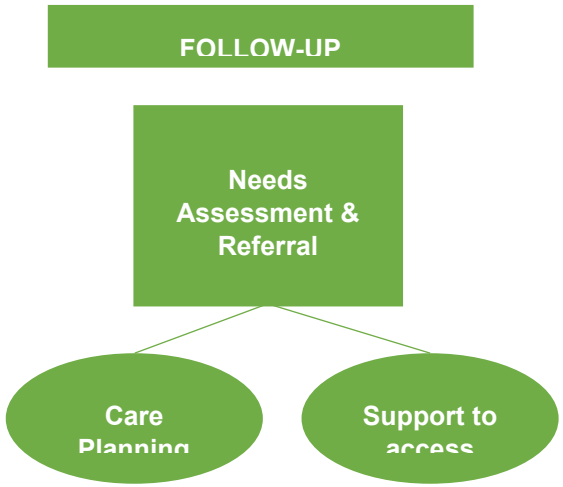
How do individuals/family/community refer individuals to a Link Worker? (e.g., warm referral, online)

LINK WORKER IS KEY: WHO SHOULD THEY BE?

There are multiple Link Worker roles (‘Professional’ and volunteer)

Link Workers: Multiple & Diverse	**THINK ABOUT:**	**LINK WORKER SKILLS** **What skills does a Link Worker need?** (e.g., communication skills, supporting clients with their mental health during social prescribing, self-care as a Link Worker) **USE OF EXISTING AND NEW LINK WORKER ROLES** **Existing Link Worker roles?** (e.g., Community Connections Program for adults aged 18-64; Care Finder for older adults eligible for aged care services; NDIS) **New Link Worker roles?** (e.g., ‘Professional’ (paid) position; Volunteer positions; expanding existing roles e.g., Practice Nurse) **LINK WORKER SUPERVISION** **How are Link Workers supervised and supported?** (e.g., new supervision role, existing council staff for volunteers, community of practice)

LINK WORKER IS KEY: WHAT DO THEY DO?



THINK ABOUT:

NEEDS ASSESSMENT

How are the client's needs determined by the Link Worker? (e.g., through a conversation, social needs screening tool)

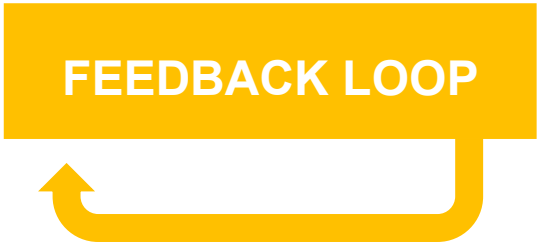
REFERRAL

How are clients referred to supports and services to address their needs? (e.g., contacting the service with/for the client; take the client to the services; referral form and client contacts the service)

CARE PLANNING

How are clients supported and followed up by the Link Worker? (e.g., case management with regular appointments; check-in phone calls)

FEEDBACK LOOP

	**THINK ABOUT:**	**WHO?** **Who is provided feedback?** **WHAT?** **What information are they provided?** **WHEN?** **When does this happen?** (e.g., once at the end of a period of time, at regular intervals) **HOW?** **How is feedback provided?** **How is a client's privacy protected?**

SUPPORTED BY TECHNOLOGY

SUPPORTED BY TECHNOLOGY APP-BASED + PAPER OPTION:	THINK ABOUT:	**DIRECTORY OF SERVICS** **What area does it cover** (e.g., local, state-wide, national) **How is the directory maintained?** (e.g., locally maintained by each area, state-wide, national) **What information is included about the services?** (e.g., patient eligibility, fees, wait times/urgent appointments, location, client feedback rating) **REFERRAL & FEEDBACK LOOP** **Inclusion of a social needs screening tool?** **Linked to/integrated with existing software?** **CARE PLANNING** **Case management for social prescribers?** **ASSESSMENT (BEFORE/AFTER ASSESSMENT TOOL)?** **PATIENT PORTAL**

SOCIAL PRESCRIBING CO-DESIGN
COMMUNITY WORKSHOP
SMALL GROUP ACTIVITY: CASE STUDIES AND JOURNEY MAPS

NOTE: Images are stock images from Microsoft Word and do not represent real cases.

SOCIAL PRESCRIBING: ALLIED HEALTH REFERRAL PATHWAY

Name: Anna

Age: 78

Marital status: Recently widowed

Family: Son and grandchildren live in Queensland

Occupation: Retired interior designer

"I'd love to see more of my grandchildren. They are growing up so fast."

Anna lives alone since her husband passed away last year. She misses her family, who live in Queensland. Anna's son has been trying to persuade her to communicate with her grandchildren using the iPad he bought her when he last visited, but she is nervous to use the iPad.

Anna has been undergoing rehabilitation with a physiotherapist after breaking her hip when she fell while walking her dog. Anna has lost confidence being out and about since the fall. She finds it difficult to shop and cook for one person, so she tends to eat toast and canned salmon for dinner.

Anna's physiotherapist is happy with her progress and suggested she no longer needs to attend the clinic. But Anna keeps coming back because she is feeling lonely and enjoys the company.

Social needs: Social connection, assistance with shopping and preparing meals, technology skills

How does the Physiotherapist know Anna needs extra support?	How does the Physiotherapist contact the Link Worker?	What happens in the appointment with the Link Worker?	How does the Link Worker connect Anna with social connection and other supports?	How does the Link Worker follow up with Anna to see how she's doing?	How does the Link Worker let the Physiotherapist know how Anna is doing?
• Conversation • Screening tool (during appointment/ in waiting room/ when doing an online booking)	• Phone call • Written referral • Online referral	Where should the link worker be located? What should the link worker do? • Screen for social needs • Have a conversation • Develop a support plan	Link worker: • Phone call • Written referral • Online referral • Go to the appointment/ community group with Anna If the Physiotherapist wants to do this without the Link Worker, how could they find out what services are available?	How often should the Link Worker follow up with Anna to see how she's doing? How should the follow-up be done (in person, phone, etc.)?	Who else should know about how Anna is doing? How much information should be shared? • Basic (e.g., I have received the referral; I have met with Anna) • Detailed (e.g., I have connected Anna to these supports; this is how he is doing) How should this information be shared? • Phone call • In writing • Online / App

SOCIAL PRESCRIBING: GP REFERRAL PATHWAY

Name: Cooper

Age: 19

Marital status: Single

Family: Lives at home with his parents

Occupation: Unemployed

"I love working with computers, but I don't know how to turn this into meaningful employment."

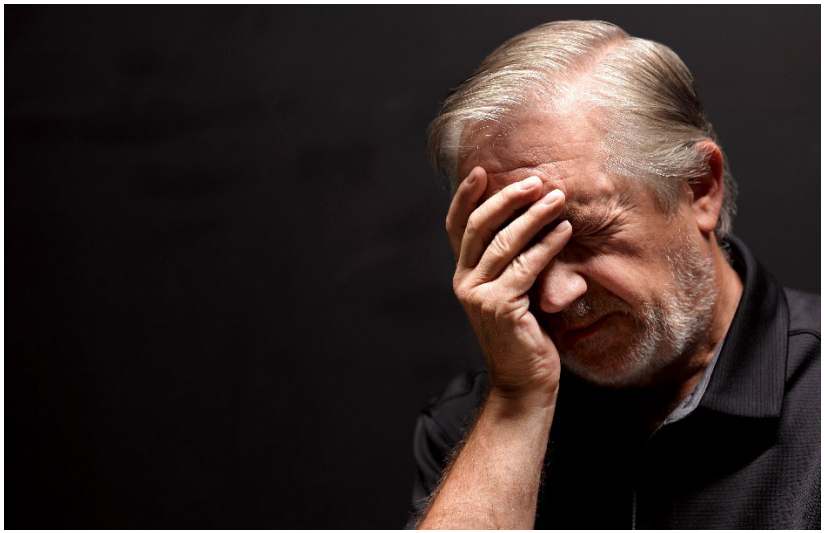
Cooper finished school a year ago. He is unemployed and spends a lot of time at home playing computer games. Cooper and his dad fight a lot about how he spends his time. Cooper tends to eat snack food rather than meals and has poor sleeping habits.

His mum is worried about his mental health and makes an appointment for him to see his GP for a mental health assessment.

Social needs: Employment/education, social connection, family issues

How does the GP know Cooper needs extra support?	How does the GP contact the Link Worker?	What happens in the appointment with the Link Worker?	How does the Link Worker connect Cooper with job support and social connections?	How does the Link Worker follow up with Cooper to see how he's doing?	How does the Link Worker let the GP know how Cooper is doing?
• Conversation • Screening tool (during appointment/ in waiting room/ when doing an online booking)	• Phone call • Written referral • Online referral	Where should the link worker be located? What should the link worker do? • Screen for social needs • Have a conversation • Develop a support plan	Link worker: • Phone call • Written referral • Online referral • Go to the appointment/ community group with Cooper If the GP wants to do this without the Link Worker, how could they find out what services are available?	How often should the Link Worker follow up with Cooper to see how he's doing? How should the follow-up be done (in person, phone, etc.)?	Who else should know about how Cooper is doing? How much information should be shared? • Basic (e.g., I have received the referral; I have met with Cooper) • Detailed (e.g., I have connected Cooper to these supports; this is how he is doing) How should this information be shared? • Phone call • In writing • Online / App

SOCIAL PRESCRIBING: GP REFERRAL PATHWAY



Name: Jim

Age: 68

Marital status: Married

Family: Adult children living in Adelaide

Occupation: Retired software engineer

"One of the best things about my job was the sense of mateship with my co-workers. I really miss that now I'm retired."

Jim and his wife, Deb, were looking forward to their retirement. They bought a caravan and planned many trips across Australia. Unfortunately, Deb had a stroke 18-months ago and has difficulties walking, toileting, and feeding herself. Jim spends his time caring for Deb.

Jim regularly sees his GP and has a Chronic Disease Management plan for his diabetes.

Jim is feeling low and isolated and feels like he is "stuck in a rut" and unsure how to move forward with his life.

Social needs: Carer support, social connection

How does the GP know Jim needs extra support?	How does the GP contact the Link Worker?	What happens in the appointment with the Link Worker?	How does the Link Worker connect Jim with carer support and social connections?	How does the Link Worker follow up with Jim to see how he's doing?	How does the Link Worker let the GP know how Jim is doing?
• Conversation • Screening tool (during appointment/ in waiting room/ when doing an online booking)	• Phone call • Written referral • Online referral	Where should the link worker be located? What should the link worker do? • Screen for social needs • Have a conversation • Develop a support plan	Link worker: • Phone call • Written referral • Online referral • Go to the appointment/ community group with Jim If the GP wants to do this without the Link Worker, how could they find out what services are available?	How often should the Link Worker follow up with Jim to see how he's doing? How should the follow-up be done (in person, phone, etc.)?	Who else should know about how Jim is doing? How much information should be shared? • Basic (e.g., I have received the referral; I have met with Jim) • Detailed (e.g., I have connected Jim to these supports; this is how he is doing) How should this information be shared? • Phone call • In writing • Online / App

SOCIAL PRESCRIBING: SELF/COMMUNITY REFERRAL PATHWAY

Name: Marianne

Age: 33

Marital status: Divorced

Family: Parents and siblings live in Holland, where Marianne was born

Occupation: Works part-time as a house cleaner

"The most important thing to me are my children. I just want to be there for them and be the best mum I can be."

Marrianne is a single mother with three children. She works part time as a house cleaner while her children are at kindy and school. Her family live overseas.

Marianne works hard to support her family but she's finding it harder to get by because of recent changes to her Family Tax Benefit income. With rising food prices, Marianne recently found herself in a situation where she couldn't afford to buy food for her family.

Marianne is feeling very stressed and worried about what people will think of her. In desperation, she reached out to the local community through the Community Facebook page to ask if anyone could help her out with some food. Her community was able to help with her immediate food needs but were not aware of how to connect her with longer term support.

Social needs: Financial assistance, food relief, financial counselling

How does Marianne find out about the social prescribing program?	How does Marianne contact the Link Worker?	What happens in the appointment with the Link Worker?	How does the Link Worker connect Marianne with food relief and financial counselling?	How does the Link Worker follow up with Marianne to see how she's doing?	How could Marianne find out about food relief and financial counselling herself if she doesn't want to see a Link Worker?
• Printed flyers in the community • Printed flyers in health settings (GP, pharmacy) • Local paper • Social media	• Phone call • Online form	Where should the link worker be located? What should the link worker do? • Screen for social needs • Have a conversation • Develop a support plan	Link worker: • Phone call • Written referral • Online referral • Go to the service/ community group with Marianne	How often should the Link Worker follow up with Marianne to see how she's doing? How should the follow-up be done (in person, phone, etc.)?	• Printed booklet • Online service directory • Social media

SOCIAL PRESCRIBING: ALLIED HEALTH REFERRAL PATHWAY

Name: Paula

Age: 29

Marital status: De-facto relationship

Family: Parents and siblings live in Adelaide

Occupation: Stay-at-home mum

"I've been feeling really lonely since moving here. I'd love to meet some people and feel part of the community."

Paula recently moved to the Barossa with her partner and her 5-year-old daughter. Paula is a stay-at-home mum and doesn't have any friends in the local community.

Paula's daughter has speech and communication issues and sees a speech pathologist.

Paula is feeling socially isolated and is finding it difficult to find friends and social connection in the community.

Social needs: Social connection

How does the Speech Pathologist know Paula needs extra support?	How does the Speech Pathologist contact the Link Worker?	What happens in the appointment with the Link Worker?	How does the Link Worker connect Paula with social connections?	How does the Link Worker follow up with Paula to see how she's doing?	How could Paula find out about available services and supports herself if she doesn't want to see a Link Worker?
• Conversation • Screening tool (during appointment/ in waiting room/ when doing an online booking)	• Phone call • Written referral • Online referral	Where should the link worker be located? What should the link worker do? • Screen for social needs • Have a conversation • Develop a support plan	Link worker: • Phone call • Written referral • Online referral • Go to the appointment/ community group with Paula If the Speech Pathologists wants to do this without the Link Worker, how could they find out what services are available?	How often should the Link Worker follow up with Paula to see how she's doing? How should the follow-up be done (in person, phone, etc.)?	Who else should know about how Paula is doing? How much information should be shared? • Basic (e.g., I have received the referral; I have met with Paula) • Detailed (e.g., I have connected Paula to these supports; this is how he is doing) How should this information be shared? • Phone call • In writing • Online / App

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Creating better lives through research

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