American Journal of Advanced Multidisciplinary Innovation and Research (AJAMIR)

E-ISSN: XXXX-XXXX ● Website: www.ajamir.com ● Email: editor@ajamir.com

Social Prescribing Pathways for Reducing Nonclinical Health Burdens

Prof. Genevieve Dingle

Professor, The University of Queensland, Australia

Abstract

Primary-care consultations frequently involve concerns that cannot be resolved through diagnosis, medication, or clinical treatment alone. Loneliness, social isolation, insecure housing, financial difficulty, unemployment, transport barriers, caregiving responsibilities, low confidence, limited community participation, and difficulty navigating welfare or support services may influence health while lying partly outside the conventional boundaries of medical care. Social prescribing has emerged as one pathway for connecting people presenting in primary care with nonclinical community resources. Rather than prescribing a standardized activity, many social-prescribing models use a link worker or community connector to understand an individual's priorities, identify available assets, and support engagement with appropriate voluntary, social, welfare, cultural, physical-activity, or community services. Earlier systematic reviews, however, cautioned that enthusiasm for social prescribing had developed faster than the quality of its effectiveness evidence. Bickerdike and colleagues found substantial methodological weaknesses in early evaluations, while later reviews continued to report heterogeneous interventions and outcomes.

The present study develops a simulation-based model examining whether different social-prescribing pathways may reduce a composite Nonclinical Health-Burden Index. Because no original participant dataset was supplied, 600 synthetic primary-care cases were modeled across three pathways: information-only signposting, link-worker referral, and a supported community pathway combining link-worker engagement with active follow-through into community resources. Numerical findings are therefore methodological illustrations rather than estimates of clinical effectiveness. All three modeled pathways began with a mean burden score of 70.

The conceptual model proposes that social prescribing is most likely to reduce nonclinical burden when referral is converted into genuine engagement. Research with service users has indicated that personalized link-worker support can strengthen confidence, social connection, problem solving, and engagement with health-promoting activities, while realist and qualitative research emphasizes trusting relationships, accessible community assets, practical support, and appropriate referral as important mechanisms. The study therefore distinguishes passive signposting from a pathway in which nonclinical needs are identified, prioritized, matched to local support, and followed through.

Keywords: social prescribing; primary care; nonclinical health burden; link workers; social determinants of health; community referral; social isolation; patient engagement

American Journal of Advanced Multidisciplinary Innovation and Research (AJAMIR)

E-ISSN: XXXX-XXXX ● Website: www.ajamir.com ● Email: editor@ajamir.com

1. Introduction

Primary care is frequently the healthcare setting in which medical and social problems become most visibly intertwined. A patient may attend with sleep difficulty while also experiencing debt, loneliness, housing insecurity, unemployment, caregiving strain, food insecurity, or social isolation. Another may repeatedly consult for symptoms whose severity is intensified by limited mobility, lack of meaningful daily activity, or absence of social support. Such circumstances are clinically relevant because they influence a person's capacity to manage illness, participate in preventive activity, maintain routines, attend appointments, or cope psychologically, yet they cannot always be addressed through pharmaceutical or diagnostic interventions. Social prescribing emerged partly in response to this boundary problem by establishing pathways from healthcare toward voluntary, community, welfare, social, cultural, and other nonmedical forms of support. Bickerdike and colleagues define the broad approach as linking primary-care patients with sources of support in the community to improve health and well-being.

Social prescribing is not a single standardized intervention. Some pathways consist primarily of giving patients information about a local service. Others refer individuals to a dedicated link worker who spends time identifying personal goals and connecting the individual to community resources. More intensive models provide supported introductions, repeated contact, motivational assistance, and follow-up when the first referral is unsuccessful. Tierney and colleagues' realist review emphasized the importance of linking people with local assets in ways that take account of individual circumstances, relationships, and available community resources rather than assuming that referral alone creates benefit. Husk and colleagues similarly concluded that social prescribing is a complex intervention whose effectiveness is likely to depend on who receives it, how referral is conducted, what support follows referral, and the context within which community services operate.

This distinction is important because many nonclinical health burdens contain practical obstacles to participation. A socially isolated older adult may be referred to a community group but lack transport. A person experiencing anxiety may understand that social participation could be beneficial yet feel unable to enter an unfamiliar group alone. Someone referred for welfare advice may be overwhelmed by administrative processes. Pescheny, Randhawa, and Pappas found that patient uptake and adherence to social prescribing could be influenced by individual motivation, perceived relevance, accessibility, previous experiences, and the quality of support surrounding referral. Wildman and colleagues likewise reported that effective engagement depended on link workers possessing time, interpersonal skill, local networks, and the capacity to develop trust without creating dependency.

Evidence concerning outcomes is promising in parts but remains methodologically uneven. Carnes and colleagues evaluated a primary-care social-prescribing service targeted particularly toward isolated or lonely patients and reported changes in well-being alongside qualitative evidence concerning participant experience. Moffatt and colleagues found that participants with long-term conditions described gains in confidence, social connection, health behavior, problem solving, and resilience after engaging with a link-worker programme. Kellezi and colleagues examined social connectedness as a mechanism within social prescribing, supporting the idea that the value of community referral may depend partly on whether participants develop meaningful social identities and relationships rather than merely attend activities. However, systematic reviews by Bickerdike and colleagues and Pescheny and

colleagues highlighted variation in programme design, evaluation quality, outcome selection, follow-up duration, and risk of bias.

The present study responds to this complexity by shifting attention from whether "social prescribing works" in general to whether different pathway intensities could plausibly produce different reductions in nonclinical health burden. The model distinguishes simple information provision from link-worker referral and from supported community engagement involving follow-through beyond referral. This distinction is grounded in realist and implementation research indicating that trust, community knowledge, service accessibility, patient readiness, and continuity of support are important components of successful pathways. Because no real participant data were provided, the paper uses transparent simulated values to demonstrate the analytical framework without claiming empirical treatment effects.

2. Objectives of the Study

2.1 To Identify Nonclinical Health Burdens Relevant to Primary Care

The first objective is to conceptualize nonclinical health burdens as social, economic, relational, and practical conditions that influence health or healthcare participation but cannot be adequately resolved through conventional medical treatment alone. The study includes social isolation, loneliness, financial strain, housing-related difficulty, employment concerns, caregiving burden, transport problems, limited community participation, and difficulty navigating support services. Social prescribing literature consistently describes the approach as relevant to wider social needs and to individuals whose difficulties extend beyond strictly biomedical problems.

These categories are not treated as interchangeable. Financial insecurity may require benefits or debt advice, whereas loneliness may require opportunities for sustained social connection. Transport problems may prevent a patient from reaching the very community activity to which they have been referred. The model therefore assumes that appropriate matching between need and resource is more important than simply increasing the number of referrals.

2.2 To Compare Different Social-Prescribing Pathways

The second objective is to compare three conceptually distinct pathways: information-only signposting, link-worker referral, and supported community engagement. Information-only signposting provides the patient with details about potentially relevant services but places most responsibility for engagement on the patient.

The supported pathway extends this model by incorporating practical follow-through, such as assistance with initial contact, problem solving around barriers, review of whether the referral was suitable, and alternative connection where the first option is unsuccessful.

2.3 To Examine Engagement as the Mechanism Between Referral and Burden Reduction

The third objective is to evaluate engagement as the central intermediary between referral and improvement. A referral that is never taken up cannot reasonably be expected to reduce loneliness, improve service navigation, or resolve practical difficulties. Pescheny and colleagues' qualitative

research on uptake and adherence reinforces the importance of examining what occurs after referral rather than counting referral events as successful outcomes.

The study therefore treats successful social prescribing as a pathway rather than an administrative transaction. The pathway begins with identification of a nonclinical burden and continues through shared prioritization, service matching, supported access, participation, feedback, and review. This formulation also makes failure analytically visible: a patient can be appropriately referred yet receive no benefit because a service has a waiting list, is inaccessible, lacks capacity, or does not fit the person's circumstances.

3. Review of Literature

3.1 From Community Referral to Link-Worker Social Prescribing

Community referral from primary care predates the contemporary terminology of social prescribing, but recent models increasingly formalized an intermediary role between healthcare and community services. Bickerdike and colleagues' 2017 systematic review identified a variety of models in which primary-care professionals connected patients with nonmedical services, but the authors concluded that the evidence base was characterized by poor-quality evaluations and high risk of bias. They argued that future research needed stronger comparative designs and clearer assessment of who benefits, under what conditions, and at what cost.

The link-worker model attempts to address one limitation of simple signposting: patients experiencing complex social difficulties may require more than information. Moffatt and colleagues studied adults with long-term conditions referred to a link-worker programme in a socioeconomically deprived area. Participants commonly experienced multimorbidity alongside mental-health concerns, reduced confidence, and social isolation. Their qualitative accounts described greater control, confidence, social participation, healthier behaviors, resilience, and problem-solving after engagement with the programme. These findings support a mechanism in which the link worker does more than identify services; the relationship itself may assist people in converting intentions into action.

Bertotti and colleagues' realist evaluation further emphasized context and mechanisms within a primary-care-to-voluntary-sector pathway. Their work demonstrated that social prescribing should be interpreted as a complex system in which referral processes, organizational relationships, local community capacity, and individual circumstances interact. Carnes and colleagues' mixed-method evaluation similarly examined implementation within primary care and reported both well-being and healthcare-use outcomes while emphasizing the practical operation of the pathway.

3.2 Social Connection, Agency, and Service Navigation

One potential mechanism of social prescribing is strengthened social connection. Kellezi and colleagues applied a “social cure” perspective to social prescribing and examined whether connection with groups and communities could help explain improvements in experience and perceived quality of care. Their findings support the proposition that participation can provide more than activity itself; it may create belonging, identity, confidence, and relational resources. Vidovic, Reinhardt, and Hammerton's 2021 systematic review also examined social prescribing in relation to loneliness, social isolation, well-being,

and connectedness and concluded that the evidence suggested potential individual and community benefits while remaining heterogeneous.

A second mechanism is increased agency. People facing several simultaneous social and health difficulties can experience a loss of control because problems interact. Debt may increase anxiety, anxiety may make social participation harder, isolation may worsen coping, and low confidence may make welfare or employment systems difficult to navigate. Social prescribing can potentially reduce this complexity by helping patients identify one manageable priority and connect it with an appropriate resource. Moffatt and colleagues' participants described enhanced confidence and problem-solving, suggesting that some benefit may arise through increased capacity to navigate difficulties rather than through resolution of a single presenting problem alone.

However, relational support must remain oriented toward empowerment rather than dependence. Wildman and colleagues found that link workers considered trust, time, local networking, and strong interpersonal skills essential, but they also emphasized maintaining appropriate professional boundaries and fostering client autonomy. They identified challenges including unsuitable referrals, volume pressures, inadequate training, long waiting lists, and service reductions. These findings demonstrate that a strong link worker cannot compensate indefinitely for weak downstream infrastructure.

3.3 Evidence Limitations, Implementation Barriers, and Equity

Systematic reviews have repeatedly cautioned against treating the rapid policy expansion of social prescribing as equivalent to definitive proof of effectiveness. Pescheny, Randhawa, and Pappas reviewed primary-care social-prescribing programmes involving navigators and identified potentially positive outcomes but substantial heterogeneity and methodological weaknesses. Husk and colleagues' realist review shifted the question toward mechanisms and contexts, while Tierney and colleagues likewise examined how linking people to local assets may work differently depending on the person and environment.

Implementation barriers occur at several points. Primary-care professionals may not know which patients are appropriate for referral. Patients may not understand the purpose of social prescribing or may perceive the referral as unrelated to the problem they brought to the consultation. Community services may have limited capacity or unstable funding.

These barriers create an equity issue. People with the greatest nonclinical health burdens may also face the largest obstacles to acting on referrals. A model that works well for a confident patient with transport, flexible time, and a nearby community service may perform less well for a person living with severe anxiety, unstable housing, caring duties, or limited mobility. Consequently, pathway quality should be assessed partly by whether additional support reaches those who need more assistance rather than by whether all patients are offered identical referral procedures.

4. Research Methodology

4.1 Research Design

The study employs a simulation-based explanatory quantitative design. No patients were recruited, no primary-care records were accessed, and no community-service outcomes were observed. Simulation

was selected because real data were not supplied and because presenting invented patient outcomes as completed empirical findings would be methodologically inappropriate.

The simulation contains 600 synthetic primary-care cases, with 200 cases assigned to each of three conceptual social-prescribing pathways. All groups begin with an equivalent mean Nonclinical Health-Burden Index of 70 to create a transparent comparison. The model then assigns different trajectories according to pathway intensity, while recognizing that genuine empirical outcomes would depend on case mix, baseline burden, service availability, referral quality, and many other factors.

The design is not intended to predict the precise effect size of social prescribing. Instead, it demonstrates what a future comparative longitudinal study could measure and how the distinction between referral and supported engagement could be incorporated analytically.

4.2 Measurement Framework

The primary outcome is the Nonclinical Health-Burden Index, a proposed composite ranging from 0 to 100. Higher scores represent greater unresolved burden. The index is designed for conceptual demonstration and is not presented as an existing validated clinical scale.

Table 1: Proposed Measurement Framework

Construct	Proposed Operational Definition	Scale	Analytical Role
Nonclinical Health Burden	Combined burden from social isolation, financial difficulty, housing concerns, caring responsibilities, transport barriers, low community participation, and service-navigation difficulty	0–100	Primary outcome
Referral Appropriateness	Degree of correspondence between identified need and the support pathway offered	1–5	Pathway-quality variable
Link-Worker Engagement	Strength and continuity of contact with a community/link worker	1–5	Explanatory mechanism
Community-Service Uptake	Whether the individual makes meaningful initial contact with the referred resource	Yes/No	Engagement outcome
Sustained Participation	Continued participation or service use after initial contact	0–12 weeks	Intermediate outcome
Social Connectedness	Perceived access to meaningful interpersonal or community relationships	0–100	Secondary outcome
Navigation Confidence	Confidence in identifying and accessing relevant social/community resources	0–100	Secondary outcome

The index deliberately separates social need from medical diagnosis. A patient's nonclinical burden can influence health without implying that housing, debt, loneliness, or employment concerns are diseases. This distinction protects social prescribing from becoming a mechanism through which social problems are inaccurately medicalized.

4.3 Pathway Classification and Analytical Procedure

The information-only signposting pathway represents provision of service information without a dedicated intermediary. Patients receive details regarding a potentially relevant resource and are expected to initiate contact themselves. The link-worker referral pathway adds personalized assessment, goal setting, resource matching, and direct link-worker support.

The supported community pathway represents a more intensive model. In addition to link-worker engagement, it incorporates active follow-through after referral, support with initial access barriers, review of whether the resource meets the person's need, and alternative referral where the first connection fails. This pathway is conceptually consistent with realist evidence emphasizing supported linkage, trust, local knowledge, and the quality of the community resource.

The primary simulated outcome is change in the Nonclinical Health-Burden Index from baseline to week 6 and week 12. Secondary modeled outcomes include community-service uptake, social connectedness, and navigation confidence. Inferential significance testing is intentionally avoided because significance tests performed on deliberately generated values would not constitute empirical evidence.

5. Analysis

5.1 Simulated Outcomes Across Social-Prescribing Pathways

The simulation demonstrates different trajectories across the three pathways despite identical baseline burden.

Table 2: Simulated Twelve-Week Outcomes Across Social-Prescribing Pathways

Outcome	Information-Only Signposting	Link-Worker Referral	Supported Community Pathway
Simulated Cases	200	200	200
Baseline Nonclinical Burden	70	70	70
Week-6 Nonclinical Burden	64	57	52
Week-12 Nonclinical Burden	59	50	44

American Journal of Advanced Multidisciplinary Innovation and Research (AJAMIR)

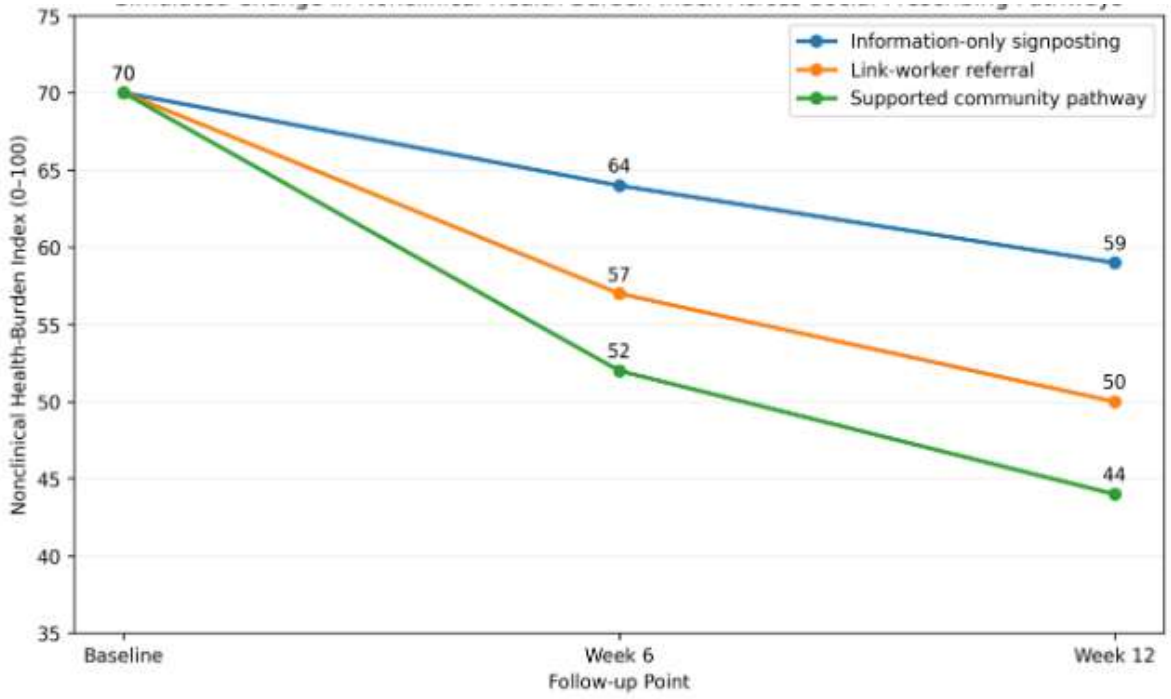
E-ISSN: XXXX-XXXX ● Website: www.ajamir.com ● Email: editor@ajamir.com

Outcome	Information-Only Signposting	Link-Worker Referral	Supported Community Pathway
Modeled Burden Reduction	11 points	20 points	26 points
Community-Service Uptake	41%	67%	82%
Sustained 12-Week Engagement	27%	51%	69%
Mean Navigation Confidence at Week 12	56	70	79

The modeled burden reduction is smallest under information-only signposting. This does not imply that signposting lacks value. Some individuals possess sufficient confidence, mobility, time, social support, and service knowledge to act on information independently. The simulation instead assumes that a substantial subgroup requires additional support in order to translate information into participation.

5.2 Change in Nonclinical Health Burden Over Twelve Weeks

Graph 1: Simulated Change in Nonclinical Health-Burden Index Across Social Prescribing Pathways



The graph shows three distinct trajectories. Information-only signposting produces a gradual modeled reduction from 70 to 59. Link-worker referral produces a larger reduction to 50, while supported community engagement reduces the modeled index to 44 by week 12.

The main analytical implication is not the exact numerical difference between groups. The important proposition is that pathway completion matters. A patient cannot receive the potential benefit of a community resource if referral does not progress to access and meaningful engagement.

Key Finding: Within the simulation, the largest improvement occurs when social prescribing combines personalized navigation with supported uptake rather than ending at the point of referral.

5.3 Why the Supported Pathway Produces a Larger Modeled Effect

The first mechanism is improved matching. A link worker who has time to understand the patient's priorities can distinguish between superficially similar needs. Someone describing loneliness may primarily need social participation, whereas another may be socially isolated because mobility or transport barriers prevent existing relationships from being maintained.

The second mechanism is reduction of access friction. Pescheny and colleagues found that patient uptake and adherence depend on more than willingness; practical and psychological barriers can interfere with participation. Supported pathways attempt to address this gap by helping patients take the first steps rather than assuming that information automatically produces action.

The third mechanism is feedback. If a referral proves unsuitable, supported follow-up allows the pathway to be revised. This avoids defining an administrative referral as success when no meaningful support was received.

6. Discussion

6.1 Social Prescribing as a Pathway Rather Than a Prescription

The simulation supports a conceptual shift away from understanding social prescribing as a single referral event. The term “prescribing” can create the misleading impression that a community activity functions like a medication: a clinician identifies a problem, selects an intervention, and the intervention subsequently produces an outcome. Social needs are often less linear. A patient may require several conversations before identifying the issue that matters most, and the appropriate community solution may change as barriers become visible.

Realist research supports this pathway interpretation. Tierney and colleagues concluded that social prescribing involves interactions among individual readiness, primary-care relationships, link-worker support, and the accessibility and acceptability of local assets. Husk and colleagues similarly found that different forms of referral and supported uptake may work differently for different populations and circumstances. Consequently, the relevant unit of evaluation should be the entire journey from recognition of need to sustained engagement rather than the number of prescriptions or referrals generated.

This perspective also changes how programme failure is interpreted. If a patient does not attend a referred community group, the explanation should not automatically be “noncompliance.” The activity may have been unsuitable, inaccessible, unaffordable, culturally inappropriate, intimidating, or

scheduled at an impossible time. A pathway-oriented system examines why engagement failed and whether another resource is more appropriate.

6.2 Reducing Nonclinical Burden Without Medicalizing Social Problems

Social prescribing offers an opportunity to respond more appropriately to problems that influence health without redefining those problems as diseases. Loneliness, debt, housing instability, unemployment, bereavement, or caring pressure may produce profound distress, but increasing medical treatment is not always the most relevant response. Moffatt and colleagues' qualitative research illustrates how patients with long-term conditions can experience intertwined physical, psychological, and social difficulties requiring a broader approach than routine primary care alone can usually provide.

At the same time, social prescribing should not become a mechanism through which structural failures are individualized. A link worker may help someone access housing advice, but social prescribing cannot create affordable housing. It may connect a financially distressed patient with welfare support, but it cannot eliminate poverty. It may refer a socially isolated person to community activities, but those activities require sustainable funding and sufficient capacity.

Wildman and colleagues documented precisely this implementation problem: link workers reported that cuts, waiting lists, and unavailable services could undermine their ability to connect clients with appropriate support. The effectiveness of social prescribing is therefore partly dependent on the health of the community and voluntary sector into which patients are being referred.

This dependency has ethical significance. Primary care should not reassure itself that a nonclinical need has been "managed" simply because a referral was made. Appropriate evaluation requires knowing whether the patient reached the service, whether the service could respond, and whether the original burden actually changed.

6.3 Implications for Primary Care, Link Workers, and Community Systems

For primary care, one implication is that referral criteria should prioritize meaningful need rather than maximize volume. Link-worker capacity is limited, and inappropriate referral can reduce the time available for people requiring complex support. Wildman and colleagues identified variation in referral appropriateness and pressure to meet referral targets as challenges to effective practice.

For link workers, training should extend beyond maintaining a directory of services. Effective work requires listening, motivational skill, boundary management, local knowledge, problem solving, and the ability to recognize when an issue requires clinical, safeguarding, social-care, welfare, or specialist intervention rather than community activity alone. The link worker is best conceptualized as a navigator and relationship builder rather than as a substitute clinician.

For community organizations, social-prescribing expansion should be accompanied by realistic capacity planning. A primary-care system can generate referrals much faster than a small voluntary organization can create trained staff, accessible facilities, transport options, or sustainable programmes. Calderón-Larrañaga and colleagues' 2021 analysis highlighted such tensions and argued that implementation must consider the wider system rather than focusing narrowly on the consultation.

Evaluation should consequently include community-side indicators such as waiting time, service capacity, referral appropriateness, participant retention, accessibility, and the financial effect of

additional referrals on voluntary organizations. Focusing only on primary-care outcomes can obscure whether benefits are being achieved by shifting workload and costs into inadequately resourced community settings.

7. Conclusion

Social prescribing represents an important attempt to respond to the reality that health is shaped by circumstances extending beyond the clinical encounter. Patients commonly experience social isolation, financial strain, housing difficulty, caring responsibilities, limited community participation, and service-navigation problems alongside conventional health conditions. Connecting these patients with relevant community and social resources can provide a more proportionate response than repeatedly medicalizing difficulties that require social or practical support.

The simulation presented in this study demonstrates why the structure of the pathway may matter as much as the referral itself. Starting from an identical Nonclinical Health-Burden Index of 70, information-only signposting produced a modeled week-12 score of 59, link-worker referral produced 50, and supported community engagement produced 44. These values are synthetic and must not be interpreted as empirical effectiveness estimates. They illustrate a hypothesis derived from the literature: greater support may reduce the loss of patients between referral and meaningful engagement.

Evidence published through 2021 supports several components of this model. Service-user research describes improvements in confidence, social connection, problem solving, and health-related behavior among people who engage with link-worker pathways, while realist studies emphasize trust, personalization, supported uptake, local asset availability, and pathway context. Nevertheless, systematic reviews consistently caution that the evidence base remains heterogeneous and that strong claims concerning clinical effectiveness, cost savings, or reduced healthcare utilization require better-controlled evaluation.

The most defensible conclusion is therefore not that social prescribing universally reduces nonclinical health burden, but that it provides a plausible organizational pathway for addressing needs that primary care cannot resolve medically. Its success depends on accurate identification of need, patient-defined priorities, skilled link workers, practical support with engagement, accessible and adequately resourced community services, and feedback when referrals do not work. Future studies should evaluate these components prospectively and should assess burden-specific outcomes rather than relying only on global well-being scores.

A mature social-prescribing system should ultimately be judged by whether patients experience meaningful reductions in the difficulties that brought social circumstances into healthcare in the first place. Referral numbers alone are insufficient. The strongest pathway is one that converts recognition of a nonclinical burden into accessible support, sustained participation where appropriate, increased personal and social capacity, and a demonstrable improvement in the patient's everyday circumstances.

References

1. Vidovic, D., Reinhardt, G. Y., & Hammerton, C. (2021). Can social prescribing foster individual and community well-being? A systematic review of the evidence. *International Journal of Environmental Research and Public Health, 18*(10), 5276. https://doi.org/10.3390/ijerph18105276
2. Reinhardt, G. Y., Vidovic, D., & Hammerton, C. (2021). Understanding loneliness: A systematic review of the impact of social prescribing initiatives on loneliness. *Perspectives in Public Health, 141*(4), 204–213. https://doi.org/10.1177/1757913920967040
3. Foster, A., Thompson, J., Holding, E., et al. (2021). Impact of social prescribing to address loneliness: A mixed methods evaluation of a national social prescribing programme. *Health & Social Care in the Community, 29*, 1439–1449. https://doi.org/10.1111/hsc.13200
4. Pescheny, J. V., Pappas, Y., & Randhawa, G. (2018). Facilitators and barriers of implementing and delivering social prescribing services: A systematic review. *BMC Health Services Research, 18*, 86. https://doi.org/10.1186/s12913-018-2893-4
5. Carnes, D., Sohanpal, R., Frostick, C., et al. (2017). The impact of a social prescribing service on patients in primary care: A mixed methods evaluation. *BMC Health Services Research, 17*, 835. https://doi.org/10.1186/s12913-017-2778-y
6. Islam, M. M. (2020). Social prescribing—An effort to apply a common knowledge: Impelling forces and challenges. *Frontiers in Public Health, 8*, 515469. https://doi.org/10.3389/fpubh.2020.515469
7. Morris, D., Thomas, P., Ridley, J., & Webber, M. (2020)**.** Community-enhanced social prescribing: Integrating community in policy and practice. *International Journal of Community Well-Being, 5*, 179–195. https://doi.org/10.1007/s42413-020-00080-9
8. Holding, E., Thompson, J., Foster, A., et al. (2020). Connecting communities: A qualitative investigation of the challenges in delivering a national social prescribing service to reduce loneliness. *Health & Social Care in the Community*. https://doi.org/10.1111/hsc.12976
9. Hamilton-West, K., Gadsby, E., Zaremba, N., & Jaswal, S. (2019). Evaluability assessments as an approach to examining social prescribing. *Health & Social Care in the Community, 27*, 1085–1094. https://doi.org/10.1111/hsc.12726
10. Bickerdike, L., Booth, A., Wilson, P. M., Farley, K., & Wright, K. (2017). Social prescribing: Less rhetoric and more reality. A systematic review of the evidence. *BMJ Open, 7*, e013384. https://doi.org/10.1136/bmjopen-2016-013384
11. Thomson, L. J., Camic, P. M., & Chatterjee, H. J. (2015). *Social Prescribing: A Review of Community Referral Schemes*. University College London & Canterbury Christ Church University.
12. Dayson, C., Bashir, N., & Pearson, S. (2013). *From dependence to independence: Emerging lessons from the Rotherham Social Prescribing Pilot*. Sheffield Hallam University.
13. South, J., Higgins, T. J., Woodall, J., & White, S. M. (2008). Can social prescribing provide the missing link? *Primary Health Care Research & Development, 9*(4), 310–318.
14. Grant, C., Goodenough, T., Harvey, I., & Hine, C. (2000). A randomised controlled trial and economic evaluation of a referrals facilitator between primary care and the voluntary sector. *BMJ, 320*, 419–423.

15. Moffatt, S., Steer, M., Lawson, S., Penn, L., & O'Brien, N. (2017). Link worker social prescribing to improve health and well-being for people with long-term conditions: Qualitative study of service user perceptions. *BMJ Open, 7*, e015203.
16. Polley, M., Fleming, J., Anfilogoff, T., & Carpenter, A. (2017). *Making Sense of Social Prescribing*. University of Westminster.
17. Polley, M., Bertotti, M., Kimberlee, R., et al. (2017). *A Review of the Evidence Assessing Impact of Social Prescribing on Healthcare Demand and Cost Implications*. University of Westminster.
18. Kimberlee, R. (2015). What is social prescribing? *Advances in Social Sciences Research Journal, 2*(1), 35–41.
19. Kilgarriff-Foster, A., & O'Cathain, A. (2015). Exploring the components and impact of social prescribing. *Journal of Health Services Research & Policy, 20*(3), 165–171.
20. Brandling, J., & House, W. (2009). Social prescribing in general practice: Adding meaning to medicine. *British Journal of General Practice, 59*(563), 454–456.