The ACDC Project in The City of Salisbury: Social Prescribing Co-Design Report

October 2025

Dr Candice Oster, Flinders University,

Caring Futures Institute

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Address for Correspondence
Dr Candice Oster
Senior Research Fellow
Caring Futures Institute, College of Nursing and Health Sciences, Flinders University
E: candice.oster@flinders.edu.au

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EXECUTIVE SUMMARY

A holistic approach to health and wellbeing is gaining recognition, with research showing that social determinants of health – the conditions in which we are born, live, work, and age – account for around 80% of health outcomes (Hood et al. 2016). Social needs such as housing, financial and food insecurity, and loneliness and social isolation are growing concerns in Australia (Oster et al. 2025). While these issues fall outside the scope of medical treatment, many individuals still present in clinical settings with these needs (RACGP, 2022), where providers are often unequipped to address them (Oster et al., 2025).

Social prescribing, which connects healthcare with social and community services to improve wellbeing, offers a promising solution. Although widely adopted internationally with evidence of improved quality of life and reduced healthcare use (Freak-Poli et al., 2025; NASP, 2024), it has yet to be implemented in South Australia.

This study used a co-design approach to develop and draft a social prescribing model for The City of Salisbury Local Government Area (LGA), focusing on supporting the non-medical needs of culturally and linguistically diverse communities. The workshop included 14 participants representing key stakeholders from the health, social, and community sectors.

Participants were asked to indicate their preferences regarding various social prescribing models and to generate ideas for what social prescribing could look like in The City of Salisbury LGA.

The study confirms that there is no one-size-fits-all model for social prescribing (Oster et al., 2023; Bhaktar et al., 2025). Instead, successful implementation requires a flexible, community-driven approach that is responsive to individual needs and local contexts. The following key themes were identified across five areas of social prescribing delivery:

Characteristics and Location of the Link Worker: A certified peer support worker with appropriate supervision, or a community-based Link Worker operating in non-traditional settings, could effectively support individuals with social needs. Link Workers should be available in informal, comfortable environments and use Motivational Interviewing and goal-setting techniques, building trust and rapport to better support individuals.

Referral Pathways: Multiple referral pathways, including general practice, allied health, social services, and community settings (e.g., through direct referral by a trusted member of the community or advertising the service in key community locations), and self-referral, were preferred. This inclusive approach ensures that individuals with diverse needs and preferences can access the support they require.

Participant Identification: A combination of professional judgement and screening tools should be used sensitively and contextually to refer individuals to appropriate support. Self-

identification and self-referral could be facilitated through digital tools such as apps and online surveys.

Service Awareness and Connection: Link Workers should have comprehensive knowledge of available services, eligibility criteria, and referral pathways to effectively provide warm referrals and connect individuals to relevant support and community services.

Formal Follow-Up Process: A formal follow-up process, tailored to the client's preferences, was considered essential to ensure continuity of care and ongoing support.

This study provides a strong foundation for developing a social prescribing model that is inclusive, effective, and sustainable within The City Salisbury LGA—and potentially adaptable to other communities.

INTRODUCTION

The need for a holistic approach to health and wellbeing is being increasingly recognised. Research shows that the social determinants of health – the conditions in which we are born, live, work, and age – account for around 80% of health outcomes (Hood et al. 2016). In Australia, people are experiencing growing rates of unmet needs relating to social determinants of health, such as housing, financial, and food insecurity, and loneliness and social isolation (Oster et al. 2025). These needs cannot be addressed through medical intervention, yet many people present in these settings with social needs (RACGP 2022), where health providers are not equipped to address non-medical needs (Oster et al. 2025).

Social prescribing has been proposed as a way of addressing these issues, having shown a range of positive outcomes including improvements in quality of life and wellbeing (Freak-Poli et al. 2025) and reduced health care utilisation (NASP 2024). Social prescribing has been defined as:

> *"a holistic, person-centred and community-based approach to health and well-being that bridges the gap between clinical and nonclinical supports and services. By drawing on the central tenets of health promotion and disease prevention, it offers a way to mitigate the impacts of adverse social determinants of health and health inequities by addressing nonmedical, health-related social needs (e.g. issues with housing, food, employment, income, social support). While it looks different across the globe, it is recognised as being a means for trusted individuals in clinical and community settings to identify that a person has nonmedical, health-related social needs and to subsequently connect them to nonclinical supports and services within the community by co-producing a social prescription – a nonmedical prescription, to improve health and well-being and to strengthen community connections. It requires collective action and collaboration among multiple sectors and stakeholders."*
> *(Muhl et al. 2023, p.9)*

Social prescribing can be made available to anyone experiencing non-medical needs. It can also be focused on specific populations (e.g., people experiencing mental health problems; older people) and address specific non-medical needs (e.g., food insecurity; lifestyle factors; loneliness and social isolation) (Oster et al. 2023).

There is no single way of delivering social prescribing and approaches vary depending on the purpose and context. Models of social prescribing range in intensity from **signposting** (providing information on available services and supports) through to **holistic approaches involving a Link Worker** who works with a client over a period of weeks or months to support them to achieve their goals (see Figure 1).

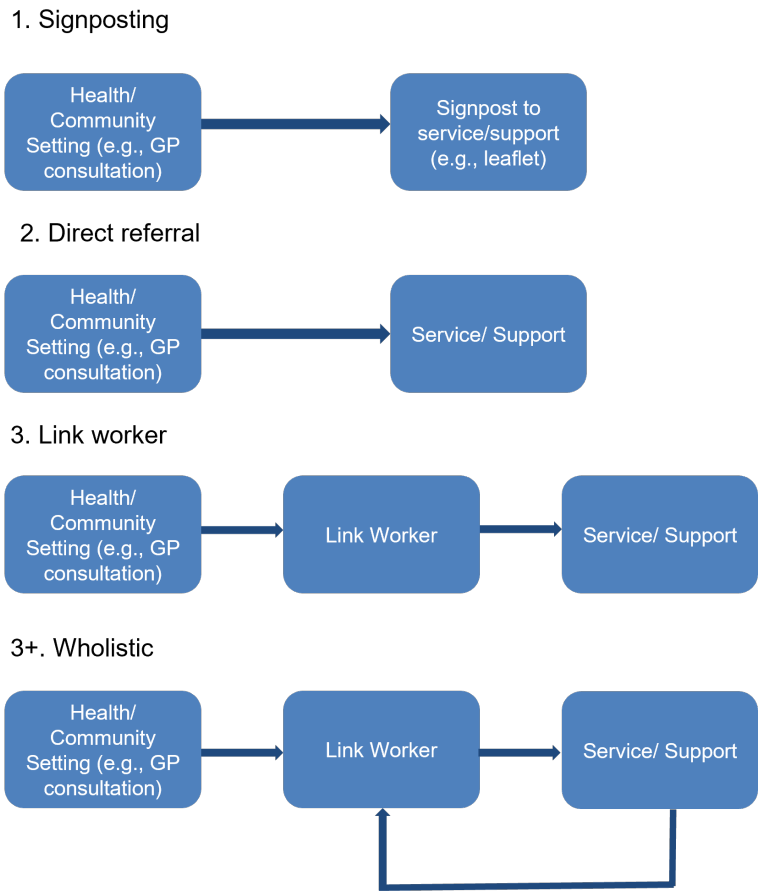

Figure 1. Models of social prescribing (adapted from Husk et al. 2020)

Bhaskar et al. (2025) proposed four different models that consider purpose/focus and referral pathways. These include **a clinical model** (focusing on lifestyle factors with referral by medical professionals), **a holistic model** (a broader focus on social determinants of health such as income, food security, and housing with referral through physicians, allied health providers, and self-referral), **an empowerment model** (focusing on self-determination and personal empowerment to achieve well-being and involving a strong relationship with a Link Worker), and **a healthy community model** (focusing on both individual and community well-being involving asset based approaches, community development, and extensive engagement with partners and community).

Given the variability of approaches to social prescribing, and the need to contextualise models to Australia's unique systems and communities, it is important to co-design social prescribing with key stakeholders (Oster et al. 2024). To this end, the Mental Health Coalition of South Australia engaged Flinders University to conduct a co-design workshop with key stakeholders.

To co-design a model of social prescribing for The City of Salisbury LGA with a focus on supporting the non-medical needs of culturally and linguistically diverse communities.

METHOD

A workshop was held to co-design an approach to social prescribing in The City of Salisbury LGA. The workshop followed the approach developed and applied in previous social prescribing co-design projects (Oster et al. 2024) and followed Trischler et al's (2019) co-design method (see 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	Use co-design tools to foster creativity in individual activities and group discussion.
6) Reflecting	Reflect on the co-design outcomes.
7) Building for change	Have an open dialogue with key stakeholders to assess feasibility and realisation of the ideas generated in the workshop(s).

The first three co-design steps, resourcing, planning, and recruiting, were undertaken by the Mental Health Coalition of South Australia (MHCSA). MHCSA identified a preference for exploring a Link Worker model of social prescribing with involvement of peer support workers as potential Link Workers.

The workshop began with a PowerPoint presentation introducing the concept of social prescribing to sensitise participants to the co-design task. Participants then completed an individual workbook activity where they rated their views (like, neutral, dislike) on various components of social prescribing models. The Ideas Workbooks presented a range of options for various elements of social prescribing, including who should be the Link Worker; the target population for social prescribing; identifying potential participants for social prescribing; the

non-clinical (social) needs to be addressed in the program; how participants should be referred to a Link Worker; how they should be referred to social and community services and supports; and whether or not there should be a follow-up process. Options for the ideas presented in the workbook were based a scoping review of models of social prescribing (see Oster et al. 2023). Participants were also able to provide written comments about the various options in the workbooks. This activity aimed to prompt participants to think about what social prescribing *could* look like prior to co-design with other workshop participants.

Participants were then divided into five groups to undertake a group activity of filling in a social prescribing journey map, describing what they would like to see happen at each stage of the social prescribing journey (from identifying social prescribing participants through connection to services/supports and follow-up). The journey maps were then presented to the larger group for discussion.

The final co-design steps of reflecting and building for change will be undertaken by MHSCA.

DATA ANALYSIS

Responses of 'like', 'neutral', and 'dislike' in the Ideas Workbooks were coded as 1, 0, and -1 respectively for each participant and the total added to provide a combined preference score. Qualitative data (from the workbooks, completed journey maps, and group discussions) were summarised descriptively. Quantitative and qualitative data analyses were combined to develop a social prescribing model.

RESULTS

Fourteen key stakeholders from the health, social, and community sectors took part in the workshop. Participant demographics are presented in Table 2.

Table 2. Participant demographics

Demographic		Number of Participants
Profession	Peer support	2
	Community development	4
	Allied health	2
	Social support	5
	Not stated	1
Year in Profession	1 year or less	1
	2-5 years	3
	>5 years	9
	Not stated	1
Gender	Male	7
	Female	6
	Not stated	1
Age	Under 25yo	1
	26-35yo	1
	36-45yo	2
	46-55yo	8
	56-64yo	1
	65+yo	0
	Not stated	1

Workbook analysis

Where should social prescribing happen?

In the individual workbook analysis, participants showed a slight preference for social prescribing to occur in allied health settings, followed by community, general practice (GP), and social service settings.

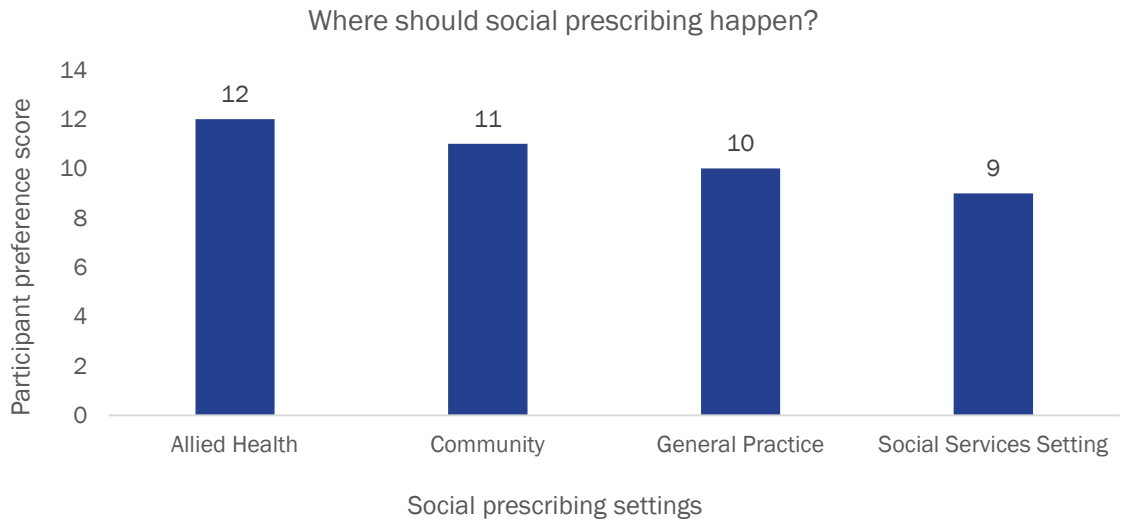

Figure 2. Preferences on different settings for social prescribing to take place.

Analysis of the qualitative comments showed a recognition that social prescribing is already occurring in community and social service settings with further work needed in GP and allied health, with a focus on referral to a Link Worker through the various settings.

For example, Participant 3 noted that social prescribing is "*already happening [in community settings] to some extent*". Participant 4 highlighted that the purpose of the GP and social services in social prescribing would be for "*referral to the Link Worker*", noting that allied health settings "*already do"* social prescribing, while community settings "*will be administering many social prescriptions*". Participant 7 stated "*I feel that this happens in all settings just need more improvement with General Practice and Allied health*".

Staffing the social prescribing model

Participants expressed a preference for the Link Worker (LW) role to be filled by a community-based peer-support worker (PSW). This was followed by a newly appointed, non-peer support community-based Link Worker with relevant expertise, such as community development work or a social work expertise.

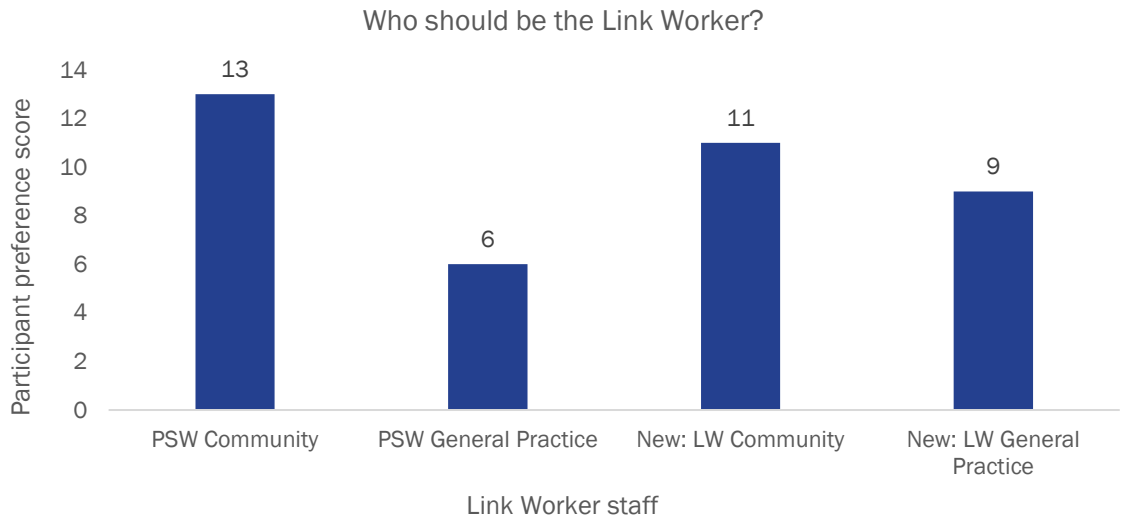

Figure 3. Preferences for Link Worker staffing.

Qualitative workbook data provided further insights about Link Worker expertise and location. For example, Participant 12 highlighted the importance of peer workers with "*lived experience*" in the Link Worker role throughout all locations. Participant 12 furthermore noted the importance of understanding "*what would be the criteria for a peer worker*", with Participant 2 commenting on how the Link Worker role should be undertaken by people who are "*certified peer support workers upholding the lived experience framework and guidelines and are provided with individual/peer supervision*". Participant 4 commented that "*social prescriptions should*

happen in social settings. GP may be the location people comfortable so having a position in GP could be beneficial".

Target population

When it comes to who should/could take part in the program, participants saw value in targeting both the general population and specific at-risk groups (e.g., people with long-term conditions, older demographics, people with mental health issues).

Figure 4. Preferences for Link Worker staffing.

Participant 2 commented "*maybe commence with at-risk groups*" while Participant 9 noted that "*already different services are engaged with people with long-term conditions, older people (GPs, physios more involved), people with mental health (drop-in supports and services)*", suggesting a gap in addressing non-medical needs of the broader population. Participant 4 commented that focusing on at-risk groups "*would be beneficial IF enough profession support is available i.e., counsellors, social workers at venues delivering prescriptions*". Participant 12 noted a benefit for at-risk groups in "*linking with other psychosocial programs*" for people with mental health issues.

Non-clinical needs to be addressed

Participants showed a preference for addressing social determinants of health more broadly rather than focusing on health behaviours/lifestyle risk factors.

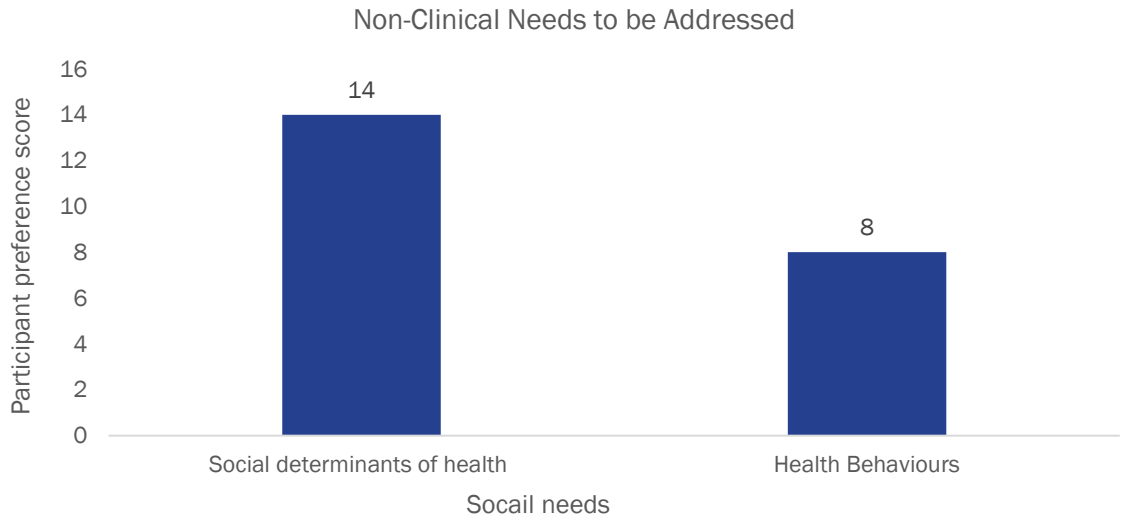

Figure 5. Preferences for the type of social needs to be addressed through social prescribing.

Participant 4 note that if we "*address [social determinants of health] … this will decrease/improve [health behaviours]*". Participant 9 identified social determinants as "*more important plus urgent need*" while the "*person needs to be ready to make changes with those behaviours [health behaviours]*". Participant 12 identified "*transport [as] a barrier*" when addressing social determinants of health, and *"[the need to access] reliable food sources"* when supporting healthy behaviours.

Identifying people for participation in the program

In terms of identifying who might benefit from a social prescribing program, participants preferred the use of professional judgement (e.g., during a medical/allied health consultation) rather than using routine screening for non-medical needs.

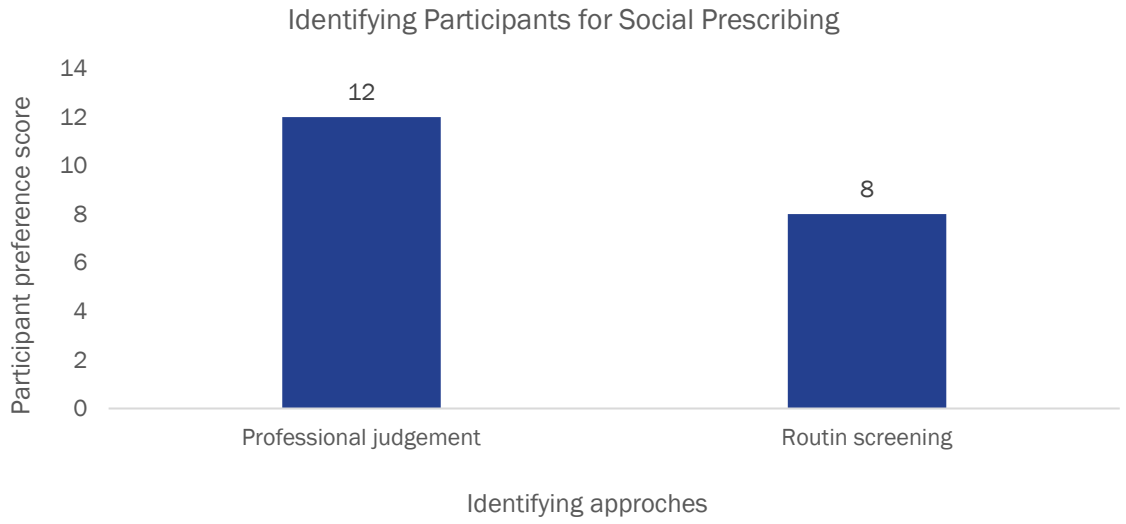

Figure 6. Preferences for different approaches to identifying and offering social prescribing.

Participant 1 commented on the need for a "*grass roots [approach] before people get to the doctor. A lot of men will not go to a GP*". In terms of routine screening, Participant 2 expressed concern that screening in a waiting room "*may be considered invasive … lack of privacy*" and Participant 12 questioned whether these participants would be "*self-referring [following screening]*". Participant 3 noted that in addition to the options provide in the workbook there is also potential for "*incidental referral through engagement out of a professional or allied health setting*".

Identifying non-clinical needs for referral

The use of a screening questionnaire was identified as useful for identifying the person's non-clinical needs for initiating a referral to social/community services and supports. This was closely followed by self-identification of needs.

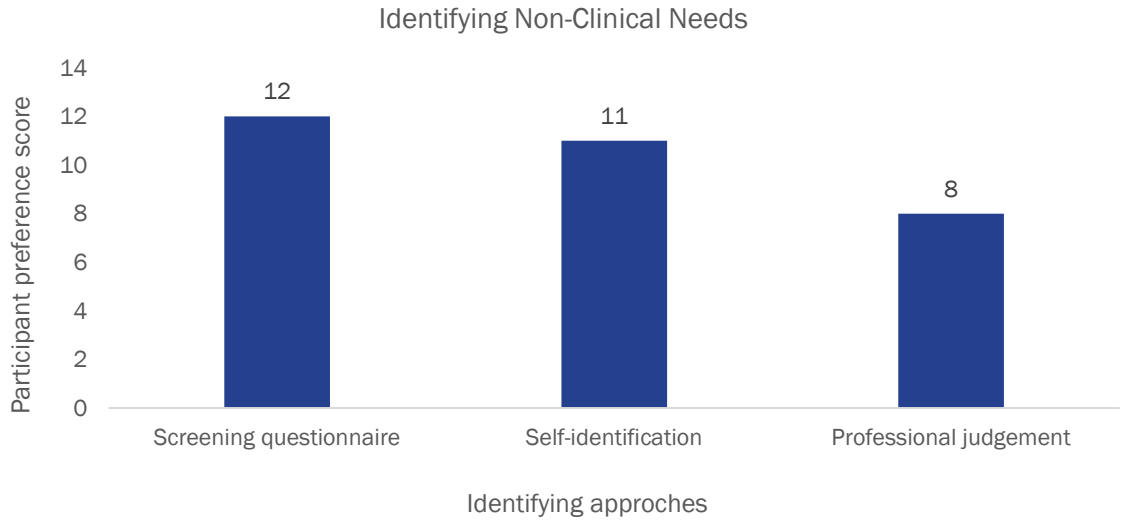

Figure 7. Preferences for different approaches to identifying and offering social prescribing.

When it comes to the use of a screening questionnaire, Participant 1 was strongly supportive, commenting "*Yes Yes Yes*" and Participant 3 noted that a screening questionnaire could be "*similar to C+ND survey (DHS) loneliness scale*". In relation to self-identification, Participant 2 suggested the possibility of "*information/brochures in waiting room etc. to assist with self-identification*" and Participant 14 stated self-identification "*could be followed up by use of a screening questionnaire*". Participant 9 commented that "*all three [processes] together can be the best ones*".

How will people be referred to the Link Worker

The preferred processes for referral to the Link Worker were self-referral (e.g., providing information about a Link Worker service) followed by warm referral by contacting the Link Worker directly for or with a client.

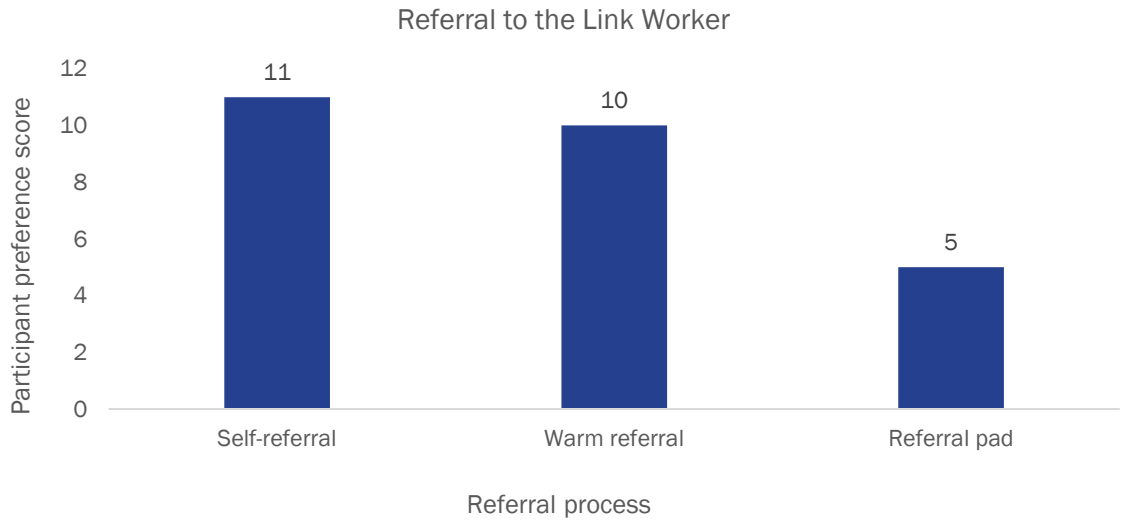

Figure 8. Preferences for referral processes to a Link Worker.

No participants provided further comments on this element of the process.

How will the Link Worker refer participants to social/community services?

When it comes to the process for the Link Worker to refer program participants to relevant social/community services, participants preferred warm referral by the Link Worker (contacting a service for or with the client) followed by self-referral (e.g., providing a booklet of services or online link to a service directory).

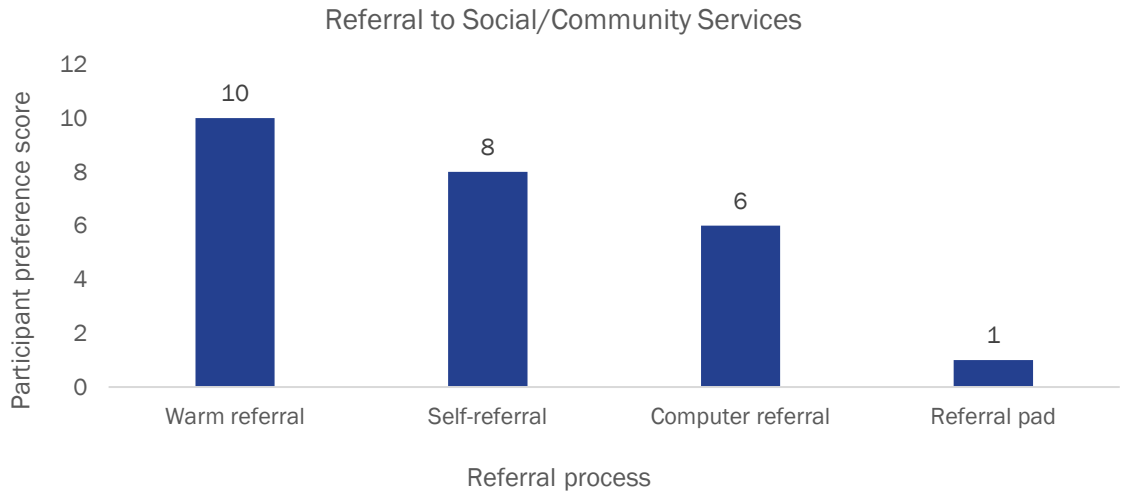

Figure 9. Preferences for referral processes to social and community services.

Participant 2 saw the value of all options "*depending on an organisation's referral procedure*", while Participant 9 noted that with a referral pad "*people can fall in cracks*" and there are "*gaps in service delivery*". In relation to self-referral, Participant 3 saw that there "*may be barriers to this*" while Participant 9 felt it "*could be useful for young adults and/or people who are reluctant for help*". An additional suggestion of using an app-based approach was made by Participant 12.

Follow-up

Finally, with regard to whether there should be a follow-up process, participants were very strongly in favour of a formal process of following up (e.g., a reminder in the client information system).

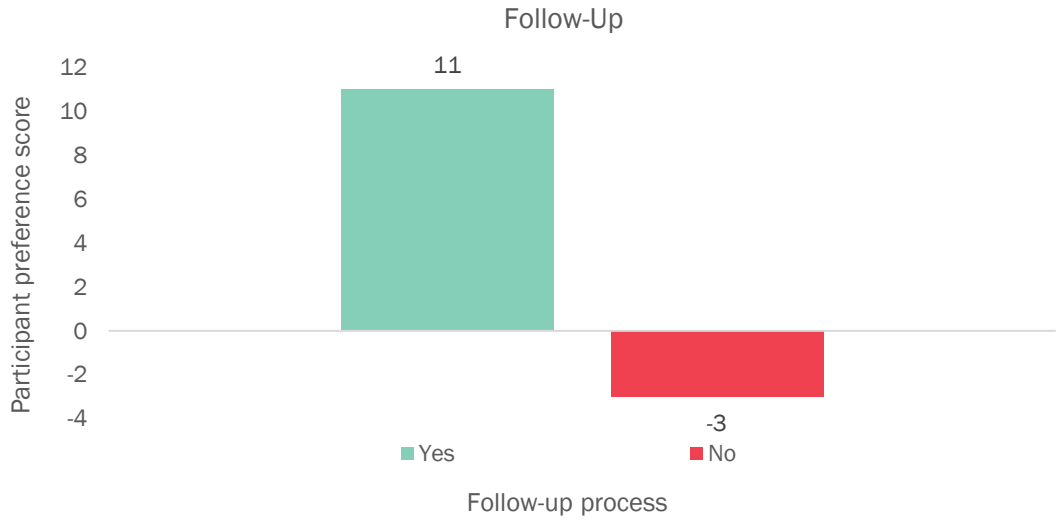

Figure 10. Preferences for having a formal follow-up process.

Two participants commented on the importance of following up, as follows: "*Absolutely required*" (Participant 2); "*Good to have follow-up to ensure the person feels supported or to make other referrals/links if needed*" (Participant 5). Participant 8 suggested the importance of asking "*Would they like follow up? Ask if appropriate*", and Participant 12 noted the need to consider "*Length of contact? Time limited?*".

Journey map analysis

The following summarises the content of the five journey maps (one per small group) for each stage of the social prescribing journey. This element builds on the individual activity of the workbook to develop ideas in collaboration with others in the small group discussions.

Identify the person for referral

A nuanced, contextual approach: The journey map data shows the identified need for a nuanced approach to identifying whether a person could benefit from social prescribing, using a combination of conversations and screening tools within "*established or trusted relationships*" (Group 2), depending on the circumstances and context.

While one group commented that "*screening tools can be daunting, feel judgey*" (Group 1), there are situations where a more formal approach would be useful:

> *"Specific circumstances might warrant more formal approach of screening such as language barriers, complexities like mental health." (Group 1)*

> *"Depends on where the person goes e.g., screening tool in health setting. Conversation in community setting e.g., sports club. Doctors should ask about people's general wellbeing [but this is] hard [due to] 15 min appt." (Group 3)*

Surveys could be located "*in a waiting room with Q to faces to gauge how they are going*" and "give [this] to [the] doctor" (Group 3). Similarly, Group 4 noted the value of "*surveys in the registration [and] can be [in] different languages*". The use of surveys can help to "*start the conversation before the professional*". Group 5 commented on potential of an "*online tool – an app with them having funnel down to specifics*".

Importantly, participants identified the need to include other community-based locations (e.g., hairdresser, sporting club, shopping centre; Group 4) for identification of those who might benefit from social prescribing, particularly given that not everyone sees a health professional:

> *"Not every person goes to the health professionals, require to capitalise on other zones." (Group 5)*

Referral to the social prescribing service

The importance of the Link Worker: Participants highlighted the need for a Link Worker-based service (a holistic model):

> *"Link Worker is critical." (Group 1)*

> *"Face-to-face contact with a linker needs to happen ASAP." (Group 3)*

Multiple referral pathways: Participants recommended multiple referral pathways to the Link Worker, including referral through health and community settings in addition to the possibility of co-location of services where a Link Worker is onsite:

> *"Interconnection of spectrum of MH (mental health) services. Library, community centres like religious, cultural hubs, grocery shops e.g., specific cultural community grocery shops, sports clubs." (Group 4)*

> *"NY (Nunkuwarrin Yunti Aboriginal Community Controlled Health Service) does social prescribing really well, all GP, nurses refer to lots of Nunk programs. Recently we have established a JP (justice of the peace) at the health service in the clinic." (Group 3)*

Considering the existing service eco-system: Participants highlighted that there needs to be a consideration of "*different funding pathways – federal or state or local community*" in addition to the need for "*more grass roots services*" and ensuring the program is "*not duplicating services*" (Group 4).

A multi-modal approach: Participants also noted the value of a multi-modal approach that uses a combination of online/app-based processes with face-to-face connection to a Link Worker.

"Written, online and follow up call options" (Group 2)

"In an app. put the option of 'Do you want to talk to someone?'." (Group 5)

In addition to the data provided in the journey maps, there was extensive discussion among the larger group around referral pathways. Social prescribing commonly involves referring patients from health settings, particularly primary care. However, participants noted that while these settings are important, many people (particularly men and those from culturally and linguistically diverse populations) do not visit primary care settings. As such, these cohorts can fall through the cracks, and their situations exacerbate. To ensure reach to such populations, participants emphasised the importance of self-identification and self-referral to social prescribing through information provided in community settings (e.g., libraries, community centres, cultural community grocery shops, and sports clubs), in addition to utilising community/cultural events to promote social prescribing.

Meeting with the Link Worker

Multiple locations: Participants again highlighted the importance of multiple options for where the meeting with the Link Worker should take place, depending on the clients, the available locations, and available funding:

"Should vary and may be dependent on funding constraints. Might be hard to have conversation in coffee shop. Might not have funding for home visit. Might be different depending on complexity/sensitivity." (Group 1)

"Meet where comfortable (community centres)." (Group 2)

"Linker to be based at clinics/GPs." (Group 3)

"Depends on the client." (Group 4)

"Less formal environment. Familiar place. Transport a consideration." (Group 5)

A holistic, culturally sensitive approach: In terms of what happens during the meeting, a holistic, culturally sensitive approach was recommended that is centred on the needs and experiences of the client:

"Clarify goals. Build rapport. Motivational Interviewing. Learn about interests past and present." (Group 2)

"Having a yarn with the person." (Group 3)

"Depending on the progression of the capacity and goals of the client. Might be all about talking services or wanting social community. Client centred tailored approach." (Group 4)

Participants also highlighted the importance of outlining clear expectations to clients and maintaining confidentiality, noting that "*specific attention needed for people with more complex or sensitive needs – probably not a volunteer role*" (Group 1).

Connection to services

Client-directed process: Participants recommended connection to services can involve different levels of intensity, from providing information, to contacting the service for the client, and to attending appointments with the client:

"E.g., go in person, call on their behalf, email with cc." (Group 2)

"Linker should make the first referral and if needed attend the first session." (Group 3)

Importantly, this should be determined in consultation with the client and ultimately directed by their preferences:

"Should make agreements re how the LW (Link Worker) will support e.g., ring or go together." (Group 1)

"Directed by client." (Group 2)

There is also a funding consideration around enabling the Link Worker to support the client with access to services/supports:

"Access to phone & car, computer or meet at home and take public transport together." (Group 3)

A further enabling factor identified by participants is "*[having a] team of Link Workers – more resources to navigate all services*" (Group 4).

Knowing what's available: A key enabler for connecting clients to services and supports is knowing what is available, eligibility criteria, and referral pathways and processes:

"Really important for Link W (Link Worker) to know what is available in community and good understanding re referral pathways or eligibility." (Group 1)

One way to ensure this knowledge is available and accessible is to have a single platform that includes all the services and supports in the area and the necessary information to support the client to access the service/support:

"Central platform. Easy to find info. Local knowledge." (Group 2)

"A platform which includes all services within the area and include referral pathway, eligibility, locations and more info." (Group 4)

Follow-up and feedback

Client-centred and holistic: A client centred approach to follow-up and feedback (e.g., to the original referrer) means the client should make the decision about what this process looks like: "*Should be agreed in the step before*" (Group 1). As a holistic service, participants identified the importance of ongoing engagement until the client has achieved or is on track to achieve their goals and had their needs met:

"Making sure referral is completed. Follow up until the goals are on track. Link Worker – 3 or 6 or 12-months engagement or crisis management." (Group 4)

Having a process: Participants identified the need for a process that uses software and a formal process, including a survey of outcomes:

"If a referral form and it's complex – health provider might ask for feedback e.g., box to tick" (Group 1)

"Reporting similar to CCP (Community Connections Program) & SWI. (Structural Wellbeing Index) Survey!" (Group 2)

"Linker to follow up after a few weeks. Manage system like Communicare." (Group 3)

"Making sure referral is completed. Follow up until the goals are on track." (Group 4)

The social prescribing model: One size doesn't fit all

Analysis of the combined data from the workbooks, journey maps, and participant discussions were combined into a social prescribing model. A key element of the model is that there is no 'one-size-fits-all' approach to social prescribing and that the journey should be tailored to people's needs and contextualised depending on referral pathways into the program (community or health settings; self-referral) (see Figure 2).

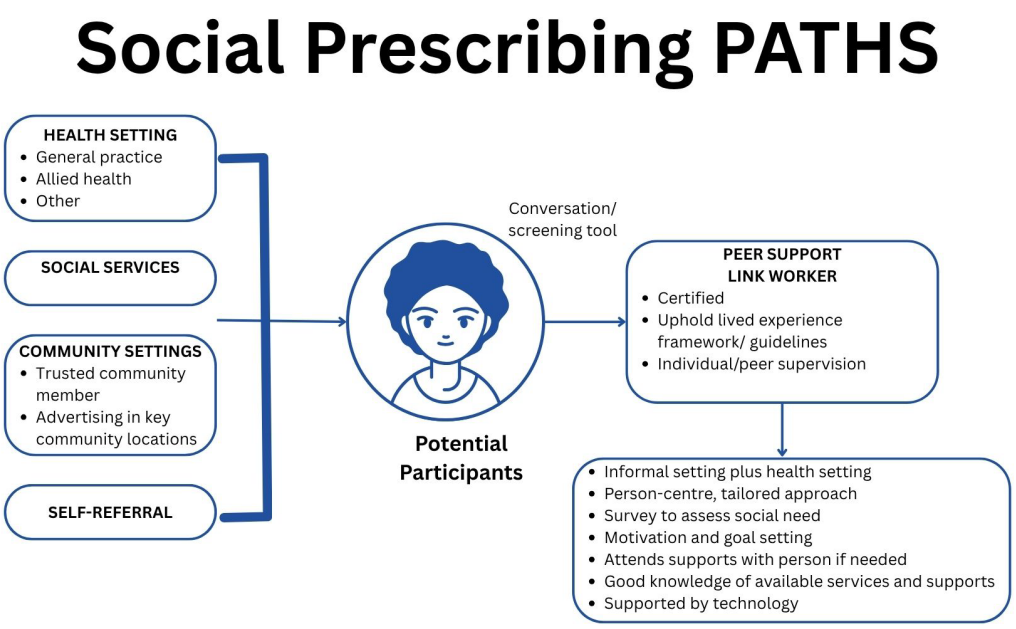

Figure 11. The co-designed social prescribing model.

Participants co-designed a person-centred, holistic, community-based approach to social prescribing that addresses broader social determinants of health and is available to anyone in the community with social needs. It includes referral pathways from health (GP, allied health), social services, and community settings (e.g., through direct referral by a trusted member of the community or advertising the service in key community locations) in addition to self-referral. Potential participants for social prescribing are identified through a combination of a conversation and screening tool, and then referred to a Link Worker.

Participants saw value in the use of peer support workers as Link Workers, if they are certified and provided with individual or peer supervision. The Link Worker should meet the person in a less formal environment in the community, if possible, but could also be available in health settings, if appropriate. They can use a survey to assess social needs. They should take a person-centred, tailored approach to conversations with social prescribing participants, working on motivation and goal setting and attending supports with the person if needed. The Link Worker needs to have a good knowledge of available services and supports, including referral pathways and eligibility, supported by digital technology. Link Workers should also establish the person's preferences for follow-up and provision of feedback to referrers.

DISCUSSION

The co-design process undertaken for The ACDC Project in The City of Salisburyhighlights the importance of tailoring social prescribing models to local contexts and community needs

(Bhaskar et al. 2025). The findings reinforce the value of a holistic, person-centred approach that addresses the broader social determinants of health, such as housing, food security, income, and social connection.

Participants in the workshop strongly supported the use of peer support workers as Link Workers, provided they are certified and receive appropriate supervision. This reflects a growing recognition of the value of lived experience in building trust and rapport with clients (Kotera et al. 2025). The preference for community-based Link Workers also aligns with the broader aim of making social prescribing accessible outside traditional health settings (Allbutt et al. 2025).

The co-design process revealed a clear preference for multiple referral pathways, including general practice, allied health, social services, and community settings, as well as self-referral. This multi-modal approach acknowledges that many individuals with unmet social needs may not engage with health services and instead interact with community spaces such as libraries, cultural centres, and sporting clubs. Participants emphasised the importance of leveraging these informal settings to identify potential participants through trusted relationships and community engagement.

In terms of identification and referral, participants advocated for a combination of professional judgement and screening tools, used sensitively and contextually. While routine screening was seen as potentially invasive, especially in clinical waiting rooms, it was also recognised as a useful tool when adapted to specific settings and populations. The use of digital tools, such as apps and online surveys, was suggested to facilitate self-identification and streamline the referral process.

The role of the Link Worker was seen as central to the success of the model. Participants envisioned Link Workers meeting clients in less formal and comfortable environments, using motivational interviewing and goal-setting techniques to support individuals in accessing services. The importance of flexibility in the location and nature of these meetings was highlighted, with considerations for funding, transport, and client preferences.

Effective connection to services was another key theme. Warm referrals – where the Link Worker contacts or accompanies the client – were preferred over passive methods like referral pads or directories. This approach was seen as more supportive and likely to result in successful engagement with services. Participants also stressed the need for Link Workers to have comprehensive knowledge of available services, eligibility criteria, and referral pathways, ideally supported by a centralised digital platform.

Finally, the importance of follow-up and feedback was strongly endorsed. A formal follow-up process, tailored to the client's preferences, was seen as essential to ensure continuity of care and support. Participants suggested using client management systems and outcome surveys

to track progress and provide feedback to referrers, reinforcing the need for accountability and ongoing engagement.

CONCLUSION

Overall, the co-design process affirmed that there is no one-size-fits-all model for social prescribing (Oster et al. 2023; Bhaktar et al. 2025). Instead, successful implementation requires a flexible, community-driven approach that is responsive to individual needs and local contexts. The insights from this workshop provide a strong foundation for developing a social prescribing model that is inclusive, effective, and sustainable within The City of Salisbury LGA and potentially adaptable to other communities.

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