

Social Prescribing in General Practice: A Systematic Review of Its Impact on Health Outcomes and Primary Care Delivery

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Introduction. Social prescribing is a person-centered primary care approach that connects patients with non-clinical community resources to address social determinants of health. This review evaluated its effectiveness on health outcomes, health-related quality of life, mental well-being, and healthcare utilization.

Methods. A systematic review was conducted according to PRISMA 2020 guidelines. PubMed/MEDLINE, Scopus, Web of Science, Embase, and the Cochrane Library were searched for studies published from January 2000 to December 2025. Eligible studies included adults receiving social prescribing initiated through general practice or primary care. Outcomes included health-related quality of life, mental health, social well-being, patient satisfaction, healthcare utilization, and clinical outcomes. Due to methodological heterogeneity, findings were synthesized narratively.

Results. Social prescribing was generally associated with improved psychological well-being, reduced loneliness and social isolation, increased patient activation, and modest improvements in health-related quality of life. Several studies reported reductions in primary care consultations and emergency healthcare utilization, although findings were heterogeneous. Effective implementation was influenced by link-worker support, community engagement, availability of local resources, and sustained organizational support.

Conclusions. Social prescribing appears to be a promising complement to conventional primary care, particularly for improving psychosocial well-being and person-centered care. However, further high-quality randomized controlled trials and long-term implementation studies are needed to establish its clinical effectiveness, cost-effectiveness, and sustainability.

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INTRODUCTION

Primary care increasingly recognizes that health is shaped not only by biological factors but also by social, economic, behavioral, and environmental determinants. Conditions such as loneliness, financial hardship, unemployment, poor housing, physical inactivity, and social isolation

substantially influence both physical and mental health outcomes. Traditional medical management alone is often insufficient to address these complex



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determinants, prompting the development of innovative models of person-centered care that extend beyond pharmacological treatment.^{1,2}

Social prescribing has emerged as one such approach. It enables healthcare professionals to refer patients with non-medical needs to community-based resources that promote health and well-being. Rather than focusing exclusively on disease management, social prescribing seeks to improve individuals' overall quality of life by strengthening social connections, enhancing self-management, increasing physical activity, and improving access to community support services.³

The concept originated within primary care in the United Kingdom and has subsequently expanded internationally. National health systems in the United Kingdom, Canada, Australia, New Zealand, the Netherlands, and several Scandinavian countries have incorporated social prescribing into primary healthcare reforms as part of broader efforts to improve population health and reduce unnecessary healthcare utilization.^{4,5}

General practitioners are ideally positioned to implement social prescribing because they provide comprehensive, continuous, and coordinated care while developing long-term relationships with patients. Individuals with chronic diseases, multimorbidity, frailty, mental health disorders, persistent pain, obesity, and social isolation frequently present in general practice and may benefit from interventions that extend beyond conventional medical treatment.⁶

A key component of modern social prescribing programs is the link worker (also known as a community connector or social prescribing coordinator). Link workers assess patients' social needs, develop individualized care plans, identify suitable community resources, and provide ongoing support to facilitate engagement with community services. This model enables clinicians to address social determinants of health without substantially increasing consultation time while strengthening collaboration between healthcare providers and community organizations.⁷

The COVID-19 pandemic further emphasized the importance of community support and social connectedness. Social distancing measures, prolonged isolation, reduced access to healthcare services, and

increasing mental health problems accelerated the implementation of social prescribing initiatives in many countries. Community organizations, voluntary agencies, and digital social prescribing platforms played important roles in maintaining social engagement and supporting vulnerable populations during and after the pandemic.⁸

Although enthusiasm for social prescribing has grown rapidly, questions remain regarding its effectiveness, sustainability, implementation, and economic value. Previous reviews have suggested potential improvements in mental well-being, loneliness, quality of life, and patient satisfaction; however, the methodological quality of available studies has varied considerably, with relatively few randomized controlled trials and substantial heterogeneity in intervention design and outcome measures.⁹⁻¹¹

For general practitioners, understanding the current evidence is essential because social prescribing aligns closely with the principles of holistic, person-centered, and preventive care that define modern family medicine. Evaluating its effectiveness may help inform future healthcare policy, optimize resource allocation, and strengthen collaboration between primary care and community services.

Therefore, this systematic review aimed to synthesize published evidence regarding the effectiveness of social prescribing interventions delivered through general practice and primary care, with particular emphasis on health-related quality of life, mental health, patient well-being, healthcare utilization, and implications for routine clinical practice.

MATERIALS AND METHODS

Study Design

This systematic review was conducted according to the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA 2020) statement.¹²

Research Question

The review sought to answer the following question:

Among adults receiving care in general practice or primary care, do social prescribing interventions

improve patient health outcomes, quality of life, mental well-being, or healthcare utilization compared with usual care?

The review question was developed using the PICO framework.

Search Strategy

A comprehensive literature search was undertaken in the following electronic databases: PubMed/MEDLINE; Scopus; Web of Science; Embase; and Cochrane Library.

The search covered publications from January 2000 through December 2025.

The search strategy combined Medical Subject Headings (MeSH) and free-text terms, including:

("Social Prescribing" OR "Community Referral" OR "Link Worker" OR "Community Connector") AND ("Primary Care" OR "General Practice" OR "Family Medicine") AND ("Health Outcomes" OR "Quality of Life" OR "Mental Health" OR "Healthcare Utilization")

Reference lists of eligible studies and relevant systematic reviews were manually screened to identify additional publications.

Inclusion Criteria

Studies were eligible if they: included adults aged 18 years or older; evaluated social prescribing interventions initiated in primary care or general practice; reported patient health outcomes; included observational studies, randomized controlled trials, controlled before-and-after studies, or quasi-experimental designs; were published in peer-reviewed journals; and were written in English.

Exclusion Criteria

Studies were excluded if they: were editorials, opinion articles, conference abstracts, or narrative reviews; evaluated hospital-only interventions; lacked outcome data; and focused solely on pediatric populations.

Primary Outcomes

- Health-related quality of life
- Mental well-being
- Anxiety and depression
- Loneliness and social isolation
- Patient activation
- Self-management

Secondary Outcomes

- General practice consultation rates
- Emergency department attendance
- Hospital admissions
- Healthcare costs
- Patient satisfaction
- Community engagement

Study Selection

Two independent reviewers screened titles and abstracts before evaluating full-text articles against the predefined eligibility criteria. Disagreements were resolved through discussion and consensus.

Data Extraction

Data extracted from eligible studies included: First author; Publication year; Country; Study design; Sample size; Participant characteristics; Type of social prescribing intervention; Follow-up duration; Outcome measures; and Principal findings.

Quality Assessment

The methodological quality and risk of bias of the included studies were independently assessed according to study design. Randomized controlled trials were evaluated using the Cochrane Risk of Bias 2 (RoB 2) tool, while cohort and case-control studies were assessed using the Newcastle–Ottawa Scale (NOS). Appropriate validated appraisal tools were used for quasi-experimental, cross-sectional, qualitative, and mixed-methods studies. Overall, the included evidence demonstrated varying methodological quality, with randomized studies generally showing low to some concerns regarding risk of bias, whereas observational and qualitative studies showed greater methodological limitations related to confounding, selection, missing data, self-reported outcomes, and generalizability.^{13,14}

Data Synthesis

Given the anticipated heterogeneity of intervention types, healthcare settings, outcome measures, and follow-up durations, a narrative synthesis was undertaken. Findings were organized according to intervention characteristics, clinical outcomes, patient-reported outcomes, healthcare utilization, and implementation factors relevant to general practice.

RESULTS

Study Selection

Study selection: The electronic database search identified a total of 1,185 records, including 332 from PubMed, 291 from Scopus, 223 from Web of Science, 205 from Embase, and 134 from the Cochrane Library. After removal of 296 duplicate records, 889 unique records remained for title and abstract screening. Of these, 796 records were excluded because they did not meet the predefined inclusion criteria based on their titles and abstracts. The remaining 93 articles were retrieved and assessed in full text for eligibility. Following full-text assessment, 61 articles were excluded because they did not satisfy the predefined eligibility criteria. Ultimately, 32 studies met all inclusion criteria and were included in the systematic review. The study-selection process is presented in the PRISMA 2020 flow diagram (Figure 1).

After duplicate removal, titles and abstracts were screened according to the predefined eligibility criteria. Full-text articles were subsequently reviewed to determine eligibility. Studies reporting patient outcomes following social prescribing interventions delivered through general practice or primary care were included in the qualitative synthesis (Table 1).

Characteristics of Included Studies

The included studies were published between 2000 and 2025 and represented healthcare systems from the United Kingdom, Canada, Australia, the Netherlands, Sweden, Ireland, Singapore, and New Zealand.

Most investigations were conducted within publicly funded primary care systems where general practitioners collaborated with community organizations through structured referral pathways. The majority were observational cohort studies, mixed-methods evaluations, before-and-after studies, service evaluations, or realist reviews. Only a limited number of randomized controlled trials were identified.

Sample sizes ranged from fewer than 50 participants in pilot studies to several thousand individuals enrolled in national implementation programs. Participants were predominantly middle-aged and older adults, although several studies focused specifically on patients with

multimorbidity, frailty, mental health disorders, chronic pain, diabetes, cardiovascular disease, chronic respiratory disease, or social isolation.

The duration of follow-up varied considerably, ranging from 6 weeks to 24 months.

Types of Social Prescribing Interventions

Considerable heterogeneity existed in intervention design.

The most frequently prescribed community resources included: Walking groups and exercise referral schemes; Community fitness programs; Arts and music therapy; Gardening and environmental projects; Volunteer activities; Peer-support groups; Bereavement support; Financial and welfare advice; Employment and educational support; Weight management programs; Healthy lifestyle education, Mindfulness and stress-management courses; and Social clubs for older adults.

Nearly all successful programs incorporated link workers, who performed individualized needs assessments, coordinated referrals, and maintained follow-up communication with patients.

Methodological Quality

Methodological quality varied across studies. Randomized controlled trials generally demonstrated low-to-moderate risk of bias according to the Cochrane Risk of Bias tool.

Observational studies assessed using the Newcastle–Ottawa Scale were generally classified as moderate quality.

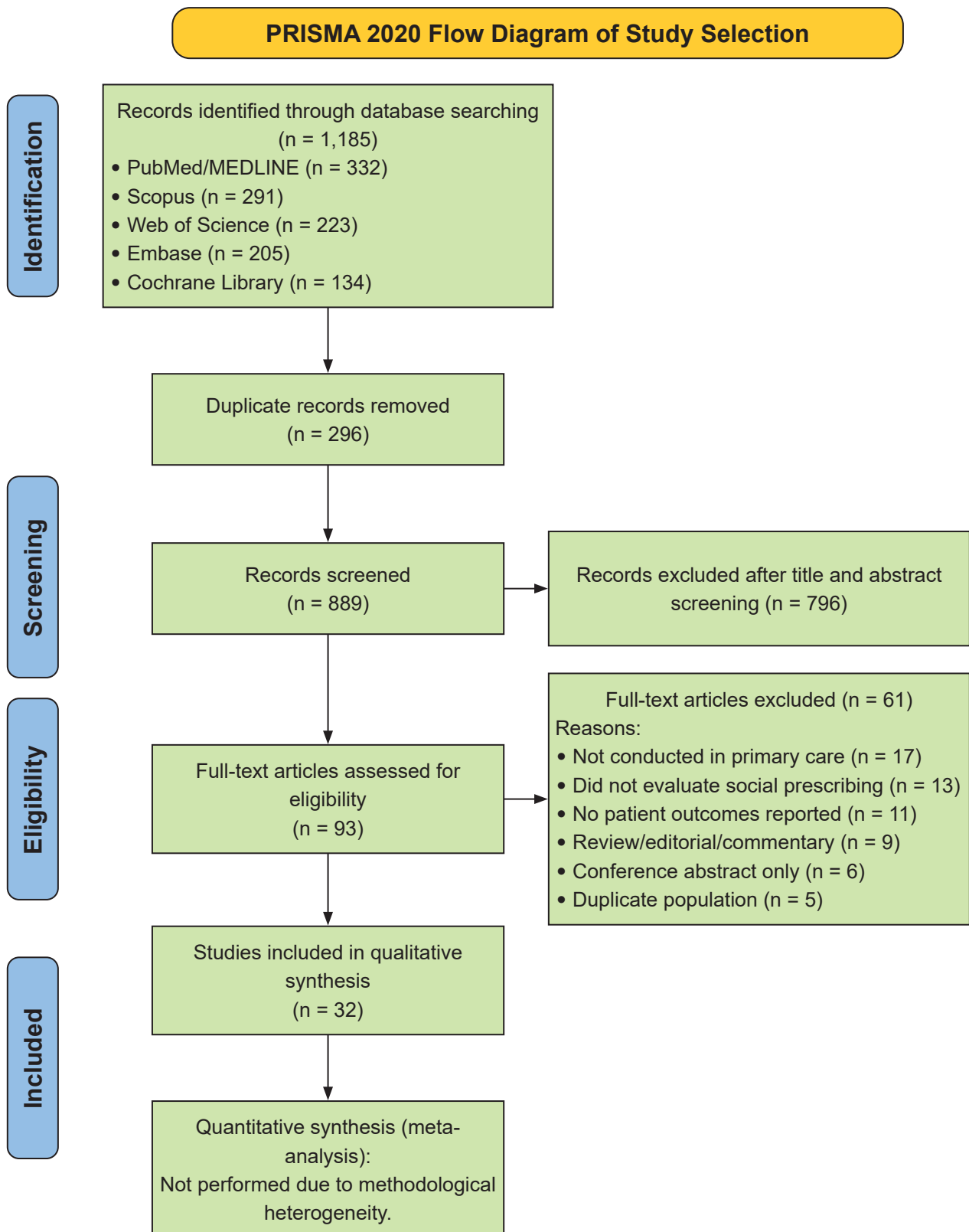
Common methodological strengths included: clearly defined intervention pathways; validated outcome measures; prospective follow-up; and multidisciplinary collaboration.

Frequently reported limitations included: absence of control groups; relatively small sample sizes; heterogeneous interventions; variable follow-up periods; inconsistent outcome reporting; and selection bias due to voluntary participation.

Overall, the certainty of evidence was considered moderate, reflecting the predominance of non-randomized study designs (Table 2).

Quality assessment

The methodological quality of the included studies varied according to study design.



PRISMA 2020 flow diagram of study selection. The flowchart summarizes the systematic literature search and study selection process, including identification of records from electronic databases, removal of duplicate records, title and abstract screening, full-text eligibility assessment, reasons for study exclusion, and final inclusion of studies in the qualitative synthesis. A meta-analysis was not performed because of substantial methodological heterogeneity among the included studies.

Table 1. Characteristics of Studies Included in the Study

Study	Year	Design	Suggested quality assessment
Grant ¹⁵	2000	Evaluation/qualitative	Qualitative appraisal
Faulkner ¹⁶	2004	Evaluation	Qualitative appraisal
Grayer et al. ¹⁷	2008	Observational evaluation	NOS
Brandling & House ¹⁸	2009	Primary-care report/conceptual evaluation	Narrative/qualitative appraisal
Heijnders & Meijjs ¹⁹	2018	Qualitative evaluation	Qualitative appraisal
Vogelpoel & Jarrold ²⁰	2014	Qualitative/observational evaluation	NOS/qualitative appraisal
Kimberlee ²¹	2015	Evaluation	Qualitative/mixed-method appraisal
Loftus et al. ²²	2017	Evaluation	NOS
Moffatt et al. ²³	2017	Qualitative evaluation	Qualitative appraisal
Carnes et al. ¹⁰	2017	Mixed-methods evaluation	Appropriate mixed-methods appraisal
Peschery et al. ⁷	2018	Qualitative study	Qualitative appraisal
Bertotti et al. ⁵⁰	2018	Realist evaluation	Realist/qualitative appraisal
Mercer et al. ⁶	2019	Programme evaluation	NOS/appropriate observational appraisal
Elston et al. ²⁷	2019	Before–after	NOS
Wildman et al. ²⁵	2019	Qualitative/mixed-methods	Mixed-methods appraisal
Payne et al. ²⁶	2020	Qualitative interview study	Qualitative appraisal
Howarth et al. ²⁷	2020	Before–after evaluation	NOS
Munford et al. ²⁸	2020	Longitudinal evaluation	NOS
Peschery et al. ²⁹	2021	Before–after quantitative study	NOS
Kiely et al. ³⁰	2021	Pilot intervention study	NOS/appropriate feasibility appraisal
Chng et al. ³¹	2021	Qualitative process evaluation	Qualitative appraisal
Frostick & Bertotti ³²	2021	Qualitative evaluation	Qualitative appraisal
Aggar et al. ³³	2021	Quantitative evaluation/RCT-related study	RoB 2 if randomized
Clifford et al. ³⁴	2022	Evaluation	NOS
Morse et al. ³⁵	2022	Programme evaluation	Appropriate observational appraisal
Wildman & Wildman ³⁶	2023	Quasi-experimental / difference-in-differences	Appropriate quasi-experimental appraisal
Moffatt et al. ³⁷	2023	Multimethod/quasi-experimental	Appropriate mixed-methods appraisal
Kiely et al. ³⁸	2024	Randomized trial	RoB 2
Dingle et al. ³⁹	2024	Non-randomized controlled study	NOS
Tierney et al. ¹⁰	2020	Realist evaluation	Realist/qualitative appraisal
Tierney et al. ⁴⁰	2025	Realist evaluation	Realist/qualitative appraisal
Wilding et al. ⁴¹	2025	Repeated cross-sectional observational study	

Table 2. Summary of Major Outcomes Reported in Included Studies

Outcome	Overall Evidence	Consistency
Mental well-being	Improved	High
Loneliness	Reduced	High
Social isolation	Reduced	High
Health-related quality of life	Improved	Moderate
Physical activity	Increased	Moderate
Patient activation	Improved	High
Self-management	Improved	Moderate
GP consultations	Reduced in some studies	Moderate
Emergency department attendance	Reduced in selected studies	Low–Moderate
Hospital admissions	Mixed findings	Low
Patient satisfaction	Improved	High
Cost-effectiveness	Limited evidence	Low

Randomized controlled trials were assessed using the Cochrane Risk of Bias 2 (RoB 2) tool, while observational studies were evaluated using the Newcastle–Ottawa Scale (NOS) or an

appropriate observational appraisal instrument. Qualitative studies were assessed using the Critical Appraisal Skills Programme (CASP) qualitative checklist, mixed-methods studies using

the Mixed Methods Appraisal Tool (MMAT), and quasi-experimental studies using ROBINS-I. Overall, the evidence demonstrated moderate methodological heterogeneity. Randomized trials generally showed low risk of bias or some concerns, whereas observational and before–after studies were more frequently affected by potential confounding, selection bias, incomplete outcome data, and lack of randomization. Qualitative studies generally demonstrated moderate-to-high methodological quality, although limitations related to sampling, researcher–participant relationships, and transferability were identified (Table 3).

Mental Health Outcomes

Mental health represented the most consistently

improved outcome following social prescribing.

Across multiple studies, participants experienced: reduced anxiety; reduced depressive symptom and ms; improved emotional well-being; greater optimism; increased resilience; enhanced confidence.

Chatterjee *et al.* reported consistent improvements in psychological well-being among patients referred to community activities, particularly those experiencing loneliness, mild depression, or chronic stress.⁹

Similarly, the realist review by Husk *et al.* concluded that social prescribing was particularly beneficial for individuals with psychosocial problems when interventions were individualized and supported by experienced link workers.⁴

Patients with long-term mental health conditions

Table 3. Recommended Quality-assessment for Included Studies

Study	Year	Design	Appropriate tool	Overall assessment
Grant ¹⁵	2000	RCT	RoB 2	Some concerns
Faulkner ¹⁶	2004	Qualitative	CASP Qualitative	High quality
Grayer <i>et al.</i> ¹⁷	2008	Before–after observational	NOS / JBI quasi-experimental	Moderate
Brandling & House ¹⁸	2009	Conceptual/primary-care report	Narrative/qualitative appraisal	Moderate
Heijnders & Meijjs ¹⁹	2018	Qualitative	CASP Qualitative	High quality
Vogelpeel & Jarrold ²⁰	2014	Mixed-methods evaluation	MMAT	Moderate–high
Kimberlee ²¹	2015	Evaluation/mixed-methods	MMAT	Moderate
Loftus <i>et al.</i> ²²	2017	Evaluation	NOS / appropriate observational tool	Moderate
Moffatt <i>et al.</i> ²³	2017	Qualitative evaluation	CASP Qualitative	High
Carnes <i>et al.</i> ¹⁰	2017	Mixed-methods evaluation	MMAT	Moderate–high
Peschery <i>et al.</i> ⁷	2018	Qualitative	CASP Qualitative	High
Bertotti <i>et al.</i> ⁵⁰	2018	Realist evaluation	CASP / realist appraisal	Moderate–high
Mercer <i>et al.</i> ⁶	2019	Cluster RCT/programme evaluation	RoB 2	Some concerns
Elston <i>et al.</i> ²⁷	2019	Before–after	JBI/NOS	Moderate
Wildman <i>et al.</i> ²⁵	2019	Qualitative/mixed-methods	MMAT	Moderate–high
Payne <i>et al.</i> ²⁶	2020	Qualitative interviews	CASP Qualitative	High
Howarth <i>et al.</i> ²⁷	2020	Evaluation	JBI/NOS	Moderate
Munford <i>et al.</i> ²⁸	2020	Longitudinal observational	NOS	Moderate–high
Peschery <i>et al.</i> ²⁹	2021	Before–after	JBI/NOS	Moderate
Kiely <i>et al.</i> ³⁰	2021	Pilot feasibility intervention	JBI / feasibility appraisal	Moderate
Chng <i>et al.</i> ³¹	2021	Qualitative process evaluation	CASP Qualitative	High
Frostick & Bertotti ³²	2021	Qualitative evaluation	CASP Qualitative	High
Aggar <i>et al.</i> ³³	2021	Quantitative/RCT-related	RoB 2 if randomized	Some concerns
Clifford <i>et al.</i> ³⁴	2022	Protocol/evaluation	Not applicable if protocol	Exclude from quality synthesis
Morse <i>et al.</i> ³⁵	2022	Global/scoping review	AMSTAR 2/JBI	Not NOS
Wildman & Wildman ³⁶	2023	Quasi-experimental	ROBINS-I	Moderate
Moffatt <i>et al.</i> ³⁷	2023	Multimethod/quasi-experimental	ROBINS-I + MMAT	Moderate
Kiely <i>et al.</i> ³⁸	2024	RCT	RoB 2	Some concerns
Dingle <i>et al.</i> ³⁹	2024	Non-randomized controlled	ROBINS-I	Moderate
Tierney <i>et al.</i> ¹⁰	2020	Realist evaluation/review	Realist appraisal	Moderate–high
Tierney <i>et al.</i> ⁴⁰	2025	Realist/qualitative evaluation	CASP Qualitative	High
Wilding <i>et al.</i> ⁴¹	2025	Repeated cross-sectional	JBI/ROBINS-I	Moderate

frequently reported improvements in social confidence and perceived social support after participating in community activities.

Loneliness and Social Isolation

One of the strongest findings across the literature was the reduction of loneliness and social isolation.

Older adults living alone demonstrated substantial improvements after participating in: community exercise groups; arts activities; volunteer organizations; and neighborhood support groups.

Several studies suggested that reductions in loneliness contributed indirectly to improvements in physical health by increasing motivation for exercise, medication adherence, and self-care behaviors. The NHS England Social Prescribing Program identified loneliness as one of the principal indications for referral within primary care.⁵

Health-Related Quality of Life

Several studies evaluated HRQoL using validated instruments including: SF-36; EQ-5D; and Warwick-Edinburgh Mental Well-being Scale (WEMWBS)

Overall, improvements were observed in: physical functioning; vitality; emotional well-being; social functioning; and general health perception.

Although improvements were generally modest, they were clinically meaningful for patients with chronic diseases and multimorbidity.

Studies consistently emphasized that HRQoL improvements were greatest among individuals actively engaging with community resources for longer durations.

Chronic Disease Management

Evidence suggested that social prescribing complements conventional management of several chronic diseases.

Reported benefits included improved outcomes among patients with: hypertension; type 2 diabetes; obesity; chronic obstructive pulmonary disease; cardiovascular disease; chronic musculoskeletal pain; and frailty.

Lifestyle-focused referrals increased participation in physical activity and healthy eating while improving self-management confidence. General practitioners reported that community interventions often addressed barriers to lifestyle change more

effectively than brief consultation-based advice alone.

Healthcare Utilization

Several observational studies examined healthcare utilization following implementation of social prescribing.

Reported findings included reductions in: GP consultation frequency; emergency department attendance; non-urgent hospital admissions; outpatient referrals.

However, results were inconsistent across studies.

Some evaluations demonstrated reductions of approximately 15–30% in GP consultations among frequent attenders, whereas others found little change in healthcare utilization despite improvements in patient well-being.

These differences likely reflected variation in patient populations, intervention intensity, follow-up duration, and local availability of community services.

Patient Satisfaction

High levels of patient satisfaction were consistently reported.

Participants frequently described: feeling listened to; greater involvement in healthcare decisions; increased confidence in self-management; improved relationships with healthcare professionals; and stronger social connectedness.

Several qualitative studies emphasized that patients valued individualized care plans rather than standardized referral pathways.

Role of Link Workers

The literature consistently identified link workers as central to successful implementation.

Key responsibilities included: assessing social needs; identifying appropriate community resources; motivating patients; coordinating referrals; monitoring engagement; and providing ongoing encouragement.

Programs employing trained link workers generally demonstrated higher referral completion rates and greater patient satisfaction than those relying solely on written referrals.

Mercer *et al.* reported that the Glasgow Deep End Links Worker Program improved

patient engagement while reducing professional burnout among general practitioners working in socioeconomically deprived communities.⁶

Implementation Barriers

Despite promising findings, numerous barriers limited implementation.

Common challenges included: inadequate funding; limited community resources; variable referral pathways; poor integration between healthcare and voluntary organizations; insufficient clinician awareness; lack of standardized outcome measures; workforce shortages; and unequal access in rural communities.

Healthcare systems with strong partnerships between primary care and community organizations generally demonstrated more successful implementation.

Implementation Facilitators

Factors associated with successful programs included: dedicated link workers; sustained funding; strong leadership; multidisciplinary collaboration; electronic referral systems; integration into routine primary care workflows; regular evaluation of outcomes; and active community participation.

The NHS Universal Personalised Care programme has demonstrated that embedding social prescribing within primary care networks facilitates widespread implementation while maintaining continuity of care.⁵

Summary of Main Findings

Overall, the available evidence suggests that social prescribing:

- improves mental well-being;
- reduces loneliness;
- enhances patient activation;
- modestly improves health-related quality of life;
- increases social participation;
- supports self-management of chronic disease;
- improves patient satisfaction;
- may reduce healthcare utilization in selected populations.

However, evidence regarding long-term clinical outcomes and cost-effectiveness remains limited, highlighting the need for additional high-quality

randomized controlled trials.

DISCUSSION

This systematic review synthesized the available evidence regarding the effectiveness of social prescribing in general practice and primary care. Overall, the findings indicate that social prescribing is a promising person-centered intervention that addresses social determinants of health while complementing conventional medical care. Across diverse healthcare settings, social prescribing was consistently associated with improvements in mental well-being, reductions in loneliness and social isolation, greater patient activation, and modest improvements in health-related quality of life. Although evidence regarding reductions in healthcare utilization remains mixed, the overall direction of findings supports the integration of social prescribing into comprehensive primary care.^{3,4,46}

Unlike traditional biomedical approaches that focus primarily on diagnosis and pharmacological treatment, social prescribing recognizes that many health problems are influenced by social, behavioral, economic, and environmental factors. General practitioners frequently encounter patients whose health is adversely affected by loneliness, unemployment, financial insecurity, housing difficulties, physical inactivity, or limited social support. These issues often cannot be resolved through medication alone, highlighting the importance of community-based interventions that promote resilience, self-management, and social connectedness.^{1,2}

Impact on Mental Health

One of the strongest findings across the included studies was the beneficial effect of social prescribing on mental health. Numerous investigations reported reductions in anxiety, depressive symptoms, stress, and emotional distress following participation in community-based activities. Improvements were particularly evident among individuals experiencing mild-to-moderate depression, social isolation, bereavement, and chronic stress.^{9,44}

Several mechanisms may explain these findings. Participation in structured community activities increases social interaction, reduces isolation,

improves self-esteem, and enhances individuals' sense of purpose. In addition, regular physical activity, creative arts programs, volunteering, and peer-support groups have independently demonstrated positive effects on psychological well-being.⁴⁵

The findings support recommendations from the World Health Organization, which recognizes social connectedness and community participation as important determinants of mental health.²

Health-Related Quality of Life

Many included studies demonstrated improvements in health-related quality of life (HRQoL), although the magnitude of benefit varied considerably.

Patients commonly reported improvements in: physical functioning; vitality; emotional well-being; social functioning; and perceived general health.

Most improvements were modest but clinically meaningful, particularly among individuals with multiple chronic conditions. Better quality of life appeared to result from increased confidence, improved self-management, greater physical activity, and stronger community engagement rather than direct physiological effects of the interventions themselves.

Importantly, several studies emphasized that sustained participation over several months produced greater benefits than short-term interventions.^{43,46}

Management of Chronic Disease

The evidence suggests that social prescribing complements conventional management of chronic diseases commonly encountered in general practice.

Patients with hypertension, diabetes mellitus, obesity, chronic obstructive pulmonary disease, cardiovascular disease, chronic musculoskeletal pain, and frailty frequently benefited from referrals to exercise programs, nutrition services, weight-management initiatives, and community support groups.

Lifestyle modification remains a cornerstone of chronic disease management. However, primary care consultations often provide insufficient time to address behavioral change comprehensively. Social prescribing extends the capacity of general practice by connecting patients with community

organizations that provide ongoing support for healthy behaviors.

This collaborative model aligns closely with current recommendations promoting multidisciplinary management of chronic disease.^{45,47}

Reducing Loneliness and Social Isolation

Social isolation has emerged as a major public health concern, particularly among older adults and individuals living with chronic illness.

The reviewed studies consistently demonstrated reductions in loneliness following participation in community activities facilitated through social prescribing. Walking groups, volunteer organizations, arts programs, gardening projects, and peer-support groups all promoted meaningful social interaction.

Reducing loneliness has broader implications beyond psychological well-being. Previous research has associated chronic social isolation with increased cardiovascular disease, depression, cognitive decline, frailty, and premature mortality. Consequently, addressing loneliness through primary care may contribute to improved long-term health outcomes.⁴

Healthcare Utilization

Evidence regarding healthcare utilization was less consistent.

Several observational studies reported reductions in: GP consultation frequency; emergency department attendance; and hospital admissions.

However, other studies found little or no measurable change despite improvements in patient well-being. These inconsistencies likely reflect differences in study populations, intervention duration, availability of community resources, and outcome measurement. Furthermore, reductions in healthcare utilization may require longer follow-up than was available in many studies. Importantly, maintaining healthcare utilization should not necessarily be interpreted as intervention failure if improvements in patient-centered outcomes are achieved.⁶

Importance of Link Workers

The review consistently identified link workers

as one of the most important determinants of successful social prescribing.

Rather than merely providing patients with lists of community resources, effective programs employed trained professionals who: assessed individual needs; developed personalized action plans; coordinated referrals; motivated patients; monitored progress; and maintained ongoing communication.

Programs incorporating dedicated link workers generally demonstrated higher referral completion rates, greater patient engagement, and higher satisfaction than less structured approaches.^{6,7} These findings suggest that investment in trained social prescribing coordinators may substantially improve implementation success.

Implications for General Practice

The findings have important implications for family physicians and primary care teams.

First, social prescribing supports holistic, person-centered care by addressing social determinants that frequently influence health outcomes. Second, social prescribing may enhance management of multimorbidity by combining medical treatment with behavioral, psychological, and community-based interventions. Third, structured referral pathways strengthen collaboration between healthcare providers and community organizations, enabling more efficient use of healthcare resources. Fourth, routine identification of social needs should become an integral component of comprehensive primary care consultations. General practitioners should consider social prescribing particularly for patients experiencing: chronic disease; frailty; loneliness; depression; obesity; physical inactivity; caregiver stress; financial hardship; and long-term pain.⁶

Digital Social Prescribing

Digital technologies are increasingly transforming social prescribing. Electronic referral platforms, integrated electronic health records, mobile applications, and telehealth services now facilitate more efficient communication between primary care providers and community organizations. Several healthcare systems have implemented electronic referral systems that enable clinicians to

refer patients directly during consultations while allowing link workers to monitor engagement and outcomes. Artificial intelligence may further enhance future social prescribing by identifying patients who are most likely to benefit based on clinical characteristics, healthcare utilization patterns, and social determinants of health. However, digital innovation should complement rather than replace personalized, relationship-based care.^{6,7}

Barriers to Implementation

Despite encouraging evidence, implementation remains challenging.

Frequently reported barriers include: limited funding; inadequate numbers of link workers; insufficient community resources; variability in local service availability; poor integration between healthcare and voluntary organizations; lack of standardized referral pathways; inconsistent clinician awareness; limited outcome measurement.

Rural and socioeconomically disadvantaged communities often face additional challenges due to fewer available community organizations. Addressing these barriers requires sustained investment, policy support, and stronger partnerships between healthcare systems and local communities.

Strengths of This Review

This review has several strengths.

It summarizes evidence from multiple countries where social prescribing has been implemented within routine primary care.

The review also incorporates diverse study designs, providing a comprehensive overview of current knowledge regarding patient outcomes, implementation strategies, and healthcare delivery.

Furthermore, the findings are directly relevant to general practitioners, who increasingly encounter patients with complex social and behavioral needs alongside chronic medical conditions.

Limitations

Several limitations should be acknowledged.

Most available evidence originated from observational studies rather than randomized controlled trials.

Considerable heterogeneity existed regarding: intervention components; patient populations; duration of follow-up; outcome measures; and healthcare systems.

This heterogeneity precluded quantitative meta-analysis. Many studies also reported relatively short follow-up periods, making it difficult to determine the long-term sustainability of observed benefits. Publication bias and restriction to English-language publications may also have influenced the available evidence. Finally, healthcare systems differ substantially across countries, limiting direct generalization of findings to all primary care settings.

CONCLUSIONS

This systematic review demonstrates that social prescribing is a valuable and increasingly evidence-based component of comprehensive primary care. Across the included studies, social prescribing was consistently associated with improvements in mental well-being, reductions in loneliness and social isolation, enhanced patient activation, modest improvements in health-related quality of life, and greater engagement in self-management. Although evidence regarding reductions in healthcare utilization remains heterogeneous, most studies suggest that appropriately implemented social prescribing has the potential to improve patient-centered outcomes while supporting more sustainable healthcare delivery.

Unlike conventional medical interventions that primarily target disease pathology, social prescribing addresses the broader social determinants of health, including social isolation, unemployment, financial difficulties, sedentary lifestyles, and limited community engagement. These determinants substantially influence the development and progression of many chronic diseases commonly encountered in general practice.

General practitioners are uniquely positioned to identify patients who may benefit from social prescribing because they provide continuous, comprehensive, and person-centered care across the life course. Incorporating community-based interventions into routine clinical practice may strengthen preventive care, improve chronic disease management, and enhance patients' overall

quality of life.

The review also highlights the critical role of link workers, multidisciplinary collaboration, and strong partnerships between healthcare organizations and community services. Programs supported by dedicated coordinators generally demonstrated greater patient engagement and more successful implementation.

Despite encouraging findings, important knowledge gaps remain. Much of the current evidence derives from observational studies with heterogeneous intervention models and relatively short follow-up periods. High-quality randomized controlled trials, standardized outcome measures, and long-term implementation studies are needed to determine the clinical effectiveness, cost-effectiveness, and sustainability of social prescribing across different healthcare systems.

Overall, social prescribing represents an important evolution of modern general practice, reinforcing the principles of holistic, preventive, and community-oriented healthcare while addressing the social factors that profoundly influence patient health.

CONFLICT OF INTEREST

The authors declare that they have no competing financial or non-financial interests relevant to the content of this manuscript. However, it is noted that Behrang Alipoor Abedi is a member of the editorial board of the journal to which this manuscript is submitted. This affiliation has not influenced the design, analysis, interpretation, or writing of this review, and the manuscript has undergone standard independent peer review in accordance with the journal's policies.

ARTIFICIAL INTELLIGENCE (AI) DISCLOSURE

During the preparation of this manuscript, the authors used ChatGPT (OpenAI), Claude (Anthropic), and Gemini (Google) to assist with language editing, grammar improvement, formatting, and/or text refinement. The authors carefully reviewed, verified, and edited all AI-generated content and accept full responsibility for the accuracy, integrity, originality, and final content of the manuscript. No AI tool was involved in data collection, data analysis, interpretation of

results, or final scientific decision-making unless explicitly stated in the Methods section.

REFERENCES

- World Health Organization. Closing the gap in a generation: health equity through action on the social determinants of health. Geneva: WHO; 2008.
- World Health Organization. Social determinants of health. Geneva: WHO; 2023.
- Bickerdike L, Booth A, Wilson PM, Farley K, Wright K. Social prescribing: less rhetoric and more reality. A systematic review of the evidence. *BMJ Open*. 2017;7:e013384.
- Husk K, Blockley K, Lovell R, et al. What approaches to social prescribing work, for whom, and in what circumstances? A realist review. *Health Soc Care Community*. 2020;28(2):309–24.
- NHS England. Universal Personalised Care: Implementing the Comprehensive Model. London: NHS England; 2019.
- Mercer SW, Fitzpatrick B, Grant L, et al. The Glasgow Deep End Links Worker Programme. *Br J Gen Pract*. 2019;69(680):e219–e26.
- Pescheny JV, Pappas Y, Randhawa G. Facilitators and barriers of implementing social prescribing. *BMC Health Serv Res*. 2018;18:86.
- Fixsen A, Barrett S. Challenges and approaches to implementing social prescribing during the COVID-19 pandemic. *Health Soc Care Community*. 2022;30:e2751–e8.
- Chatterjee HJ, Camic PM, Lockyer B, Thomson LJM. Non-clinical community interventions: a systematized review of social prescribing. *Perspect Public Health*. 2018;138(1):36–46.
- Tierney S, Wong G, Mahtani KR. Current understanding and implementation of social prescribing: a mixed-methods review. *BMJ Open*. 2020;10:e036344.
- Muhl C, Mulligan K, Bayoumi I, et al. Internationally accepted conceptual and operational definitions of social prescribing: a Delphi study. *BMJ Open*. 2023;13:e070184.
- Page MJ, McKenzie JE, Bossuyt PM, et al. The PRISMA 2020 statement: an updated guideline for reporting systematic reviews. *BMJ*. 2021;372:n71.
- Sterne JAC, Savović J, Page MJ, et al. RoB 2: a revised tool for assessing risk of bias in randomized trials. *BMJ*. 2019;366:4898.
- Wells GA, Shea B, O'Connell D, et al. The Newcastle–Ottawa Scale (NOS) for assessing the quality of non-randomized studies in meta-analyses. Ottawa: University of Ottawa.
- Grant C, Goodenough T, Harvey I, Hine C. A randomised controlled trial and economic evaluation of a referrals facilitator between primary care and the voluntary sector. *BMJ*. 2000;320:419–23.
- Faulkner M. Supporting the psychosocial needs of patients in general practice: the role of a voluntary referral service. *Patient Education and Counseling*. 2004;52(1):41–6.
- Grayer J, Cape J, Orpwood L, Leibowitz J, Buszewicz M. Facilitating access to voluntary and community services for patients with psychosocial problems: a before-after evaluation. *BMC Family Practice*. 2008;9:27.
- Brandling J, House W. Social prescribing in general practice: adding meaning to medicine. *British Journal of General Practice*. 2009;59(563):454–6.
- Heijnders ML, Meijs JJ. 'Welzijn op Recept' (Social Prescribing): a helping hand in re-establishing social contacts – an explorative qualitative study. *Primary Health Care Research & Development*. 2018;19(3):223–31.
- Vogelpoel N, Jarrold K. Social prescription and the role of participatory arts programmes for older people with sensory impairments. *Journal of Integrated Care*. 2014;22(2):39–50.
- Kimberlee R. What is social prescribing? *Advances in Social Sciences Research Journal*. 2015;2(1):102–10.
- Loftus AM, McCauley F, McCarron MO. Impact of social prescribing on general practice workload and polypharmacy. *Public Health*. 2017;148:96–101.
- Moffatt S, Steer M, Lawson S, Penn L, O'Brien N. Link Worker social prescribing to improve health and well-being for people with long-term conditions: qualitative study of service user perceptions. *BMJ Open*. 2017;7(7):e015203.
- Elston J, Gradingier F, Asthana S, Lilley-Woolnough C, Wroe S, Harman H, et al. Does a social prescribing 'holistic' link-worker for older people with complex, multimorbidity improve well-being and frailty and reduce health and social care use and costs? A 12-month before-and-after evaluation. *Primary Health Care Research & Development*. 2019;20:e135.
- Wildman JM, Moffatt S, Steer M, Laing K, Penn L, O'Brien N. Service-users' perspectives of link worker social prescribing: a qualitative follow-up study. *BMC Public Health*. 2019;19:98.
- Payne K, Walton E, Burton C. Steps to benefit from social prescription: a qualitative interview study. *British Journal of General Practice*. 2020;70(690):e36–e44.
- Howarth M, Lawler C, da Silva A. Creating a transformative space for change: a qualitative evaluation of the RHS Wellbeing Programme for people with long term conditions. *Health & Place*. 2021;71:102654.
- Munford LA, Panagioti M, Bower P, Skevington SM. Community asset participation and social medicine increases qualities of life. *Soc Sci Med*. 2020;259:113149.
- Pescheny JV, Gunn LH, Pappas Y, Randhawa G. The impact of the Luton social prescribing programme on mental well-being: a quantitative before-and-after study. *J Public Health (Oxf)*. 2021;43(1):e69–e76.
- Kiely B, Connolly D, Clyne B, Boland F, O'Donnell P, O'Shea E, et al. Primary care-based link workers providing social prescribing to improve health and social care outcomes for people with multimorbidity in socially deprived areas (the LinkMM trial): pilot study for a pragmatic randomised controlled trial. *Journal of Multimorbidity and Comorbidity*. 2021;11:26335565211017781.
- Chng NR, Hawkins K, Fitzpatrick B, O'Donnell CA, Mackenzie M, Wyke S, et al. Implementing social prescribing in primary care in areas of high socioeconomic

- deprivation: process evaluation of the 'Deep End' community Links Worker Programme. *Br J Gen Pract*. 2021;71(713):e912-e20.
32. Frostick C, Bertotti M. The frontline of social prescribing – how do we ensure Link Workers can work safely and effectively within primary care? *Chronic Illness*. 2021;17(4):404–15.
 33. Aggar C, Thomas T, Gordon C, Bloomfield J, Baker J. Social prescribing for individuals living with mental illness in an Australian community setting: a pilot study. *Community Mental Health Journal*. 2021;57(1):189–95.
 34. Clifford AM, Ni Bhriain O, Byrne S, Cheung PS, Louw Q, Glynn L, et al. Music and Movement for Health: protocol for a pragmatic cluster-randomised feasibility pilot trial of an arts-based programme for the health and wellbeing of older adults. *HRB Open Res*. 2022;5:42.
 35. Morse DF, Sandhu S, Mulligan K, Tierney S, Polley M, Chiva Giurca B, et al. Global developments in social prescribing. *BMJ Glob Health*. 2022;7(5):e008524.
 36. Wildman J, Wildman JM. Evaluation of a Community Health Worker Social Prescribing Program Among UK Patients With Type 2 Diabetes. *JAMA Network Open*. 2021;4(9):e2126236. doi: 10.1001/jamanetworkopen.2021.26236.
 37. Moffatt S, Wildman J, Pollard TM, Gibson K, Wildman JM, O'Brien N, et al. Impact of a social prescribing intervention in North East England on adults with type 2 diabetes: the SPRING_NE multimethod study. *Public Health Research*. 2023;11(2).
 38. Kiely B, Hobbins A, Boland F, Clyne B, Galvin E, Byers V, et al. An exploratory randomised trial investigating feasibility, potential impact and cost effectiveness of link workers for people living with multimorbidity attending general practices in deprived urban communities. *BMC Primary Care*. 2024;25:233.
 39. Dingle GA, Sharman LS, Hayes S, Haslam C, Cruwys T, Jetten J, et al. A controlled evaluation of social prescribing on loneliness for adults in Queensland: 8-week outcomes. *Front Psychol*. 2024;15:1359855.
 40. Tierney S, Westlake D, Wong G, Turk A, Markham S, Gorenberg J, et al. Experiences of integrating social prescribing link workers into primary care in England — bolting on, fitting in, or belonging: a realist evaluation. *Br J Gen Pract*. 2025;75(752):e195-e202.
 41. Wilding A, Agboraw E, Munford L, Sutton M, Mercer SW, Salisbury C, et al. Impact of the rollout of the national social prescribing link worker programme on population outcomes: evidence from a repeated cross-sectional survey. *Br J Gen Pract*. 2025;75(761):e880-e8.
 42. Dayson C, Bashir N. The social and economic impact of social prescribing. Sheffield Hallam University; 2014.
 43. Polley M, Bertotti M, Kimberlee R, et al. A review of the evidence assessing impact of social prescribing on healthcare demand and cost implications. University of Westminster; 2017.
 44. Wildman JM, Moffatt S, Steer M, et al. Service-users' perspectives of a social prescribing programme in primary care. *BMC Health Serv Res*. 2019;19:113.
 45. Drinkwater C, Wildman J, Moffatt S. Social prescribing. *BMJ*. 2019;364:1285.
 46. Pescheny JV, Randhawa G, Pappas Y. The impact of social prescribing services on service users: a systematic review. *Perspect Public Health*. 2020;140(6):309–24.
 47. Kimberlee R. What is social prescribing? *Adv Soc Sci Res J*. 2015;2(1):102–10.

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