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RESILIENCE THROUGH
NATURE-BASED THERAPIES

Prescribing nature

A practical guide to nature-based therapies for health and social care professionals

Project information

Project Number: 101081420

Project: RESONATE

Duration: 48 Months

Start date of Project: 01-06-2023

End date of the Project: 31-05-2027

Coordinator: University of Vienna

Deliverable: 4.1

Due date of deliverable: 31/08/2026

Actual submission date: 31/08/2026

Work package number: WP4

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Version: 1

The RESONATE project is funded by the European Union's Horizon Europe Research and Innovation programme under grant agreement No. 101081420 and co-funded by the UK Research and Innovation grant award No. 10063874.

Co-funded by
the European Union

UK Research
and Innovation

Acknowledgments
The authors wish to thank everyone who contributed to the development of this guide, from inception to completion. First, we would like to thank all the health and social care professionals in Europe and in Canada who agreed to be interviewed. Their input was key to producing this document and developing the recommendations. Second, to BC Parks Foundation in Canada, a big thank you to the PaRx team, Canada's national nature prescription programme, for their warm welcome in Canada, for teaching EuroHealthNet all about PaRx, and for their support during the interview process in Canada. Third, from the University of Vienna, we would like to thank Mathew White, RESONATE's Coordinator, Julia Egger, RESONATE's Project Manager, and Addi Wala, RESONATE's Organisational Assistant, for their continuous guidance and support throughout the whole project, and all RESONATE project partners for their generosity in sharing knowledge and all our exchanges over the project. In particular, we would like to thank Rebecca Lovell, from RESONATE project partner the University of Exeter, who reviewed this guide. Finally, from EuroHealthNet, to Caroline Costongs, Director, and Lina Papartyte, Project Coordinator, who reviewed the guide, and to Sanna Seddiki, EuroHealthNet's Research Intern, for her contribution to the literature review that informed the development of this guide.

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Suggested citation
EuroHealthNet (2026). Prescribing nature: A practical guide to nature-based therapies for health and social care professionals. Deliverable 4.1 RESONATE; https://resonate-horizon.eu/resources/deliverables/.

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Foreword

Nature is one of the oldest medicines we have, and one of the least prescribed. The evidence that time in green and blue spaces supports mental and physical health, strengthens social connection and builds resilience, is becoming substantial. What has been missing is a bridge between that evidence and the daily reality of health and social care practice. This guide is that bridge.

At EuroHealthNet, the European partnership for improving health, equity and wellbeing, we have long argued that the future of health lies in health promotion and prevention, not only in treatment. Nature-based therapies embody this shift. On top of this, they are low-cost, low-risk, and rooted in the communities where people live. When designed with inclusion in mind, they can help reduce health inequalities.

This guide does not ask you to become an expert in ecology or overhaul your practice. It meets you where you are, whether nature-based therapies are entirely new to you, or whether you are already prescribing and want to help change the system around you. It offers evidence, practical steps and real examples.

To general practitioners, nurses, link workers, social workers, pharmacists, physiotherapists, mental health providers and all other health and social care professionals who pick up this guide: you are trusted voices. A conversation in your consultation room can be a moment a person reconnects with the natural world, and through it, with their own health and with others. Few prescriptions can do so much, for so many, at so little cost.

I hope this guide gives you the confidence and practical means to make nature part of care. Our health, and the health of the planet we depend on, will be better for it.

Caroline Costongs,
Director, EuroHealthNet

Purpose of the guide

This guide aims to support the wider use of nature-based therapies (NbTs) in health and social care practice, to promote health and wellbeing. It offers practical guidance for professionals who want to start prescribing or referring people to NbTs, or who want to strengthen and scale up existing practice.

The guide is intended for professionals working in health and social care settings who are well placed to recommend, refer to or prescribe NbTs. This may include, but is not limited to: general practitioners, link workers, nurses, mental health clinicians, specialists, social workers, pharmacists, and physiotherapists. Throughout the guide, we use the term "prescriber" broadly to include all of these roles. The guide is designed to be useful whether the idea of nature-based social prescribing is new to you or already part of your practice.

The guide is grounded in the realities of practice. EuroHealthNet interviewed health and social care professionals across Europe and Canada to understand what helps and hinders the uptake of NbTs, including the barriers prescribers face, what makes prescribing easier, and what support they need. These findings were combined with wider RESONATE project resources, such as a review of grey and peer-reviewed literature exploring the same research question. Findings from research led by EuroHealthNet also focused on the health equity impacts of NbTs. For more information on how this guide was developed, please consult Annex 7.2 Methodology.

The guide was developed by EuroHealthNet, a European partnership of public health organisations working on health promotion, disease prevention and health equity. EuroHealthNet was supported by the RESONATE Coordinator, the University of Vienna, and drew on knowledge from across project partners.

This guide is part of the RESONATE toolbox. The RESONATE project (Building individual and community resilience through nature-based therapies) brings together experts in nature-based therapies (NbTs) to demonstrate nature's biopsychosocial, resilience-building capacities, and to show how locally acceptable and inclusive NbTs can be implemented to help build healthier and more resilient individuals and communities.

In case you are reading this guide as a paper copy, all hyperlinks are active in the online version, which can be found here: https://resonate-horizon.eu/resources/deliverables/

How to use this guide

This guide is designed for readers with different levels of familiarity and experience with nature-based therapies (NbTs). You do not need to read it from beginning to end. Start with the part that best matches where you are now and move between sections as your needs change.

The guide is organised around four starting points:

1

"I am not familiar with nature-based therapies"

Start here if the concept is new to you. This part explains what NbTs are, how they work, and what they can look like in practice.

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2

"I have heard of nature-based therapies but would want to know more before considering them"

Start here if you have heard of NbTs but are unsure whether they are useful or relevant to your work. This part summarises the evidence and its implications for practice.

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3

"I am interested in nature-based therapies but unsure how to prescribe them"

Start here if you believe there is potential value in NbTs but are unsure how to act. This is the practical core of the guide. It offers a step-by-step approach to prescribing or referring, supported by tools, examples and case studies.

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4

"I am already prescribing nature-based therapies, but I want to do more"

Start here if NbTs are already part of your practice and you want to strengthen or expand your use of them. This part focuses on the wider conditions that support implementation, including funding, infrastructure, partnerships and advocacy.

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This structure reflects the fact that professionals, like patients, adopt new practices gradually. It is informed by the Transtheoretical Model of Behaviour Change, which describes a general movement from awareness, to consideration, to action, and finally (hopefully) to sustaining and expanding a new behaviour (1). The guide is therefore designed to meet you at your current stage and support your next step.

The authors recognise that professionals are faced with high workloads and competing priorities, making it challenging to take on additional responsibilities or tasks. This guide does not intend to place additional burden or expectations on anyone, but rather to provide recommendations and resources that could facilitate prescribers' work, improve the systemic conditions for prescribing and increase NbT uptake. You are welcome to read and act upon the sections that you find most appropriate and that align to your professional objectives, interests and capacities.

Glossary

Nature-based therapies (NbTs): Within the RESONATE project, a consensus exercise among partners agreed the following definition: "Planned therapeutic techniques performed in natural settings and based on nature–human active participation and connection." (2). For the present guide, we expand on this slightly to also include unplanned, more generic activities and have a working definition of "Nature-based activities that aim to improve a person's mental health and physical health through a nature-based experience (adapted from Shanahan et al. (2019)(3)). This terminology is explored in more detail in Annex 7.1.

Social prescribing: A means for trusted individuals in clinical and community settings to identify that a person has medical, non- medical, health-related social needs and to subsequently connect them to non- clinical supports and services within the community by co-producing a social prescription—a non-medical prescription to improve health and wellbeing and to strengthen community connections. Working definition slightly adapted from Muhl et al. (2023) (4), to also include in the present guide the use of social prescribing for medical needs, understood as complementary to existing treatment.

Nature-based social prescribing: A specific aspect of social prescribing, connecting people with nature-based therapies and experiences. Working definition adapted for this research (5–8).

NbT uptake: Uptake refers to the "intention, initial decision, or action to try to employ a new intervention"(9). In this guide, uptake refers to the act of using, adopting, recommending, referring to, or prescribing NbTs to potential end users or patients.

Prescribers: Health and social care professionals working in local agencies such as health and social care facilities, or in community-based organisations, including but not limited to general practitioners, health specialists, nurses, mental health clinicians, social workers, and link workers. These are professionals who would most likely prescribe, use or recommend NbTs to patients.

NbT provider: Organisation or entity that offers and delivers nature-based therapies.

End users: Individuals or patients who are referred by a health or social care professional to a nature-based therapy. The terms "end users," "persons," and "patients" are used interchangeably in this guide.

Table of contents

I am not familiar with nature-based therapies

1.1 What are nature-based therapies?

In the present guide, nature-based therapies (NbTs) are understood as nature-based activities which aim to improve a person's mental health and physical health through a nature-based experience (3). They are sometimes referred to as nature-based interventions, green care, or nature on prescription . These therapies tend to adopt a holistic and personalised approach and offer potential for preventive care and health promotion, and in some cases, opportunities for community engagement in local activities. They should be understood as a complement to established care.

1.2 What types of nature-based therapies exist?

NbTs are highly diverse. They can vary in:

- the types of activities;
- the level of activity they engage in, depending on the level of participants' physical, behavioural or cognitive engagement with the NbT;
- nature's focus, meaning whether nature is the central therapeutic agent or has a supportive or contextual role (primary versus secondary focus).

The diversity of NbTs enables prescribers and end users to co-develop personalised care plans based on an individual's health conditions and interests. NbTs can be offered in the community as a guided activity, done collectively in groups, such as horticultural therapy or hiking clubs. Other NbTs are self-guided and can be done independently, such as gardening at home or going for a run or walk in nature. A non-exclusive list of NbTs is included in Table 1 (10,11):

Horticultural therapy Gardening and plant care
Nature viewing In outdoor or indoor settings. Sitting or walking slowly while observing nature
Green exercise Walking, running, tai chi, or other intentional movement in nature
Blue exercise Activities conducted in blue spaces with the potential to promote human health and wellbeing, such as open water swimming, surfing, or sailing
Wilderness or adventure therapy A form of more complex, longer-term outdoor activities such as hiking, trekking or camping. This NbT is often characterised by involving a certain form of risk or challenge to overcome in nature
Forest bathing, also called shinrin-yoku Involving a conscious and mindful approach to a forest immersion through all five senses
Care farming Use of farms and agricultural landscapes for promoting mental health and physical health through regular farming activities
Nature play Unstructured nature-based interventions for children, allowing them to play in settings with natural elements such as gardens, forests, ponds, water, plants, rocks or mud
Environmental volunteerism Tidying trails, soil preparation, tree planting or recycling

Table 1: **Types of Nature-based therapies**

1.3 How do nature-based therapies contribute to health and wellbeing?

Research shows that spending time in nature is good for both physical and mental health; the evidence is detailed in Section 2.2. This section looks at how those benefits come about. NbTs work through several distinct pathways, and most interventions draw on more than one at the same time:

1. **Reducing stress.** Stress Reduction Theory proposes that nature contact triggers a rapid, largely automatic response that shifts the body out of heightened arousal and activates the parasympathetic nervous system: the "rest and digest" counterpart to the stress response. This is reflected in outcomes such as lower cortisol, heart rate and blood pressure (12).

2. **Restoring attention.** Attention Restoration Theory suggests that the constant concentration, planning, and filtering of distractions required in everyday life draw on a limited pool of directed attention that becomes depleted with overuse and can leave people mentally fatigued. Natural stimuli, such as moving water or swaying trees, hold attention effortlessly ("soft fascination"), helping to restore this depleted capacity (13).

3. **Building capacity for healthier habits**. This pathway holds that nature contact creates opportunities for physical activity and active commuting, social interaction, creativity, growing self-esteem and confidence. Over time, they also support behaviour change by helping people feel capable, set goals, and develop routines they can maintain. These shifts in behaviour may account for much of the cardiovascular and metabolic benefit observed in the evidence (14,15).

4. **Strengthening immune and biological health.** Contact with biodiverse environments, including exposure to compounds released by plants (phytoncides), supports immune and biological function: it can lower stress hormones, help maintain a healthy gut microbiome, reduce markers of inflammation, and increase the activity of natural killer cells, part of the body's immune defence (14,15).

5. **Reducing harmful environmental exposures.** At the population level, green and blue spaces also protect health by buffering people from environmental stressors such as air pollution, noise and urban heat (14,15).

RESONATE's own theoretical contribution, nature-based biopsychosocial resilience theory (NBRT), brings these pathways together into a single framework. Its central argument is that nature helps people build and maintain resilience resources, and that resources can be drawn on to stay well and to cope when life is difficult (16).

NBRT describes three kinds of resilience resource that nature contact helps build and maintain: biological resources (such as a stronger immune system and better cardiovascular health), psychological resources (such as enhanced emotion regulation skills and better working memory), and social resources (such as stronger social interpersonal relations and community cohesion). A person can draw on these resources at three phases: before a difficult event, to lower the risk of harm in the first place (preventive resilience); during it, to limit its immediate impact (response resilience); and afterwards, to recover more fully (recovery resilience) (16).

For a prescriber, this may reframe the purpose of a nature prescription. Rather than treating a single symptom in isolation, it helps build a person's overall reserves – biological, psychological and social – that they can draw on before, during and after the kinds of pressures that drive so much of the chronic-disease and mental-health burden seen in primary care.

1.4 Who can nature-based therapies be beneficial for?

NbTs can be beneficial for (represented in Figure 1):

- Healthy individuals, as a form of health promotion (primary prevention);
- Individuals at-risk of developing a health condition who use NbTs to prevent the development of such a condition (secondary prevention); or
- Individuals with existing conditions who use NbTs to complement existing health treatments

to manage symptoms and reduce potential complications or worsening of condition (tertiary prevention).

Section 2.2 provides more details on the clinical evidence of NbTs' effectiveness for physical and psychosocial and mental health and its implications for practice with an indication on how to use NbT prescriptions for, for example, chronic diseases, social isolation or sleep disorders.

For more information and reflections on how nature-based therapies can support population groups at risk in terms of health equity, please consult the parallel RESONATE "**Guide to ensuring health equity in nature-based therapies**" (available in December 2026 on the RESONATE website).

1.5 Who can prescribe nature-based therapies, and what does a prescription consist of?

Prescribers working in health and social care facilities, in some cases also in community-based organisations, can prescribe NbTs. This may include, but is not limited to general practitioners, link workers, nurses, mental health clinicians, specialists, social workers, pharmacists, and physiotherapists.

An NbT prescription is a formal recommendation given by a prescriber, in an oral or written way, that supports individuals to engage in NbTs to improve their mental and physical health, often as part of a personalised care plan.

It is worth noting that individuals do not necessarily need to receive a formal prescription to benefit from an NbT. They can access NbTs through self-referrals (see more in Section 1.6).

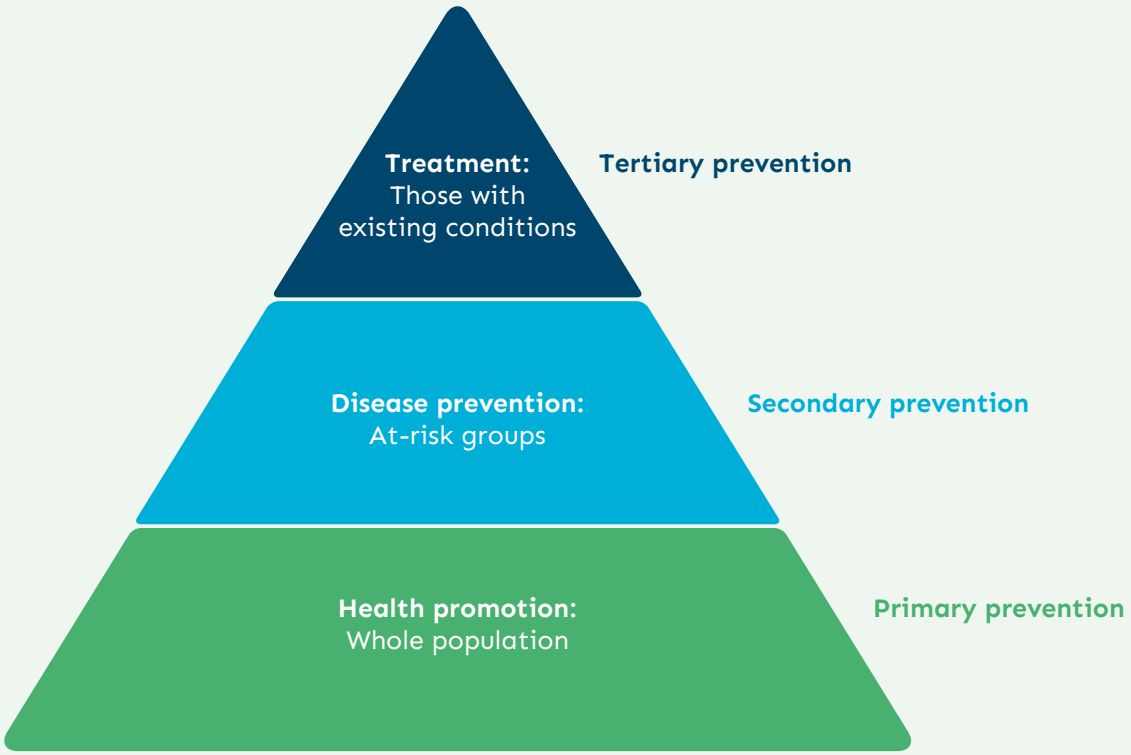


Figure 1. **Levels at which NbT prescriptions can be applied**

Social prescribing as a supporting framework for NbT prescription

What is social prescribing?
Social prescribing offers a holistic and integrated approach to health, allowing prescribers to connect patients to a range of non-clinical services or resources at a community level to improve health and wellbeing, through integrated and personalised support care plans (17).

Social prescribing is an any-age, whole population approach that might work particularly well for people who: have one or more long-term conditions, need support with mental health issues, are lonely or isolated, or have complex social needs which affect their wellbeing (18). It builds on the evidence that addressing social determinants of health (the conditions in which people are born, grow, work, live, and age, that significantly influence health) is key to improving health outcomes (17). This is why social prescribing schemes not only point individuals to nature-based, arts and culture-based, or physical activities to improve their health and wellbeing, but also to statutory services like debt counselling or housing services (18).

How is this connected to NbTs?
The prescription of NbTs generally fall under social prescribing schemes, which put in place the mechanisms in health and social care systems for linking individuals to non-medical community resources, like NbTs, through multiple referral pathways, as explained in the next section. Specifically, the mechanism of referring individuals to local NbTs is called 'nature-based social prescribing' (NBSP). This is the terminology used in this document. It has also been referred to as 'green social prescribing', though this fails to recognise the potential of blue spaces.

1.6 How does nature-based social prescribing work in practice?

There is no one-size-fits-all approach to social prescribing and NBSP. Social prescribing schemes, under which NBSP operates, link individuals to NbT providers through multiple referral pathways, as shown in Figure 2 and explained more in detail in Section 3.4 'Step 4: Choose the right prescription route'.

Prescribers in health and social care facilities can refer patients directly to an NbT at a community level or to an intermediary figure, who will then refer the patient to an NbT. In some social prescribing schemes, intermediary figures exist in the referral pathway, sometimes called link workers or community connectors. They receive patients referred by professionals working in health and social care facilities and support patients by spending time with them and gaining a deeper understanding of what matters to them. In this process, they co-produce an integrated and personalised care plan that could include, among other things, referrals to local NbTs. In addition, in some schemes individuals can also self-refer themselves to link workers or to NbT providers directly.

Although the principles of social prescribing are the same across countries, in practice, the manner and level of implementation is very heterogeneous (19). It can take various forms, in terms of policy frameworks defining the functioning of these schemes, funding resources allocated for the provision and sustainment of such schemes, the scale of implementation (national, regional, pilot), referral pathways, and target populations (whole population, at-risk groups and/or patients with specific health conditions).

It is worth noting that the term 'social prescribing' can be labelled differently in different countries. For example, in Slovenia the term 'community health approach' is used instead and, thus, roles and pathways may have different terminologies attached across Europe.

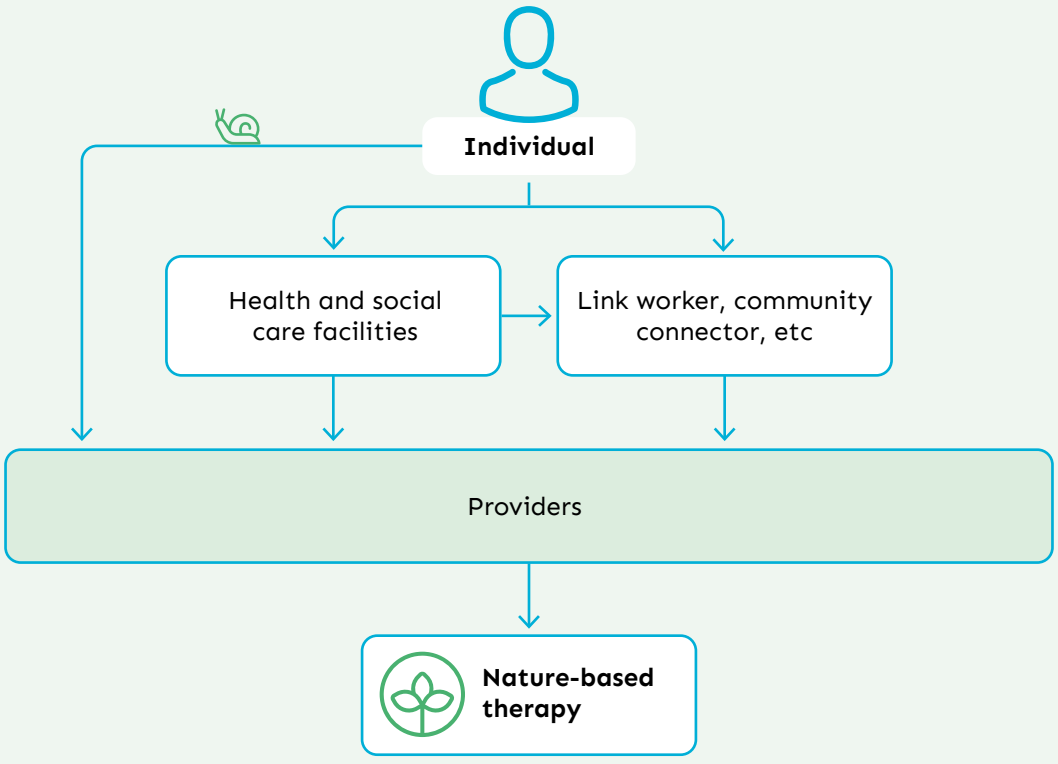


Figure 2. **Social prescribing referral pathways for individuals to NbTs**

I have heard of nature-based therapies but would want to know more before considering them

This section presents the evidence on nature-based therapies (NbTs) that is most relevant to prescribing in practice: how NbTs can support health and wellbeing, where the evidence is strongest, and where caution is needed. It is organised in three parts:

- 2.1 What professionals and patients think about prescribing NbTs;
- 2.2 Clinical evidence organised by health conditions;
- 2.3 Evidence on cost-effectiveness.

How to use this section

If you already understand what NbTs are and need the clinical evidence to support specific referral decisions, go directly to **Section 2.2: The clinical evidence**. If you are uncertain whether your patients would engage or whether colleagues would take this seriously, start with **Section 2.1: Where professionals and patients stand**. If you are looking for evidence on cost-effectiveness, go to **Section 2.3**.

2.1 Where professionals and patients stand

A common assumption that emerged from the interviews informing this guide (see Section 7.2 Annex II: Methodology for more details) is that prescribing NbTs may involve the need to inform some of the more sceptical professionals and a subset of patients who are reluctant about potential benefits. However, recent surveys found that the majority of both professionals and patients are broadly open to the idea of NbTs, and that the main barriers are practical rather than attitudinal: knowing what is available locally, how to refer, how to manage risk, and how to make activities accessible.

2.1.1 Professionals' perceptions and attitudes

Similar results were found in a 2023 national survey of Scottish general practitioners (GPs, i.e. family doctors), indicating strong openness to NBSP: 81.3% of Ps said they would be happy to refer patients to NBTs (20). In a large survey conducted in 2022 in England, 94% of clinicians felt favourable towards NBSP, and 87% saw value in using it alongside medication and therapy (21).

Belief in NbTs' effectiveness on improving health outcomes is not what is stopping prescribers from recommending them: only 3% of clinicians in the English survey thought NBSP was ineffective. The more common obstacles were not knowing how to refer, not realising referral was possible, and not knowing what was available locally (21).

2.1.2 Patients' perceptions and attitudes

In the same survey from England, 87% of patients said they would be likely to spend time in nature to support their mental health, and 59% said that a recommendation from a professional or link worker would make them more likely to do so. Of those actually referred to NbTs, 78% took part (21). Further, analysis of nature-based recreation data from over 67,000 adults in England found that around 6.7% stated that a recommendation from a doctor or other health professional was a key reason for their most recent nature visit or time spent in a garden. Scaled up to the whole population, this would represent around 3 million people acting on nature prescriptions a year (22). Combined, these results indicate that a simple recommendation from a trusted professional could in itself be an effective intervention.

What we did in RESONATE

A RESONATE survey of European stakeholders across various sectors (healthcare, social care, education, nature conservation, forestry and silviculture (controlling the establishment, growth, composition, and health of forests and woodlands), fisheries, agriculture and farming, tourism and recreation, green space management, policy making, administration, land planning, and rural development) from Italy, Spain, Austria, Germany, and the Netherlands, conducted in 2025, found high levels of awareness and acceptability of NbTs. Most respondents strongly favoured integrating NbTs into health, social care, and education. 85% said they would likely take up a referral themselves if a trusted healthcare professional suggested it. Respondents pointed to lower cost, easier access, and professional endorsement as the main enablers (18).

The above evidence, however, should be read with care: RESONATE's survey reached many professionals already working in or around nature, so they likely overstate baseline openness, while the other evidence is drawn largely from the UK, where social prescribing is well established. The consistency between these surveys is nonetheless encouraging, and suggests that where NbTs meet hesitancy, the obstacle is more often infrastructure than conviction.

2.2 The clinical evidence of effectiveness on health outcomes

The overall picture is still emerging, but broadly positive. A 2022 scoping review of 39 studies found improvements in 92% of health outcomes among people who engaged with natural outdoor environments. Mental health was the most studied outcome (62% of studies) and improved in 98% of cases; physical and cognitive outcomes improved in 83% and 75% of studies, respectively (23). The evidence is therefore weighted toward mental health, with physical and cognitive outcomes less studied but still favourable.

A few caveats apply throughout. Studies define "nature" and measure exposure inconsistently, using different thresholds for dose and duration, which limits how directly their findings can be compared. They also differ in design: many are cross-sectional, capturing a single point in time, while fewer are longitudinal, following the same people over a period and offering stronger evidence of cause and effect. Much of the evidence, therefore, establishes an association without reliably quantifying its direction or magnitude. For instance, a positive association between mental health and time in nature may be due to happier people visiting nature more. Although possible, an 18-country study found that people taking depression medication visited nature just as often as those not on mental health medication, and those taking anxiety medication visited nature significantly more (24). In other words, the reverse causal pathway is not particularly well supported. Participants also generally know whether or not they are spending time in nature, posing challenges for experimental research and trials. Studies cannot be blinded in the way a pharmacological trial can, where people can be kept unaware of whether they are receiving the treatment. This makes it harder to separate nature's effects from the influence of expectation. The direction of effect is nonetheless consistent and encouraging across studies. The specific figures cited below should be read as indicative rather than exact.

The evidence that follows is drawn from reviews and meta-analyses published between 2020 and 2026, organised into two domains: 1) physical health, including cardiovascular disease and hypertension, cancer, metabolic health and physical activity, fatigue, pain, and neurological conditions and 2) psychosocial and mental health, including depression and negative affect, anxiety and stress-related conditions, sleep disorders, loneliness and social isolation. The conditions covered are those most commonly appearing in the literature; the list is not exhaustive. The evidence is accompanied by information on implications for your practice. It is worth noting that NbTs are understood as complements rather than as alternatives to established care practices.

2.2.1 Physical health

Cardiovascular disease and hypertension

Recent meta-analyses indicate that NbTs can lower blood pressure and heart rate in both clinical and general populations, though the effect on systolic blood pressure is inconsistent across studies. Table 2 below provides further information on effect sizes for systolic blood pressure, diastolic blood pressure, and heart rate across these studies (25–27).

> **What this means for practice**
> NbTs may be particularly relevant for patients with elevated blood pressure, hypertension or cardiovascular risk factors. NbTs should not replace cardiovascular medication, monitoring or rehabilitation where these are needed, but can sit within a broader lifestyle and self-management plan.

Cancer

The evidence for cancer survivors is small but promising. A 2023 scoping review of 12 studies (2,786 survivors, spanning breast, prostate, colorectal and haematological cancers) examined gardening, forest bathing, nature walks and outdoor recreation. Across studies, NbTs were associated with reduced stress, anxiety, depression, fatigue and pain, and with better sleep, quality of life and wellbeing; cancer survivors described nature as a source of coping and restoration during and after treatment (28).

A separate 2022 review reported gains in health behaviours and physical functioning among cancer survivors, including fruit and vegetable intake, activity, strength, and endurance (29).

> **What this means for practice**
> NbTs may help cancer survivors experiencing fatigue, anxiety, low mood, social isolation, sleep difficulty or reduced quality of life, especially when adapted to the person's energy levels and stage of recovery.
> Current studies do not show that NbTs affect cancer recurrence, progression or survival.
> Benefits are understood as supportive care, not cancer treatment.

Metabolic health and physical activity

Much of the physical health benefit of NbTs comes from encouraging people to move more, whether through structured activity (a walking group, an outdoor exercise session) or incidental movement (walking to a park, gardening, joining a conservation activity, or simply spending more time outdoors).

A 2023 meta-analysis found that NbTs significantly increased daily step count by around 900 steps per day but did not significantly increase weekly time spent in moderate-intensity physical activity. Effects on daily step count were strongest in the studies where a health or social professional had referred people into the programme (26).

Gardening also helps raise physical activity alongside other psychosocial gains. Gardening

Review	Population	Systolic BP	Diastolic BP	Heart rate
Struthers 2024	Clinical (physical conditions)	non-significant	−3.73 mmHg (−7.46, −0.00)	−7.44 bpm (−14.81, −0.06)
Nguyen 2023	Heterogeneous	−4.82 mmHg (−8.92, −0.72)	−3.82 mmHg (−6.47, −1.16)	Not reported
Bao 2026	General population	−5.14 mmHg (9.44, -0.84)	−2.48 mmHg (−4.68, −0.29)	−2.34 bpm (-3.72, -0.97)

Table 2: **Evidence summary on nature-based therapies' effect on cardiovascular health**

Figures are the mean difference (MD) versus control, with 95% confidence intervals. BP = Blood Pressure; RCT= Randomised Controlled Trial.

may be particularly useful because it can make movement purposeful, flexible and embedded in daily life, rather than framed as "exercise" (30).

Evidence on body composition is more mixed. A 2024 meta-analysis found a significant reduction in body-fat percentage among people with endocrine conditions (MD −3.61%, 95% CI −5.05 to −2.17); other measures, including body mass index, waist circumference, cholesterol and fitness, generally moved in a favourable direction without consistently reaching statistical significance (27).

> **What this means for practice**
> NbTs may be most useful for patients who would benefit from gentle increases in activity, have low confidence in exercise, or find conventional physical activity settings and weight-focused programmes unappealing.
> The aim is not necessarily to prescribe "exercise" in a formal sense, but to help the person find a way of moving that feels acceptable, enjoyable and repeatable.

Fatigue, pain and neurological conditions

Here, the evidence is promising but limited. A 2024 review on nature-based mindfulness for persistent pain, including fibromyalgia, identified only three studies with 266 participants in total, but found significant improvements in pain and depression compared with control groups (31). A larger 2026 meta-analysis of 62 studies conducted in collaboration with the RESONATE team found that exposure to nature was associated with a small-to-moderate reduction in pain (SMD = 0.53). The studies covered a wide range of contexts, from experimentally induced pain to pain associated with minor to major medical procedures (32).

For fatigue in fibromyalgia and multiple sclerosis, a 2024 meta-analysis found a moderate, consistent reduction (SMD −0.50, 95% CI −0.82 to −0.18) (27). One further study reported reduced fatigue and reduced levels of anxiety and depression in people with neurodegenerative conditions, including Parkinson's, but the findings remain preliminary (33).

> **What this means for practice**
> NbTs are worth considering for people living with chronic pain, fatigue or neurological conditions when the aim is to support gentle activity, relaxation, coping, confidence or social connection.

2.2.2 Psychosocial and mental health

The evidence is strongest and most consistent for psychosocial and mental health. This partly reflects that mental health has been studied far more than most other outcomes, so a stronger evidence base here does not necessarily mean NbTs work best for mental health. It means we know most about that.

Natural environments can reduce stress and physiological arousal, support recovery from mental fatigue, and create space for reflection and emotion regulation. Many NbTs also carry other helpful ingredients, such as gentle movement, routine, meaningful activity, social contact and time away from stressful settings (14).

Benefits are reported for depression, anxiety, stress, rumination, mood, quality of life, and sleep quality across the general adult population (25,26,34,35), people with mild-to-moderate mental health conditions (36), and people living with long-term physical illnesses such as cardiovascular disease, hypertension, chronic obstructive pulmonary disease, stroke, and cancer (28,34,37).

Depression and negative affect

Literature strongly shows NbTs' contribution in reducing depressive symptoms. The improvement is moderate in heterogeneous adult populations (26) and large in people with a diagnosed mild to moderate mental health condition (36). Reviews also report parallel gains in mood, more positive and fewer negative emotions (25,34).

Anxiety, stress and stress-related illness

Literature strongly shows NbTs' contribution in reducing stress-related symptoms. The improvement is moderate in a heterogeneous population (26,34) and large in people with a diagnosed mild to moderate mental health condition (36). Individual studies vary more in how big an effect they find, but every review points to a favourable direction (26,34,36).

NbTs also support people with stress-related illnesses, including burnout, exhaustion and adjustment disorders. Garden- and forest-based programmes in particular have been shown to help with stress, burnout, low mood, wellbeing, self-confidence and return to work (38).

Review	Population	Depression	Anxiety	Other
Coventry 2021	Heterogenous adults	SMD −0.64 (−1.05 to −0.23)	SMD −0.94 (−0.94 to −0.01)	Negative affect -0.52 (0.77 to -0.26)
Nguyen 2023	Heterogenous	SMD −0.50 (−0.84 to −0.16)	SMD −0.57 (−1.12 to −0.03)	
Jessen 2025	Diagnosed with mild to moderate anxiety/ depression /stress	SMC −0.87 (−1.18 to −0.56)	SMC −0.80 (−1.56 to −0.04)	Overall mental health SMC +0.58 (0.39 to 0.77)
Bao 2026	General population	Not reported	Not reported	Negative affect -4.09 (-5.94, -2.24), WHO-5 Well-Being Index + 0.68 (0.45, 0.90)

Table 3: **Evidence summary on nature-based therapies' effect on mental health**

SMD = standardised mean difference; SMC = standardised mean change with 95% confidence intervals. RCT = Randomised Controlled Trial

Sleep disorders

A 2026 meta-analysis of 13 randomised controlled trials (886 adults) found that NbTs consistently improved sleep quality compared with conventional care. Effects across the significant intervention types ranged from moderate to large (SMD −0.49 to −1.02), and differences between modalities were generally modest. The authors conclude that the benefit comes from time spent in nature rather than from any particular activity (35).

Pooled effect sizes from studies containing quantitative data are presented in Table 3.

> **What this means for practice**
> Consider NbTs for patients with mild-moderate depression, negative affect, anxiety or stress-related illness (e.g. burnout). The evidence here is the most consistent in this guide, holding across the general population, people with diagnosed mild-to-moderate mental health conditions, and people with long-term physical illness. That breadth makes NbTs a reasonable option to consider, as a complement to established treatment.

Specific populations

Long-term conditions. People living with long-term physical conditions carry a disproportionate mental health burden. They often experience a co-occurring mental health condition or poorer psychological wellbeing than those without a long-term condition, which in turn drives higher rates of general practitioner visits and unplanned admissions. Yet psychosocial care is rarely a routine part of condition management, which makes a low-intensity, acceptable option worth having.

A systematic review of NbTs in people with long-term conditions, including hypertension and high-normal blood pressure, chronic heart failure, chronic obstructive pulmonary disease, stroke and cardiac rehabilitation, reported across all 13 included studies a positive effect on psychological wellbeing: reduced tension and anxiety, lower depression and anger, less fatigue and confusion, improved vigour, and gains in quality of life. Several studies also recorded physiological changes in a positive direction, including lower blood pressure, reduced heart rate, increased parasympathetic activity and reduced stress-hormone secretion, which suggests the psychological benefit and the relaxation response move together (37).

For **cancer survivors**, the evidence shows reduced anxiety, depression, stress and fatigue, with nature described as a coping resource through diagnosis and treatment (28).

Loneliness and social isolation. NBSP may be particularly valuable for people experiencing loneliness or social isolation. The evidence suggests that structured group activities in nature can help reduce loneliness and build social connectedness, especially among older adults living alone, people in deprived areas, and people with mental health conditions. Specifically, group-based activities can create a sense of belonging, routine and shared purpose (39).

Children and young people. Evidence here is limited. A 2024 meta-review found that nature is beneficial for mental health, emotional wellbeing, attention, cognitive development, and stress across green school environments, outdoor learning, nature play, and structured outdoor activity, with the strongest evidence in general non-clinical populations. Among clinical conditions, Attention Deficit Hyperactivity Disorder (ADHD) has had more attention than most conditions probably due to the popularity of attention restoration theory (See Section 1.2 for more explanation). However, most studies were conducted in non-clinical populations, so they support the idea that nature is broadly helpful for attention and hyperactivity symptoms, rather than serving as an established ADHD treatment. Evidence for other diagnoses is still thin; the review found no studies at all in children or adolescents with autism spectrum disorder, eating disorders, bipolar affective disorder or psychosis (40). Therefore, promoting NBSP as a stand-alone treatment for children would be premature; it should complement, not replace, standard care.

Older adults. NbTs may support several aspects of healthy ageing. A 2025 systematic review of 84 studies reported benefits for psychological wellbeing (mood, depression, anxiety, self-esteem, perceived isolation), physical indicators (blood pressure, heart rate, cortisol, balance, mobility, activities of daily living), and cognitive and social outcomes (memory, attention, reduced loneliness, stronger relationships, belonging) (41). However, most of this evidence comes from relatively healthy, community-dwelling older adults. Less is known about people with multimorbidity, dementia, frailty, or complex needs, so activities should be carefully adapted to the person's abilities, preferences, and support needs.

2.3 Evidence of cost-effectiveness

For many, especially commissioners and budget holders, the case for NBSP depends not only on whether it improves health and wellbeing, but also on whether it offers good value for money and helps reduce pressure elsewhere in the system. The economic evidence is still developing and much of it remains limited to UK-based findings (although see summary of RESONATE's results in Austria, Italy, Spain and Sweden on the next page), but the available studies point to positive outcomes, especially regarding social value and potential cost savings.

A recent nationwide analysis of general social prescribing in the UK estimated that every £1 invested in social prescribing returned around £9 in wellbeing benefits. This was based on a 1.57-point improvement in reported life satisfaction, valued at £4,252 per person over an average period of 2.5 months * (42). This is not specific to NBSP, but it gives a useful indication of the potential scale of return from social prescribing more broadly.

Nature-specific evaluations also suggest favourable returns. A systematic review of economic studies on NBSP found five UK-based evaluations, all reporting positive health and economic findings. Three used social return on investment methods and reported between £2.60 and £5.10 in social value for every £1 invested †. One cost-benefit study estimated returns of £6,000 to £14,000 per person after one year, rising to £8,600 to £24,500 over ten years ‡. One cost-utility analysis § estimated a cost of £8,600 per quality-adjusted life year gained, which is below the £30,000 threshold commonly used in the UK and would therefore be considered cost-effective under NICE criteria ** (43).

The clearest savings appear when nature-based prescriptions reduce the need for more expensive care. A review of NbTs for long-term conditions identified eleven studies reporting cost savings; all but one (a small study) found that NbTs reduced costs relative to usual care. Examples included a surf-therapy intervention costing around £215 less per person than standard mental health care and a community rehabilitation programme linked to reductions of around 88% in inpatient admissions and 90% in inpatient days in the following year (44).

What we did in RESONATE

We conducted four randomised controlled trials to explore the potential benefits for health-related quality of life (HRQoL) of taking part in a 5-week nature-based mindfulness programme compared with wait-list controls. Full details are provided in our "Guidance on assessing the Economic Value of Nature-based Therapies" guide (available here in December 2026). In summary, all four interventions were both cost-effective in terms of utility values for Quality Adjusted Life Years (QALYs) and had a positive cost-benefit ratio once delivery costs were accounted for (45).

* This was reported using a "wellbeing valuation" approach: they measure a change in self-reported life satisfaction, then convert that change into a monetary figure using a UK Treasury-recommended method that estimates how much income would be needed to produce an equivalent improvement in reported life satisfaction. The resulting figure is an estimate of the wellbeing value generated, expressed in monetary terms so it can be compared against the cost of delivering the programme.

† Social return on investment (SROI) is a method that expresses the wider social, environmental and economic value generated by a programme as a ratio to the money invested in it. In these NBSP studies, "social value" was calculated by monetising outcomes such as improved mental wellbeing, increased physical activity, greater self-efficacy or confidence, and stronger social connection or trust, using standardised valuation tools, then adjusting the total downward for the share of benefit that would likely have occurred anyway

‡ Cost-benefit analysis converts both the costs and the outcomes of a programme into monetary terms, allowing a direct financial comparison between what is spent and what is gained. In this study, the estimated returns combined the monetised value of improved life satisfaction and happiness with reduced public health service costs and costs linked to loneliness, set against programme costs of £320–£1,400 per person

§ Cost-utility analysis is a form of economic evaluation that weighs the cost of an intervention against the health gains it produces, measured in both length and quality of life.

** NICE (the National Institute for Health and Care Excellence) is the UK body responsible for assessing whether health interventions represent good value for the public health system. It commonly uses a threshold of £20,000–£30,000 per QALY gained as a benchmark for cost-effectiveness.

I am interested in nature-based therapies, but unsure how to prescribe them

Prescribing nature-based therapies – also known as nature-based social prescribing (NBSP) – is best understood as a pathway, rather than a single action.

Depending on the local system, NBSP can look quite different from one place to another. In some systems, the same health or social care professional stays with the person from the first conversation through to a co-created prescription. In others, that professional's role is only to open the conversation and make the referral into the social prescribing system; a different professional, such as a link worker, social prescribing professional, social worker, occupational therapist or community connector, then takes over to explore the person's needs in more depth and co-create the actual prescription.

This section sets out the two most common ways that NBSP works, as well as other routes a referral can take. It is therefore written for health and social care professionals who may play different roles in the prescribing pathway. Some may identify people who could benefit from nature-based therapies (NbTs) and make a referral. Others may assess needs, support motivation, address barriers and help choose an activity. Some may also deliver NbTs themselves as part of their therapeutic, rehabilitation, mental health or social care role.

The authors of this guide recognise the pressures professionals are working under, particularly in primary care, where workloads are already high, demand continues to grow and consultation time is limited. The steps below are set out in full to show what good practice can involve, but they do not need to happen all at once or be carried out by one person.

How to use this section

This section is for prescribers who see the potential value of NbTs but are looking for further guidance on applying it in their own practice. It walks you through nine steps, from understanding your local system to following up with a patient. Not every prescriber does every step themselves: depending on your role and where you sit in the referral pathway, you may lead the whole process or focus only on the steps that fall to you. We recommend reading through all nine steps once to see the full pathway, even if you are not involved in all of them. The nine steps described in this section are the following:

Key principles of Nature-Based Social Prescribing

The following principles, adapted from the National Academy of Social Prescribing's Green Social Prescribing Toolkit (46) and the Alliance for Healthier Communities' Social Prescribing Guidebook (47), should guide the planning and delivery of NBSP.

- **Person-centred:** Start with understanding what matters to the person. NBSP should give people choice and control, rather than offering a one-size-fits-all activity.
- **Partnership-based:** Work across sectors, collaborating with health and social care, voluntary and community organisations, social enterprises, local authorities and nature-based providers. Strong partnerships help make programmes more sustainable, accessible and integrated.
- **Equity-focused:** Actively address inequalities in access, experience and outcomes. This means listening to people, gathering feedback and designing services with the communities they aim to support.
- **Life-course oriented:** Design services that respond to different life stages, transitions and settings, recognising that social, economic, environmental and behavioural risk factors vary across the life course.
- **Community-led:** Build on local assets, relationships and knowledge. NBSP is more likely to be meaningful and sustainable when communities help shape what is offered and how it is delivered.

See also RESONATE's guide **"Towards new cultural trajectories: Factors influencing awareness and societal acceptability of nature-based therapies"** available on the Resonate website in December 2026.

3.1 Step 1: Know your context

Before prescribing anything, it helps to understand the system you are working in. This step has three parts:

- **1a. At what stage is your local system:** relevant to all prescribers, since it determines how much of the NBSP falls to you;
- **1b. What NbT offer is available locally:** relevant to link workers, or to health and social care workers working in a system without a link worker;
- **1c. How to judge the quality of the NbT provision:** relevant to link workers, or to health and social care workers operating in a system without a link worker.

1a. At what stage is your local system?

NBSP, and social prescribing in general, are more established in some places than in others. Where your system sits determines how your patient's journey will work.

Questions you can ask yourself are:

- Is there a social prescribing pathway in your area?
- Is there a link worker, social prescribing professional, community connector or equivalent role who acts as an intermediate figure in the prescribing pathway?
- Can people self-refer to participate in NbTs, or do they need a professional referral?

The key question is whether a link worker is available within the system. The role goes by different names and sits in different places depending on the system: there may be a dedicated social prescribing link worker or navigator, a community connector, or, in some settings, a social worker based in primary care who takes on this function. What matters is whether someone is available to explore the person's needs, connect them to local provision, and follow up.

If there is a link worker, much of the journey can run through them: they can explore the person's needs in depth, match them to local provision, handle the referral, and follow up. Your role may be mainly to identify who could benefit from NbTs, open the conversation, and then hand over.

If there is no link worker, more of the journey falls to you, and the next two parts of this step matter more directly to your own practice.

1b. What is available to you?

Start by finding out whether a directory of NbT offers already exists in your community.

- Does the local authority or municipality maintain a directory of community activities or run programmes directly?
- Do green organisations (e.g., parks bodies, conservation or landscape organisations, community gardens) or mental health and wellbeing organisations hold lists of the activities they offer or know of?

Where no directory or tool exists, mapping local assets together with colleagues in your health or social care facility, may be worthwhile. This means identifying nearby parks, green or blue spaces, community gardens, walking or "green gym" groups, conservation volunteering, care farms, and activities run by local landscape, environmental, or wellbeing organisations. You can then reuse this mapping and share it with other colleagues and units.

Some of the information to gather about each offer might include:

- What kind of activities are offered and at what time are these conducted?
- Who is this NbT suitable for?
- Are they free or low-cost?
- Are they accessible by public transport or close to where people live?
- Are they suitable for people with mobility, sensory, language, cultural or mental health support needs?
- What information does the provider need before someone attends?
- Is there a process for follow-up or feedback?

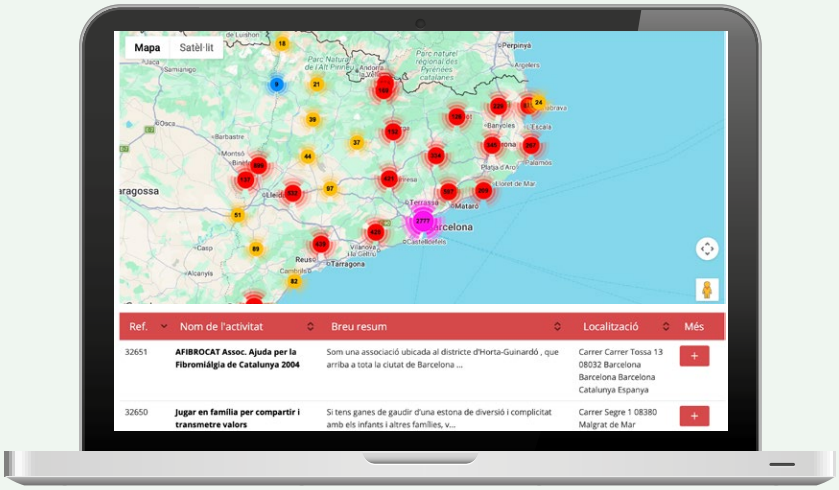
The mapping can start small, but each entry should ideally be well documented from the outset. This includes practical information such as accessibility, cost, referral criteria, provider capacity, safeguarding and risk management arrangements, and contact details. A handful of well-documented opportunities is more useful than a long list with very little information. The mapping can then grow over time as more options are identified.

Incomplete or outdated information is a common reason referrals fail. People may arrive to find that a programme is no longer running or is different from what they expected. For someone who may already feel uncertain about taking part, even a small mismatch can be enough to put them off. Having clear, complete information also helps people understand their options and make more informed choices, which can support uptake and continued participation. You can find a template to map these community resources here. Promoting and advocating for building such infrastructure where it does not yet exist is addressed separately in Section 4.

CASE STUDY

A shared map of local assets (Catalonia, Spain)

Catalonia operationalises the assets-based approach through Actius i Salut, an online community health-assets map run by the regional public health agency (ASPCAT). The tool is built on the concept of an "asset": any resource, whether a person, place, activity or organisation, that supports health and wellbeing in a community. Community organisations and providers register their activities and resources, and each is geolocated so anyone, professional or resident, can see what exists near a given location. Users can search by municipality, keyword or target population. The model is shared and maintained through a community-health network, with entries reviewed annually and time-limited activities expiring automatically to keep the map current



1c. Assess the quality of NbT provision

When you deliver an NbT yourself, you have direct oversight of its quality. When referring or signposting to an external provider, it is still important to make sure the activity you are recommending meets the appropriate standards of quality and safety. A prescription is only as good as the activity it points to. Referring to an activity that is poorly run, unsafe, or a poor match can do more harm than offering nothing, because it can leave a person more discouraged, less willing to try again, or even harm the relationship and trust between a patient and prescriber. Assessing quality before you refer is therefore part of prescribing responsibly.

Start by checking what your own setting already requires of you. Where social prescribing is established, there are usually standard operating procedures for assessing the quality of the activities you refer to, along with defined lines of accountability and liability between the referrer and the provider. Your organisation may also hold agreements with approved providers, in which case the assessment has largely been done, and your task is to work within it and to feed back when something is wrong.

Where no such system exists, or where the activity sits outside it, the assessment falls to you. The questions below set out what to look for.

A provider running a credible activity can describe it clearly and consistently. If basic information is vague or unavailable, treat that as a signal to look more closely. Useful things to establish include (48):

- whom the activity is intended for, including the age range, the level of physical fitness assumed, and the kinds of need it is, and is not, equipped to support;
- what a session involves, what time of day and how long and how frequent sessions are, what happens at the first visit, and whether it is guided (in a group, with an instructor) or self-directed;
- the practical information about the site, such as terrain, accessibility for people with mobility impairments, shelter, toilets, seating, and what to wear or bring;

- how the site can be reached, and whether the location is reachable by public transport;
- group size and make-up, and whether single-sex or community-specific groups are available where that matters to the person;
- how much the activity costs, and whether equipment, clothing or protective gear is provided;
- how flexible the programme is when someone's physical or mental health means they miss sessions;
- what support does the provider offer someone attending for the first time, for example a call beforehand, someone to meet them, or the option to observe rather than take part?
- what experience or training staff have in supporting people with the relevant mental or physical health needs;
- whether the activity is culturally sensitive and linguistically adapted, including whether an interpreter or translated materials can be arranged;
- whether there are safeguarding arrangements in place, including site safety (lighting, path maintenance), the presence of a guide or group where relevant, risk assessments and appropriate insurance.

Most NbT providers are confident supporting people at the earlier, preventive end of need, or people with more mild and moderate needs, but fewer are equipped to support people with complex needs. Matching the activity to the person's level of need is itself a safeguarding judgement. Someone experiencing paranoia, for example, may not feel comfortable outdoors or in an unfamiliar group setting, so suitability should always be discussed with the patient directly. This is also why NbTs should be considered as part of the treatment package: the judgement about whether, and how, to introduce NbT is part of the person's wider care, plan and not a separate decision made in isolation. More detailed evidence on how NbTs can benefit specific conditions is available in Section 2.2. For guidance on co-creating the activity with the person, see Step 6.

CASE STUDY

A trusted-provider scheme (Nottingham & Nottinghamshire, England)

In Nottingham and Nottinghamshire, the GreenSpace programme brought green and blue providers together with social prescribing link workers to make referrals to nature-based therapies easier and safer. The result was a "Trusted Provider" scheme that gives referrers and participants a vetted menu of options, supports appropriate referrals, and builds confidence between referrer, provider and participant. Providers are assessed against a structured checklist that prioritises the assurances a referrer most needs: insurance, safeguarding, health and safety, risk assessments, data protection, volunteering policies and first aid training. Further checks are applied according to the activity and the level of need it serves. Rather than simply vetting providers, the coordinating organisation also gave applicants tailored feedback, support and training to help them meet the standard, and several organisations went on to appoint dedicated, trained safeguarding leads as a result. GreenSpace launched in 2021 as one of seven national Green Social Prescribing Test and Learn sites, with the extended funding phase ending in October 2025.

Trusted Provider Assessment Check

Priority Order	Policy / Procedure	Requirement for TP	Type of check	Sufficient or insufficient needs further support / feedback	Potential support routes
1	Insurance (public liability including volunteer cover etc)	Mandatory	Review Certificate		
2	Safeguarding Policy	Mandatory	Review Policy		
3	Health & Safety Policy	Mandatory (size dependent)	Review Policy		
4	Risk Assessments (assess an example of the risk assessments used)	Mandatory	Review document		
5	Data Protection/GDPR	High Priority	Review Policy		
6	Covid Procedures	High Priority	Site visit/ Verbal check due to constant variance		
7	Food Hygiene Certificates (where appropriate)	Mandatory (where required)	Verbal check		
8	Volunteering Policy	High Priority	Review Policy		
	Volunteer Induction Procedure	High Priority	Review Policy / Verbal Check		
9	Equality & Diversity Policy	High Priority	Review Policy		
10	First Aid training	Medium Priority	Verbal check / Review Certificates		
11	Lone Working Policy	Medium Priority	Verbal check / Review Policy		
12	Volunteer DBS checks	Need dependent	Verbal check		
13	Mental Health First Aid Training	Low Priority	Verbal check		
14	Digital Media Guidelines	Low Priority	Verbal check / Review Guidelines		

3.2 Step 2: Identify who might benefit

The first thing to do is to recognise when an NbT option might be relevant. This can happen in many settings: primary care, mental health care, rehabilitation, social care, community nursing, pharmacy, occupational therapy, physiotherapy, youth work, older people's care, disability services or community outreach.

Identifying who might benefit requires prescribers to have a holistic view of the person. Healthcare professionals, who are used to focusing on the medical aspects of care, may not be in the habit of asking questions that could identify the need or opportunity for an NbT prescription. Therefore, recognising who might benefit means deliberately looking beyond the presenting medical problem to the social, emotional and everyday context around it.

A few open questions that can help surface these needs include:

- *How do you spend your time at the moment?*
- *Have there been times you've felt lonely or cut off from things?*
- *Are there things that you used to enjoy doing but find it hard to find time for nowadays?*
- *Are there places in your community or neighbourhood where you feel calm, safe, or like you belong?*
- *Is getting outdoors something that's part of your life now, or something you'd like more of?*

As described in Section 2.2 of this guide, evidence shows that NbTs may be particularly relevant for people who:

- are experiencing mild to moderate anxiety, depression, low mood, stress or sleep disorders;
- are socially isolated or would benefit from meaningful social contact;
- are managing a long-term condition, fatigue, chronic pain or recovery after illness;
- would benefit from gentle, enjoyable physical activity;
- would benefit from routine, confidence-building or purposeful activity;
- find conventional exercise or clinical settings unappealing;
- already have a positive relationship with nature and would like support to use it more regularly;
- are curious about NbTs but need encouragement, information or practical support.

It is also helpful to recognise that NbTs are not only for people who are already unwell. They work across all three levels of prevention:

- **Level 1 (primary prevention):** whole populations using nature to stay well and prevent ill health. Anyone can benefit from more regular contact with nature.
- **Level 2 (secondary prevention):** at-risk groups, such as people with high blood pressure or sedentary lifestyles, using nature to reduce their risk of disease.
- **Level 3 (tertiary prevention):** people with existing conditions using nature to help manage symptoms and support treatment.

It should be noted that NbTs are not suitable for everyone, and they should not replace clinical or social care where they are needed. They should be considered as one option within a wider plan of support. See Section 2.2 for more information on evidence-based benefits of NbTs.

3.3 Step 3: Open the conversation

Prescribers do not necessarily need to "sell" NbTs. The aim is to offer them as one possible option, depending on the person's needs, preferences and circumstances. For some people, this may sit alongside a clinical treatment plan; for others, particularly where clinical treatment is not indicated or available, it may be one of the main forms of support. Introducing NbTs can be as simple as having a short, open conversation about whether the person is interested, or mentioning nature alongside other protective lifestyle factors as part of routine counselling.

A simple three-step approach, adapted from that used in Ontario's Community Health Centres, can guide the conversation (47):

- **Recognise** that this is a legitimate part of the person's care: "Your well-being matters. In addition to what we're already doing for your health, I'd like to think about other things that might help you feel better day to day."

- **Acknowledge** that nature has been shown to benefit health in various ways and is one route some people find helpful: "Some people find that getting outside, a walk in the park, a bit of gardening, time near water, helps with things like stress, sleep, or feeling more connected. This wouldn't replace your current care; it's an extra source of support. Is that something you'd want to explore?"

- **Determine** the next step according to the person's interest and readiness. If they are keen and able, you can move toward step 4. If they are unsure, hesitant, or facing practical barriers, consider referring them to a link worker, where available, who can spend more time exploring options and support needs. Alternatively, start with a smaller, more manageable step: "We can start really small, perhaps with ten minutes near home, and choose something together that feels realistic and fits into your week."

This first conversation may also highlight a person's concerns about accessibility, affordability, personal fit, time, or other barriers. The important thing is to treat these concerns as information to design the prescription around, not resistance. If you are referring the person to a link worker, flag these concerns in your referral; it gives them a head start when exploring options with the person. See Step 5 for more explanation on exploring needs, preferences, and barriers.

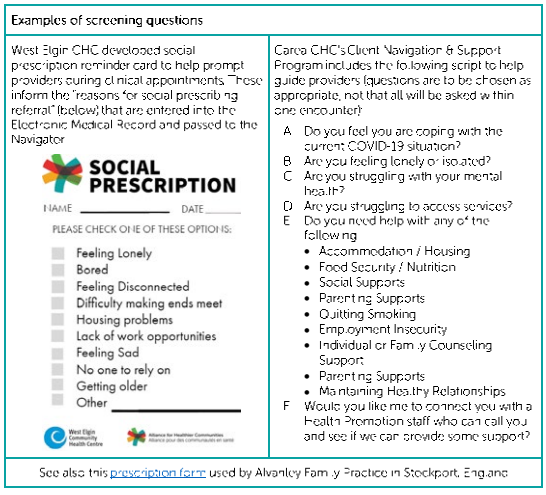
The relationship behind the suggestion may itself add to the effect. There is some evidence that NbTs have a stronger impact when they are recommended or organised by a health or social care professional who already has a connection with the person (26). The relationship a professional has already built is, therefore, an asset when opening this conversation.

For prescribers who want a structured approach to these conversations, motivational interviewing offers well-tested, time-efficient techniques for exploring a person's own reasons for change rather than persuading them. Brief tools, such as asking how important a change feels on a scale of 0 to 10 and why, can highlight motivational issues in just a few minutes, even during a short consultation. A concise, practical guide for primary care is available from the Australian Family Physician journal (49).

CASE STUDY

Social prescribing screening questions in Community Health Centres, (Ontario, Canada)

Ontario's Community Health Centres (CHC) recommend highlighting non-medical needs through organic conversation during an ordinary appointment rather than a standardised screening tool, but several centres have developed simple prompts to support providers. West Elgin CHC uses a "Social Prescription" reminder card that a person can tick, covering feelings such as loneliness, boredom, disconnection or sadness. CHC instead gives providers a longer script to draw from as appropriate, asking about coping, loneliness, mental health, access to services, and other specific areas of need.


Examples of screening questions

West Elgin CHC developed social prescription reminder card to help prompt providers during clinical appointments. These inform the "reasons for social prescribing referral" (below) that are entered into the Electronic Medical Record and passed to the Navigator

SOCIAL PRESCRIPTION

NAME _____ DATE _____

PLEASE CHECK ONE OF THESE OPTIONS:

- Feeling Lonely
- Bored
- Feeling Disconnected
- Difficulty making ends meet
- Housing problems
- Lack of work opportunities
- Feeling Sad
- No one to rely on
- Getting older
- Other _____

Carea CHC's Client Navigation & Support Program includes the following script to help guide providers (questions are to be chosen as appropriate, not that all will be asked within one encounter)

A Do you feel you are coping with the current COVID-19 situation?
B Are you feeling lonely or isolated?
C Are you struggling with your mental health?
D Are you struggling to access services?
E Do you need help with any of the following
- Accommodation / Housing
- Food Security / Nutrition
- Social Supports
- Parenting Supports
- Quitting Smoking
- Employment Insecurity
- Individual or Family Counseling Support
- Parenting Supports
- Maintaining Healthy Relationships

F Would you like me to connect you with a Health Promotion staff who can call you and see if we can provide some support?

See also this prescription form used by Alvanley Family Practice in Stockport, England

3.4 Step 4: Choose the right prescription route

Once the patient is interested in engaging with an NbT, the next step you should take as a prescriber depends on the local system you work in.

Route A: Referral to a link worker or social prescribing professional

Where a link worker or equivalent role is available, the health or social care professional prescribing to a patient does not need to create the full prescription alone. Their role is to identify the need, explain the options, gain consent and make a clear referral. The link worker can then spend more time exploring the person's goals, preferences, barriers and support needs, before co-creating a personalised plan.

A good referral should include (48):

- why the person is being referred;
- relevant health, mental health, mobility or safeguarding information;
- the person's goals or concerns, if known;
- any accessibility or communication needs;
- whether the person has agreed to be contacted;
- any urgency, risk or boundaries around what is appropriate.

Route B: Direct referral to a nature-based provider

In some places, health or social professionals can refer directly to a nature-based provider. This may be appropriate when the person's needs are relatively clear, the provider is trusted, and the activity has suitable support in place. Direct referral still requires a good match between the person and the activity.

Route C: Signposting or self-directed prescription

For people with lower support needs, the most appropriate option may be signposting or a self-directed plan. This could include finding time in one's diary for regular walking in a nearby park or blue space, or joining an open community gardening session. Even here, the advice should be specific enough to act on.

Route D: Prescriber as provider

In some settings, the health or social professional may also deliver the NbT. For example, an occupational therapist may use gardening as part of rehabilitation, a physiotherapist may run outdoor movement sessions, a psychologist may use walking sessions, or a care setting may integrate nature into daily routines. In these cases, the prescription becomes part of the therapeutic or care plan.

CASE STUDY

Green mental healthcare (Netherlands)

In the Netherlands, the Groene GGZ (Green Mental Health) initiative, led by Nature For Health and IVN Natuureducatie, works with mental health institutions to make nature part of treatment rather than something patients are referred elsewhere to find. A partnership of provider organisations has committed to embedding nature across their care. This includes delivering treatment outdoors in nature as part of the therapeutic process, designing institution grounds so that clients, families and staff can use green space to recover and recharge, and connecting with the surrounding neighbourhood through shared "social green" spaces such as community gardens and walking routes. The aim is for participating institutions to integrate nature into treatment plans and invest in biodiversity on their own land.

3.5 Step 5: Explore needs, preferences and barriers

Whether this is done by a link worker, social care professional, clinician or provider, the next step is to move from "what is the matter with you" to a "what matters to you?" conversation. Helpful questions include:

- *What matters most to you at the moment?*
- *What would you like to feel more able to do?*
- *Are there places where you feel calm, safe or welcome?*
- *Would you prefer to go alone, with someone you know, or in a group?*
- *What kind of activity would feel manageable?*
- *What might make it difficult to take part?*
- *Would cost, transport, childcare, mobility, language, weather or safety be an issue?*
- *How much support would you need to start?*
- *What would make this easier?*

Pay particular attention to the question about going alone or in a group. Social anxiety is one of the most common reasons people decline an otherwise suitable offer, and the prospect of spending time with a group of strangers can be more daunting than the activity itself. This matters most where social connection is the goal, since the mechanism of benefit is also the barrier to entry.

This step is also where equity becomes a practical issue. A prescription is only useful if the person can realistically access it. Distance, cost, transport, safety, time of day, childcare, cultural fit, physical activity levels, disability access, toilets, seating, language, group size and a person's level of confidence in engaging in these activities all affect whether someone can take part.

The RESONATE toolbox includes a "**Guide to ensuring health equity in nature-based therapies**" (available in December 2026 on the RESONATE website). It is primarily aimed at researchers and providers – the people who design and implement NbTs. However, the considerations on equity are also relevant for health and social professionals.

This step's real task is exploring what the prescription needs to work around to match the person to an activity they can realistically reach and use. A local directory that maps available community offers against these needs makes this step much easier. See Step 1c for more information on developing this directory.

It helps to convey that meaningful contact with nature does not depend on dramatic landscapes or money. A walk to the nearest park, tending a few plants on a balcony or windowsill, or time in a shared garden all carry potential benefits, and nature in this everyday sense is free and open to everyone. Where factors such as anxiety, mobility, distance, or transport completely rule out access to green or blue space, consider what is realistic instead: an indoor option such as indoor horticulture or flower arranging, or nature closer to home, rather than defaulting to no prescription at all. Where the gap is structural rather than individual, for example, no green space within reach for an entire community, that becomes a case for infrastructure advocacy; see Section 4.

Prescribers work within very different constraints. A general practitioner may have ten to fifteen minutes with a patient, while a social prescribing link worker or community nurse may have more time. What "co-creating a prescription" looks like depends on which options or time you have. In a short consultation, opening the conversation and planting the idea may be enough, with the details of co-creating the prescription handed to a link worker or picked up at a follow-up. In a longer session, there may be room to explore needs and shape the prescription in one sitting. Neither is better; what matters is that the person leaves with a clear next step rather than a rushed plan.

CASE STUDY

Friends in Nature (Melbourne, Australia)

Friends in Nature was an eight-week nature-based social prescribing programme co-designed with and for LGBTIQA+ asylum seekers and refugees in Melbourne, as part of the EU-funded RECETAS project. Rather than offering a fixed activity, the team began by exploring barriers directly with participants, identifying fear of the outdoors, transport difficulties and safety concerns, and built the response around them: sessions were held in pre-selected accessible green and blue spaces, transport tickets were provided, participation in every activity was optional, and facilitation was trauma-informed and culturally responsive. Results suggest that taking part in the programme was associated with reduced loneliness and increased connection to nature. The lesson for this step is that the prescription worked because it was shaped around cost, transport, safety, cultural fit and trust, not in spite of them.

3.6 Step 6: Co-create the prescription

The prescription should be developed **with** the person, not **for** them. Use the information collected in Step 5 (understanding what they would realistically like to do, feel able to do, and continue doing) to guide the co-creation process.

NbTs can support both mental and physical health. Reported benefits include reductions in symptoms of depression, anxiety, stress, negative affect, sleep problems, loneliness, and social isolation, as well as improvements in cardiovascular indicators such as heart rate and blood pressure, physical activity, metabolic health, pain, and fatigue. See Section 2.2 for more information.

However, the evidence is less clear about whether one NbT format is consistently better than another for a specific condition. Most reviews pool findings across different activities and settings. As a result, they provide evidence for NbTs in general, rather than demonstrating the superiority of one activity for a given diagnosis.

The best option is usually the one the person is motivated to try, can safely access and take part in, and is likely to sustain (please see Table 1 for a list of NbT examples). Rather than following a fixed ranking of activities, use two practical questions to guide the choice.

1. How active should the activity be?

Some activities require physical, behavioural or cognitive engagement, such as walking, gardening, conservation work, decision-making or skill-building. Others are more passive, such as sitting in a garden, spending quiet time outdoors or viewing nature.

Active engagement may offer additional physical and psychological benefits, especially when it helps people build a stronger connection with nature. Purposeful activities, such as gardening or conservation work, may also support wellbeing through social connection. Group delivery can strengthen this effect. For example, community gardening has been associated with higher nature connection and wellbeing than gardening alone or at home (34).

However, active options also require more motivation, confidence and capacity. More passive activities may be more suitable for people with fatigue, low confidence, limited mobility, low capability, or limited access to high-quality natural spaces (10,34).

Practical examples include:

- **Walking in green space**, often a simple starting point, with evidence of improved mood and reduced stress and anxiety compared with similar walks in built environments in several studies (50).
- **Gardening and horticultural activities**, which can improve wellbeing and reduce stress and social isolation, making them practical, low-barrier options for many people (30).

2. Is nature the main focus, or the setting?

In some activities, nature is the main therapeutic element, such as forest bathing. In others, nature provides a supportive setting, such as education or group activities held outdoors.

Activities where nature is a secondary focus may be easier to introduce for people who are less familiar or comfortable with NbTs. Activities where nature is the primary focus may require stronger alignment between the person's capability, opportunity and motivation, but may also support deeper nature connectedness (10).

Some things to keep in mind:

Frequency and duration
The evidence on NbTs does not identify one correct "dose". The figures below are reference points for starting a conversation and should be adapted to the person's routine, mobility, confidence, and symptoms. For some, this may mean a weekly group activity; for others, it may mean several short visits to a nearby park, garden or green space.

A starting point for organised structured activities could be around 8 to 12 weeks, with sessions lasting 20 to 90 minutes once a week. This comes from a review of mental health outcomes broadly, rather than from trials that directly compared different durations or session lengths to identify an optimal dose. It should be treated as a flexible starting range, not a fixed rule (34).

Another practical weekly target is around 120 minutes in nature. In a large study, people who spent at least 120 minutes per week in nature were more likely to report good health and wellbeing, with benefits peaking at around 200 to 300 minutes per week (51). This 2hr a week threshold held for individuals of all ages, genders, income levels, and ethnicities, as well as for those with and without chronic health conditions, and for rural and urban individuals. How one achieved the 2hrs a week did not seem to matter (e.g., 2 x 1hr walks or 4 x 30 mins in the park), making it a feasible target for people with different abilities, lifestyles, and local nature access.

Where the activity involves movement, NBSP can also support physical activity goals. The World Health Organization recommends that adults do at least 150 to 300 minutes of moderate aerobic activity (e.g. fast walking, jogging, cycling, swimming) per week, while children and adolescents should average 60 minutes per day (52). Even small amounts of activity are better than none, so the prescription should start from what feels manageable and build from there.

As a rule of thumb, longer and more regular engagement is likely to be more beneficial than a one-off activity. But this has to be weighed against what a person can realistically commit to. For someone new to NbTs, starting small, like a single session or a short, low-commitment activity, can be a more realistic entry point that builds confidence and routine before stepping up to a longer programme. Where the person is willing and able, a programme over several weeks is preferable to a single session (10), but the better long-term outcome should not come at the cost of the person disengaging altogether.

Open-ended activities, such as a weekly walking group or a community garden that runs continuously and can be joined at any point, can be particularly valuable. They allow people to build up gradually at their own pace, and because there is no fixed course to complete, missing a few weeks does not mean dropping out or having to start again. For people who find commitment daunting, including those with anxiety, this can make the difference between trying something and not.

Age appropriateness
NbTs may be relevant across the life course, from children to older adults, but not every activity is suitable for every age group. Age should be considered alongside physical ability, confidence, energy levels and support needs. For example, physically demanding activities such as long hikes may be inappropriate or even harmful for some older adults (10).

For older adults, benefits do not always require being outdoors. Indoor horticulture, flower arranging and nature-based arts and crafts can offer psychological, cognitive and social benefits. This may be especially important for people with reduced mobility, frailty, transport barriers, or those living in residential care (41).

Loneliness and social isolation
Where social connection is a main goal, group-based activities may be particularly relevant. Longer programmes appear more promising than one-off activities (39). Who else is in the group matters as well: people are more likely to continue where they feel they belong, and more likely to withdraw where they feel conspicuously different from the others. Getting someone with social anxiety through the first session often requires active support rather than a referral alone. See Step 7 for more information.

Stress-related illness, burnout and exhaustion
Gardening, forest-based programmes and other NbTs may support recovery when they are self-paced, meaningful and flexible. The goal is not performance or productivity, but gradual recovery, confidence and reconnection. The activity should feel restorative, not like another task to complete (38).

3.7 Step 7: Connect the person to the activity

The prescription can be written, oral, included in a care plan, or formalised through a referral system. There is no single correct format. A handwritten note, a verbal agreement, an entry in the care record, or a structured referral can all work; what matters is clarity. That said, there is some evidence that a written prescription is taken more seriously than verbal advice alone, so writing something down, however brief, is often worthwhile. This could include:

- what the person will do;
- where it will happen;
- how often and for how long;
- who will support them;
- what the purpose is;
- what to do if it does not work;
- when it will be reviewed.

For example:

"Over the next four weeks, try a 20-minute walk in the park near your home twice a week. Start with the shorter route. If going alone feels difficult, ask your neighbour or son or daughter to join you once, or we can discuss a local walking group. We will check how it went at your next appointment."

Or, for a structured referral to an NbT provider:

"Referral to the community gardening group at [location], once a week for 8 weeks. The aim is to support low mood through routine, gentle movement and social connection. The person prefers a small group, needs access to toilets and seating, is anxious about attending alone and prefers an accompanied first visit if possible."

A referral might need to be more than a passive handover. Some people will need help making the first contact, understanding what to expect, arranging transport or attending the first session. This is especially important for people who are anxious, isolated, unfamiliar with the setting, or unsure whether they belong there. Depending on what the person needs and what your service can offer, this might mean:

- the provider phoning the person before the first session;
- arranging for someone to meet them at the entrance;
- agreeing that they can observe rather than take part the first time;
- arranging for a family member, friend or volunteer to accompany them;
- helping to plan the journey, or arranging transport where this is available;
- agreeing a specific date rather than leaving it open.

For the person, before they start, they should know wherever possible:

- who will contact them;
- when they should expect contact;
- where they need to go;
- what will happen during the first session;
- what they should wear or bring;
- whether there are toilets, seating or indoor options;
- the accessibility conditions of the site or activity, so they can judge in advance whether it suits their mobility, frailty or physical capacity;
- whom to contact if they cannot attend;
- whether they can bring someone with them.

For the provider, enough information should be shared to support the person safely, while respecting privacy and confidentiality and complying with data protection rules. At a minimum, this usually includes any relevant mobility, health, or safeguarding considerations; the person's goals for the activity; any access or communication needs; and an agreed way to stay in contact.

3.8 Step 8: Follow up and adapt

Follow-up is part of the prescription. It helps the prescriber understand whether the activity was taken up, whether it was suitable, and whether the person needs a different type of support. Follow-up is not only a way to learn whether the referral worked; it also helps sustain behaviour change, particularly for people who were hesitant to start or who struggle to stay engaged. However, timely follow-up depends on having a monitoring and feedback loop in place, and in practice this is often missing. A few practical arrangements can help close this gap:

- **Provider or link worker feedback to the referrer:** Establish upfront with an NbT provider (or a link worker where applicable) how they will let you know about attendance or any noted change. This can also be part of the same quality assessment covered in Step 1c, so it is a condition of referring to an NbT provider.

- **A dedicated follow-up appointment:** Building a short check-in into the person's existing care plan makes follow-up more likely to happen at all, rather than being left informal or incidental.

- **Self-tracking methods:** Everyday tools such as a phone or wearable step count let a person keep their own record of activity, which they can share with the referrer at a later appointment. Animal, bird, and plant species-identification and citizen-science apps such as iNaturalist gamify engagement with nature itself, allowing users to log sightings, earn badges, and build a personal record of what they have noticed outdoors. This can help sustain motivation, particularly for people who respond well to a sense of progress or achievement and gives both patient and referrer something concrete to look back on. Dedicated nature-exposure tracking apps are also emerging and expected to expand into European markets, it is worth keeping an eye on as this space develops. A simple personal logbook works too: keeping their own record of what they did and noticed helps people become aware of improvements, needs no device, and gives the follow-up conversation something concrete to start from.

Once a follow-up is happening, useful questions include:

- *Did you attend or try the activity?*
  - If yes: What did you do, where, and how often?
  - If no: What made it difficult?

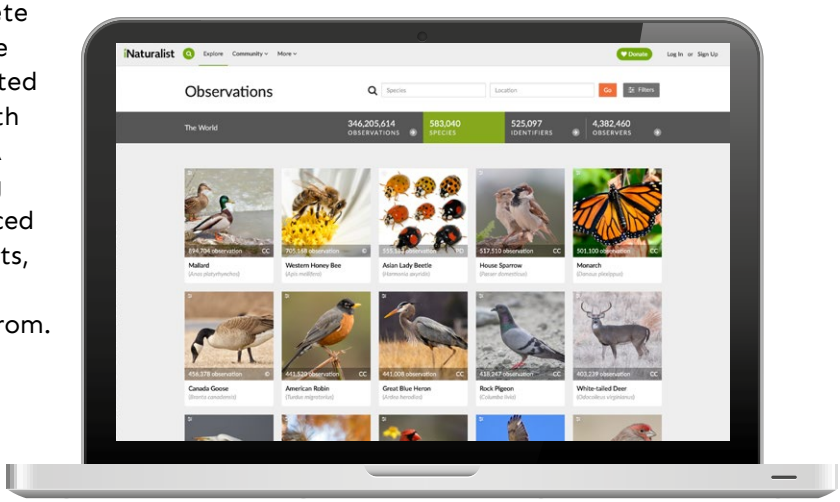
- *How did it feel?*
  - Did the activity feel enjoyable, calming, manageable, too demanding, unsafe, lonely, or not relevant?
  - What got in the way?

- *Were there any barriers?*
  - For example: time, transport, cost, weather, mobility, safety, confidence, language, caring responsibilities, or not wanting to go alone.

- *Would you like to continue, change, reduce or increase the activity?*
  - The next step may be to make the activity smaller, choose a different place, add social support, refer to a link worker, or connect the person with a local group.

- *Has anything changed in your mood, routine, confidence, movement, stress, sleep, pain or social connection?*

Follow-up also helps services learn whether referrals are working. If certain groups are not attending or dropping out, the pathway may need to be adapted.



3.9 Step 9: Plan for continuation or step-down

For some people, a short programme may be enough to build confidence and establish a routine. Others may need longer-term support or a step-down option after a structured programme ends. **The aim is not only to complete a specific referral, but to help people build nature into their lives in a way that supports long-term health and wellbeing.**

A helpful approach is to plan the ending from the beginning. When a time-limited programme is agreed at Step 6, start discussing what could happen afterwards rather than wait until the final session. A programme may provide much more than the activity itself: a regular time slot, a familiar facilitator, social contact and a sense of commitment. Thinking ahead about what will replace some of that structure can make the transition easier and help people maintain the progress they have made.

In many cases, instead of a step-down, the patient might benefit from continuation. Continuation can take different forms, depending on the person and what is available locally. This links back to the mapping in Step 1b. Options may include:

- Moving into an open-ended activity, such as a regular walking group, community garden or conservation activity.
- Continuing informally with the same group, where participants want to keep meeting after the structured programme ends.
- Taking on a different role, for example as a volunteer, peer supporter or group leader.
- Continuing independently, for example by returning to a place or activity the person has become familiar and comfortable with.

Moving from a structured programme into a new or less structured activity can bring back some of the same barriers experienced at the beginning, such as uncertainty about what to expect, joining an unfamiliar group or no longer having a familiar facilitator. The practical support described in Step 7 may therefore be useful again. For example, the facilitator could introduce the person to the next activity, or they could attend it once before the current programme ends.

Not everyone needs to continue. Some people may have achieved their goals and feel ready to stop. At follow-up (Step 8), discuss whether they would like to continue, change activity, reduce their involvement or stop.

CASE STUDY

One pathway in practice (Silkeborg, Denmark)

Silkeborg Municipality runs multiple nature-based prescription programmes, each matched to a different population (Step 2): Nature on Prescription (Natur på Recept) serves citizens on sick leave or who are unemployed with mild to moderate stress, anxiety or depression; Forces of Nature (Naturkræfter), Come to your senses (Kom til Kræfter ude), and Life forces (Livskræfter) are designed for those who have or have had cancer; Cardiac Exercise Outdoors (Hjertemotion i det fri) delivers nature-based rehabilitation for people recovering from a range of cardiac conditions; and Stress Management in Nature (Stresshåndtering i naturen) offers nature-based stress management for mental health and wellbeing.

The Nature on Prescription programme (Natur på Recept) illustrate how the steps in this section can come together in one system. Referral (Step 4) can come from a job-centre case worker, a GP, or the citizen themselves; all routes lead to a single municipal health coordinator, who holds a pre-course conversation to explore fit and readiness (Step 5) before the person joins. The co-created element sits less in individual activity choice and more in group composition and pacing: sessions run twice weekly over 9–10 weeks (Step 6), led throughout by the same facilitator, so participants build trust with one consistent contact rather than a rotating cast. Content is delivered in partnership with the national nature agency, a local wildlife park, with activities such as campfire walks, foraging, or boat trips. After the structured course ends, a voluntary weekly "anchoring offer" continues the group informally, giving participants a step-down rather than an abrupt close (Step 9).

I am already prescribing nature-based therapies, but I want to do more

The use and upscaling of NbT prescriptions depend not only on prescribers' or patients' capabilities and motivation, but also on the infrastructural, legal, economic, and operational conditions that support the availability of NbTs and their prescription, through nature-based social prescribing (NBSP). There may be no clear referral pathway, local providers may lack capacity, patients may be unable to afford transport or equipment, colleagues may not have access to training, or NbT prescription may not be recognised in organisational policies, professional guidance or funding arrangements.

Many of these conditions are structural and often beyond the remit or ability of an individual prescriber or an NbT provider to change directly, also in recognition of high workloads that leave little room for additional tasks. This guide does not intend to place additional burden or expectations on health and social care professionals, but rather provide tools that can support their work.

Prescribers can play an important role in making barriers to NbTs visible and contributing to wider change, also working in collaboration with colleagues. Through your contact with patients and services you can identify recurring barriers, show how they affect health and equity, bring together relevant partners, formulate practical proposals and use organisational and professional channels to reach those with decision-making power within and beyond health and social care facilities.

How to use this section

How to use this section:

This section is divided in two parts:

- **Section 4.1**: A first part with step-by-step guidance on how to carry out advocacy for systems change, facilitating NbT prescription;
- **Section 4.2**: A second part with key asks to strengthen the system within and beyond health and social care facilities, organised by 'pillars'. Each pillar contains a list of recommendations for actions that you can take, with case studies and resources that you can use as reference and make the case for NbTs.

The step-by-step guidance provides prescribers with the means to implement the recommendations, that can contribute to achieving the asks, with the support of case studies and resources.

4.1 Guidance on how to carry out advocacy for systemic change

The following seven-step approach can be applied to any of the pillars described in Section 4.2 'Pillars for advocacy to strengthen an environment that facilitates NbT prescription'. It is adapted from SMART Advocacy, an advocacy approach developed and refined by the Advance Family Planning initiative at the Johns Hopkins Bloomberg School of Public Health in the USA (53), to recognise that health and social care professionals may contribute to bringing about change through direct action and collaboration as well as formal advocacy.

4.1.1 Step 1: Diagnose the barrier

With this step you distinguish between a problem with an individual prescription and a recurring problem due to the system. For example, one person cannot attend an NbT because a specific activity does not suit them, vs people repeatedly not being able to attend because there is no affordable transport.

Look beyond the visible problem to understand what is driving it. For example, low attendance may reflect transport costs, inconvenient timing, inaccessible venues, limited provider capacity or a referral process that does not offer enough support.

Working in collaboration with your peers, the questions below can help to identify hidden barriers:

- What is happening repeatedly, and at which point in the pathway does it occur?
- What evidence do we have from referrals, waiting lists, patient feedback, providers or colleagues?
- What appears to be driving the problem?
- Who is affected, and are some groups affected more than others?
- Could the current system unintentionally widen inequalities in access, experience or outcomes?

An equity lens is essential. A pathway may work well for people who have flexible time, private transport, or suitable clothing, while excluding people on low incomes, people with disabilities, or people with caring responsibilities.

The RESONATE toolbox includes a "**Guide to ensuring health equity in nature-based therapies**" (available in December 2026 on the RESONATE website). This guide includes information on population characteristics and health determinants that impact people's ability and motivation to access NbTs.

4.1.2 Step 2: Define the change you want to see

Turn the barrier into a concrete goal that can be acted.

Too broad: Access to NbTs should improve.
More useful: People referred from this neighbourhood need affordable transport to reach the available programme.

Too broad: We need better infrastructure.
More useful: Our service needs one maintained directory showing provider capacity, accessibility, cost and referral requirements.

Too broad: Staff need more awareness.
More useful: All new staff in the primary care network should receive a short introduction to the referral pathway and local NbT offers.

4.1.3 Step 3: Identify who holds the levers

Identify whoever holds the relevant levers for change. Depending on the issue, this may be one or a combination of a practice coordinator, clinical lead, service manager, municipality, regional health authority, national ministry or third-sector funder. The right actor will depend on the nature of the change, the level at which it needs to happen and who has the authority and resources to implement it.

This requires understanding how the legislative responsibilities are divided across health and social care systems. In some cases, national authorities may set policy and legislation, while regional or municipal bodies may organise, finance or deliver services. Where possible, think about starting with the level closest to the problem and the lever you can realistically reach, then involve higher levels where possible.

4.1.4 Step 4: Formulate a feasible, concrete request

Step 2 defined what needs to change. This step turns that goal into an actionable proposal for the person or organisation that can help deliver it. State what you are asking them to do, for whom, within what timeframe and with what resources or responsibilities. As an example, a concrete request to address unaffordable transportation in a neighbourhood could be asking the municipality to fund return transport for an eight-week pilot involving 30 referred participants, with uptake and attendance reviewed after three months.

4.1.5 Step 5: Determine how you can contribute

You can contribute in more than one way to the same goal:

- **Act yourself:** Initiate a partnership with a local provider or green space manager, run a small test or pilot in your own service, present anonymised referral evidence to your management, share opinion pieces in the media, or use storytelling of individuals and communities benefiting from NbT prescriptions, with appropriate consent.

- **Work with others**:
  - join or set up a peer network;
  - work through a representative organisation specific to your field of practice, such as the national association of primary care, nurses, paediatricians or social workers, many of which respond to consultations on behalf of the sector, develop position statements, form alliances and meet decision-makers, and in whose internal processes you can take part;
  - collaborate with research groups on evaluations and practice-based publications;
  - join working and advisory groups at national, regional or municipal level;

Different allies contribute different knowledge: patients the practical consequences, providers the capacity constraints, managers the organisational processes, municipalities the local infrastructure, researchers the evidence. Working together also avoids designing solutions for providers or communities without involving them.

- **Influence decision-makers directly:** Respond to public consultations on national strategies, new regulations or budget planning; governments often offer citizens the opportunity to contribute when policy frameworks are developed or amended. You can also contribute evidence to regional or national strategies, speak at hearings or stakeholder meetings, or communicate with local representatives or authorities.

4.1.6 Step 6: Make the case

Once you have identified who can help make the change, frame your case around what matters to that audience and connect your proposal to their responsibilities. A service manager may care about workflow, demand and staff capacity; a municipality about prevention, inclusion and community development; a commissioner about value for money and measurable outcomes.

The Green Social Prescribing Advocacy Pack, co-developed by the National Academy for Social Prescribing, provides an audience matrix which pairs each audience group to the messages most likely to resonate with them (54). For evidence on health outcomes, see Section 2.2: The clinical evidence. For evidence on cost effectiveness, see Section 2.3.

Consider also the political priorities of the government currently in office, especially in the health, environmental and social domains, and make the link between your goal and those priorities explicit: if a prevention, wellbeing or social prescribing framework already exists, use its terminology and cite it, because a goal that is already authorised by an existing strategy is negotiated from a much stronger position.

4.1.7 Step 7: Follow the change through

Follow the change into implementation and use what is learned to adapt or strengthen it.

- Confirm what was agreed, who is responsible and the expected timeline.
- Check whether the necessary staff time, funding, provider capacity and practical arrangements are in place.
- Monitor whether the change reaches the people who were previously excluded or underserved.
- Gather feedback from patients, providers and professionals, including unintended effects.
- Use the findings to adapt the approach and make the next request, where needed.

Further details and tips on how to do this can be found in RESONATE's guide on process evaluation "**Understanding how and why your nature-based activity works: A practitioner's guide to process evaluation**" (see here, available in December 2026).

4.2 Pillars for advocacy to strengthen an environment that facilitates NbT prescription

The four pillars below gather actions and asks that can help you, as a prescriber, shape an enabling environment around you to facilitate NbT prescription. These actions and asks were identified as factors that influence the uptake of NbT prescription by the research that informed this guide (see more details in Section 7.2 Annex II: Methodology).

Each pillar includes recommendations for actions and asks, as well as useful resources and case studies. The four pillars are the following:

- **Pillar 1:** Raising awareness and building knowledge
- **Pillar 2:** Mobilising resources
- **Pillar 3:** Strengthening infrastructure
- **Pillar 4:** Shaping policy frameworks

The seven-step approach described in Section 4.1 'Guidance on how to carry out advocacy for systemic change' can be applied to any of the four pillars described in this section. Step 3 'Identify who holds the lever' is particularly important for you to implement the recommendations.

4.2.1 Pillar 1: Raising awareness and building knowledge

a) Raising awareness

Actions to increase awareness of NbTs, their health benefits, and their availability at the community level can increase acceptability among policy- and decision-makers, prescribers, and end-users. This could support the improvement of legal, economic and operational conditions that make the availability of NbTs in the community possible, increase prescription uptake among prescribers, and promote engagement of end-users in NbTs.

Ways to do this include:

- **Use evidence summaries in your everyday conversations with your patients and colleagues in your practice or peer-networks that you are part of, if any, on the health and wellbeing benefits of nature exposure and NbT engagement, and co-benefits related to reducing social isolation and loneliness.** Nature is a resource valuable to everyone. The level of activity and nature engagement varies across NbTs, offering opportunities for personalised support care plans. You are welcome to use the evidence presented in Section 2.2 of this guide.

- **Develop targeted promotional materials on NbTs, adapted for different populations (parents, young people, older adults, people with low health literacy, or by gender) on what is available in the community**. These materials can support people to engage in NbTs in their daily routine and increase motivation to continue visiting natural spaces. When necessary, translate these materials into languages relevant to different people in your community and make them available in both printed and digital formats. If possible, try to make the information visible in your practice, including printed materials in your own waiting room (here an example of a poster that could be adapted and displayed on your walls). Through these materials, you can aim to promote the visibility of services in the community that support accessibility of patients to NbTs.

CASE STUDIES

A yearly calendar with self-led activities to explore nature (United Kingdom)

In the United Kingdom, the Royal Society for the Protection of Birds (RSBP) created a calendar with ideas and suggestions of self-led activities that people can do from home, on their own or with others, to explore ways of connecting to nature. Some prescribers use this calendar to support their nature prescriptions.

A directory of NbT providers (Nottingham, England)

The Big Green Book is a directory of NbTs designed to be used by prescribers and individuals who are looking for an activity in Nottingham City, with some extending to the wider country Nottinghamshire. The information is organised by location and includes guidance for referrers and participants on the mental health support that each provider can offer.

- **Develop awareness campaigns targeting decision-makers on the effectiveness of NbTs to improve health and wellbeing, as well as the emerging evidence on cost-effectiveness, to secure funding and resources for the provision and sustainability of NbTs.** The case for NBSP depends not only on whether it improves health and wellbeing, but may also relate to whether it offers good return on investment (see the evidence Section 2.3). As part of these awareness campaigns, you can:
  - Create promotional materials showing the health benefits of NbTs and cost-effectiveness of NbT prescription, making sure that these materials are written in accessible language. You can use information in Sections 2.2 and 2.3 as a reference.
  - Showcase successful case studies that indicate positive health effects from the exposure to an NbT.

- Showcase successful case studies from other countries. The United Kingdom is in this case a great example, with favourable data indicating positive cost-effective outcomes of NBSP. See the evidence presented in Section 2.3.
- Engage trusted public figures to amplify public health messages.
- Collaborate with research institutions for instance on publishing relevant research to disseminate and raise awareness on NbT-related evidence, as well as to share opinion pieces in the media highlighting individuals and communities benefiting from NbT prescriptions, while making sure to adhere to data protection rules.
- Highlight that more investment is needed in research to overcome knowledge gaps and create a strong evidence base, focusing for instance on funding clinical trials or research on cost-effectiveness of NBSP at national levels (43).

b) Building knowledge for prescribers

Ensuring prescribers have access to capacities, knowledge and agency related to NbTs and NBSP is key to a greater uptake of NbT prescriptions. The following are recommendations on actions to improve or create the conditions to access educational opportunities for you and your peers, beyond the facilities that you work in. Your role here is to identify and connect with the people in the institutions who have the responsibility to decide on the development and implementation of professional development.

Key elements to focus on are:

- **Set up or support peer networks to share knowledge and best practices on NbTs within and across local agencies where prescribers work.** These networks can be a useful resource for prescribers to connect with peers across different local agencies and with NbT providers, share knowledge and experiences, and learn from each other. These collaborations can be done at national and international levels.

CASE STUDIES

England

The NHS England Social Prescribing Network is a dedicated space for those working with, collaborating with, and supporting social prescribing, where they can connect with others, share ideas and access resources. The FutureNHS collaboration platform is an online network to access key resources, share learning and stay up to date with social prescribing developments. Webinars for social prescribing link workers are held every two weeks.

Germany

The Social Prescribing Competence Network, coordinated by the Charité – Universitätsmedizin Berlin, aims to bring together all stakeholders interested in social prescribing, especially from Germany, Austria and Switzerland, and jointly advance in this field.

- **Recommend that decision-makers invest in education and training to strengthen workforce knowledge and capacity on NbTs, and as feasible and relevant, provide or support this training yourself.** This also includes recommending to embed training on NbTs in the curricula of higher education. Education and training can help share the latest evidence on NbTs and its benefits to health, and support prescribers and future professionals to understand how they can raise awareness, prescribe, and scale up NbTs. In addition, specific training on how to overcome specific barriers of NBSP such as high workloads or prescribing to patients with complex needs would be useful. These training and capacity building programmes should be developed and offered by trusted institutions.

CASE STUDIES

Region of Catalonia, Spain

Professional training from the Social Prescribing Programme of the region of Catalonia: aims to provide the knowledge and skills necessary to implement social prescribing effectively in various areas, including primary care, social services, community organisations and other sectors involved in the promotion of health and wellbeing. This training is accredited by the Catalan Council for Continuing Education of the Health Professions (CCFCPS).

England

Social prescribing e-learning modules for link workers, provided by NHS England, to equip link workers with the knowledge and skills to deliver social prescribing. The online course takes around 3h to complete.

Nebraska, United States

A Retreat-Based Course for Fourth Year Medical Students course was developed at Creighton University on topics related to nature connectedness and health implications in preparation for their future work as future physicians.

4.2.2 Pillar 2: Mobilising resources

a) Secure funding to strengthen an environment that facilitates NbT prescription

NbTs and the infrastructure around them need sustainable funding. Demonstrating that NbTs have positive mental and physical health effects (see Section 2.2), and that they are a good return on investment (see Section 2.3) makes a strong case for why investors should consider funding them. Below are included ways to identify financial opportunities for securing resources for NbT access or creating or improving structural components in health and social care facilities that support their prescription.

This section recognises that in practice it is more common for NbT providers than for prescribers to seek financial resources for running NbTs and facilitating their access. However, funding can be a big barrier for NbT uptake and by taking up on the recommendations below, in collaboration with your peers and/or NbT providers, guided by the steps listed in the previous section (see Section 4.1), you could play a role in overcoming this barrier.

For a more detailed discussion of funding issues, see RESONATE's "**Nature-based therapies sustainable financing guide: A market and financing overview of nature-based therapies in Europe**" (see here, available in December 2026).

Opportunities for small-scale funding:

- **Start small, by identifying the biggest cost barrier your patients face, whether it is equipment, activity fees or provider capacity, and gather concrete local evidence of it.** For example, "twelve patients this year could not attend because of activity fees". With this evidence approach a local NbT provider, green space manager or third-sector partner about a small, joint bid that solves one barrier well. A successful pilot is the most persuasive thing you can put in front of a commissioner later, as it builds the evidence base for a larger ask later on. See examples in Section b) Supporting equitable access.

- **Explore health insurance as a funding route where the system allows it.** In several European countries, health insurance funds have a mandate or interest in financing preventive and wellness activities. This is a means by which activity fees could be covered, and it could overcome accessibility issues for some individuals.

CASE STUDY

Health insurance supporting NbT reimbursement (Belgium)

In Belgium, mutual health insurance funds (mutualités) offer supplementary cover for preventive care and wellness activities alongside compulsory health insurance, funded through membership contributions rather than general taxation. They fund structured, GP-referred movement pathways: Bewegen op Verwijzing (Exercise on Referral), which connects patients with a professional coach to build an individualised plan for a more active life. Some funds also reimburse members for participation in recognised sports and activities, including walking and cycling.

- **Target funders already working at the intersection of health and environment.** A funder whose portfolio already bridges both fields may not only be more likely to entertain a nature-based prescribing bid but may already be building the field around you. Identifying who is funding adjacent work in your country and positioning your initiative within that momentum can help rapid progress.

CASE STUDY

Organisation that funds health and environmental initiatives (Portugal)

The Calouste Gulbenkian Foundation in Portugal, one of the largest endowed foundations in Europe, structures its grant-making around multi-year programmes that span both health and the environment, including Access to Care and Climate and Ocean. The Foundation has helped anchor the wider social prescribing movement by hosting the 2024 launch of the Social Prescribing Portugal Network and the country's first social prescribing manual.

- **Engage adjacent local businesses.** Identify businesses that benefit indirectly from more people spending time in and with nature, for example, outdoor games and equipment companies and local outdoor retailers, that may have a commercial interest in increased outdoor activity in their area. A local NbT scheme is well placed to approach these businesses directly for sponsorship, in-kind support (e.g. donated equipment or protective products), or small-scale local partnerships.

CASE STUDY

Partnerships with local businesses (Sheffield, England)

In Sheffield, a tool manufacturer partnered with Sheffield & Rotherham Wildlife Trust to donate garden tools to support community groups creating and maintaining local green spaces.

Opportunities for large-scale funding:

- **Identify opportunities for national funding.** A pilot funded through the routes above builds the evidence base to advocate for system-level change. Public financing in most cases is the only way to build the infrastructure and institutionalise the processes that one-off projects cannot sustain. With evidence and successful case studies in hand, potentially in partnership with an advocacy organisation active in the field (for example, the national association for primary care), connect with the people who hold the budget. This can be done by having a say as part of an institutional expert advisory or working group, or during a public consultation on health strategies or budget planning.

CASE STUDY

National funding schemes for social prescribing

England: The Social Prescribing Fund, in England. This proposed 10-year national fund aims to blend local investments from health partnerships, business and philanthropy with national support for community-based services linked to social prescribing, building capacity to meet higher demand.

Austria: As part of Health Promotion 21+, the Federal Ministry of Social Affairs, Health, Care and Consumer Protection in Austria provides funding for primary healthcare facilities to gain experience in the implementation of social prescribing.

b) Support equitable access

Identifying barriers to equitable access and securing adequate resources to overcome them is key to ensuring that all individuals can benefit from NbTs, regardless of their background and health or social condition. Underlying these recommendations is the need to create or reinforce links between health, social, environmental, mobility and civil society sectors, as well as to collaborate with trusted mediator figures from different communities who struggle to access NbTs.

The RESONATE toolbox includes a **"Guide to ensuring health equity in nature-based therapies"** (available here in December 2026). It is primarily aimed at researchers and providers – the people who are designing and implementing NbTs. However, the considerations on equity are also relevant for health and social professionals. Some ideas are included below, and more details can be found in the equity guide.

Ways to support equitable access to NbTs include:

- **Identify cost barriers preventing some individuals from accessing NbTs and advocate with funders to support equitable participation.** Potential funders are likely to include local authorities and businesses (as detailed above). They can support equity in NbTs by providing:
  - Participation subsidies. Partial or full reimbursement of activity costs for a specific group, for example, low-income participants.

CASE STUDY

Subsidies for participation (Sweden)

The Leisure Card (Fritidskortet) is a national initiative introduced by the Swedish government that gives children and youth between 8 and 16 years old financial support to participate in sports, culture, and outdoor activities, with the goal to lower financial barriers and promote an active and inclusive lifestyle.

  - Equipment provision. Lending banks for footwear, rainwear, walking poles and gardening or activity-specific tools remove a hidden upfront cost of participation, and are small and concrete enough for a single service to pilot.

CASE STUDY

Equipment banks (Sweden)

Fritidsbanken are equipment banks available in different locations in Sweden, with sports and leisure gear, where you can borrow items like skis, skates, fishing rods, balls of various kinds, and tents for up to 14 days completely free of charge.

  - Support for childcare options. Adults with caregiving responsibilities and no options for childcare may find it difficult to take part in NbTs. Providing safe childcare options, for instance integrated with other health services, could be an option to facilitate participation.

- **Advocate for support for volunteers.** People who are not used to engaging with nature may need additional help to support their motivation or to support their access. This could involve for instance pick-up services who would collect people in their homes, which may be particularly important for people with mobility impairment, or translators, or to support NbT providers to deliver their activities.

- **Promote the expansion and maintenance of green and blue spaces appropriate for NbTs.** Elements to focus on are: accessibility and safety, making spaces more attractive, implementing designs to support social interaction and physical activity, and that these spaces function as restorative spaces supporting psychological recovery and improving emotional wellbeing.

CASE STUDY

National programme to protect and restore urban green spaces (United Kingdom)

The Future Parks Accelerator in the UK is a programme that supports local authorities to improve the quality, sustainability, connectivity and access to urban green spaces at local level, to ultimately improve people's health and wellbeing.

- **Promote a diverse offering of activities.** From your practice with patients, you could identify unmet needs and liaise with providers and funders to increase the variety of NbTs available in the community, attractive and accessible to people with different needs (see more details on this in Section 4.2.3 a). Having a range of offers available that can meet everyone's needs is a core step in making a prescription and addressing potential for exacerbating inequalities (linked to Section 3, Step 5: Explore needs, preferences, and barriers).

- **Identify measures that make green and blue spaces easy to access for everyone and advocate with local authorities for their uptake.** Some examples include the provision of frequent public transport options, ideally for free or subsidised for particular groups, e.g. those from low-income neighbourhoods with little access to green or blue spaces. Invest in walking and cycling routes alongside public transport, again considering how to subsidise these options for those who need it.

CASE STUDY

Free public transport (Luxembourg)

Luxembourg is the first country in Europe to introduce universal The Fare-free public transport (FFPT) for all modes at a national level, contributing to an increase of passengers since its implementation, although that is also explained by an improvement of the transport infrastructure. Many European cities have implemented FFPT schemes over the last 20 years, at a smaller or limited scale.

4.2.3 Pillar 3: Strengthening infrastructure

a) Forming partnerships and promoting collaborations

Coordinated action between the health and s ocial systems in partnership with the NbT providers in the community is key for a smooth referral process, facilitating NbT prescription and individuals' uptake while making the link between the systems' needs and the service provision by NbT providers.

Ways to promote this include:

- **Improve the processes for the identification of appropriate NbT providers.** It is important to agree on how NbTs should be mapped, how to engage with NbT providers and what information should be gathered from them (see more details in Section 3.1c). Liaise on this matter with high-level leadership within your health or social care facilities, to assign this task to someone among the staff that has workload capacity and time. In England, for instance, link workers are often in charge of community development and outreach to NbT providers, although they are sometimes faced with high workloads and caseloads that hinder the completion of these types of tasks (55).
- **Form partnerships and connections with NbT providers in the community.** Formal partnerships are an official way to connect NbT providers with NBSP schemes. These partnerships with providers facilitate a smoother referral process, greater access and integration of community resources, release pressure from NbT providers, and help the scaling-up of NBSP schemes. The authors of this guide recognise that NbT providers face severe pressures to respond to healthcare and social care demands while accommodating a variety of individuals with multiple needs and conditions, challenged by limited funding and staff capacity (56).

The following two actions can help you:

- Identify if there is a person in charge in the facility in which you work, such as a link worker, to formalise these partnerships within local agencies and NbT providers. If there is no person formally in charge, identify who has decision-making power at a municipal or regional level to make these partnerships possible and liaise with the leadership in your practice to make the case, showcasing existing examples like the one from Canada below.
- Seek and promote the endorsement of these partnerships by professional associations in health and social care sectors. This could contribute to credibility, supporting NbT uptake and prescriptions, and could help convince authorities to integrate NBSP in the public system.

RESOURCES & CASE STUDIES

Mapping community resources

Region of Catalonia, Spain:
In the region of Catalonia, an online search tool exists called 'Actius i Salut' that identifies community groups and services. The platform allows individuals and organisations to add community activities and resources, and it also enables the identification of assets within a specific area.

Region of Västernorrland, Sweden:
Nature activity on prescription – digital maps for health trails, in Västernorrland County in Sweden, identify health trails and opportunities for outdoor recreation for different areas in the county, based on the level of difficulty.

CASE STUDY

PaRx Programme (Canada)

The PaRx is Canada's national nature prescription programme with more than 20,000 licensed prescribers and practitioners registered from across the country to prescribe nature. Thanks to formal partnerships with various stakeholders, various activities can be prescribed, including an annual pass to access Canada's National Parks, free entry to local botanical gardens or art exhibitions that bring nature indoors, and benefits of "free kms" for car-sharing services. In addition, the PaRx Connectors programme connects patients with trained practitioners, who can guide and support them in spending time outdoors.

- **Encourage active signposting.** Active signpost schemes involve staff in health and social care facilities, such as administrative teams at a front desk, providing information to people on NbTs, using directories and local knowledge. This often works best for patients who are confident and skilled enough to find their own way to NbTs. This is different from what prescribers do, since the prescription of an NbT is part of a personalised support plan to address underlying issues which may be affecting their health and wellbeing.

- **Promote collaborations between health and social sectors.** Formal collaborations and integrated action between the health and social sectors, in coordination with other relevant sectors (environment, economic) contribute to a smoother referral process and a more holistic approach to health. In practice, this can include connecting services provided in hospitals, primary care and nursing homes, ensuring the interoperability between systems for recording and sharing clinical data, or defining collaborative care models within multidisciplinary teams in primary care to manage specific health conditions. It can be helpful to identify if there is a person in the facility in which you work in charge of coordinating the connections between health and social care facilities. If no one is formally in charge, identify who has decision-making power at a municipal or regional level to make these collaborations possible and liaise with the leadership in the health or social care facility where you work to make the case, showcasing existing examples like the one presented in the box below.

CASE STUDY

Integrated health and social care for older adults (Denmark)

In Denmark, health and social care services are available on a universal basis depending on the need of the person requesting the service, and not because of age or being able to pay for it. In this context, following an integrated care approach, services such as home help, home nursing, rehabilitation and nursing homes are offered to the elderly at a municipal level.

b) Strengthening health and social care infrastructure

It is important to have an infrastructure that supports the effective functioning of NBSP and the uptake of NbT prescriptions. This refers to the physical configuration and other tangible materials in healthcare and social care facilities, technological systems, working and organisational infrastructure.

The following are recommendations, case studies and resources that you could use to improve the environment where you work to facilitate NbT prescription. As with the other recommendations, the authors realise that prescribers may not have the remit or capacity to take these forward. Some, for instance, are service-level decisions that would need the support of a clinical lead or engaged manager. The recommendations aim to help foster further thinking and provide support where action is feasible, rather than add an additional to-do list to busy schedules.

The recommendations are grouped in two categories, according to whether social prescribing schemes already exist in your context or not.

1) If a social prescribing scheme does not exist in your area or country:

- **Start small through a pilot project in collaboration with your team and immediate managers.** During this process, you can decide on referral routes to NbT providers, the role and involment of various professionals in the referral pathways, deciding who holds the community-asset list, or protecting time for the conversation an NbT prescription needs.

CASE STUDY

Social prescribing pilot project (Austria)

Between 2023 and 2025, 15 institutions from six federal states, including primary care units, paediatric practices and a facility for uninsured persons, were involved in a pilot project to test the effectiveness of social prescribing in various areas of the country. The pilot proved to be effective and, as a consequence, the Ministry of Health plans for an expansion in the coming years.

- **Support the development of a formal, nature-based social prescribing scheme or programme to facilitate the uptake of NbT prescriptions among prescribers in health and social care settings.** This can be done at the national, regional or local level. Such a scheme ideally includes a framework defining the target population and its needs, establishing a management structure, defining the roles and responsibilities of stakeholders involved (managers in health and social care facilities, clinicians, link workers, NbT providers / community-based organisations), and defining various referral pathways between patients and community-based organisations or groups in the context of well-connected health and social services for smoother referral process while making sure end users have sufficient access to NbTs.

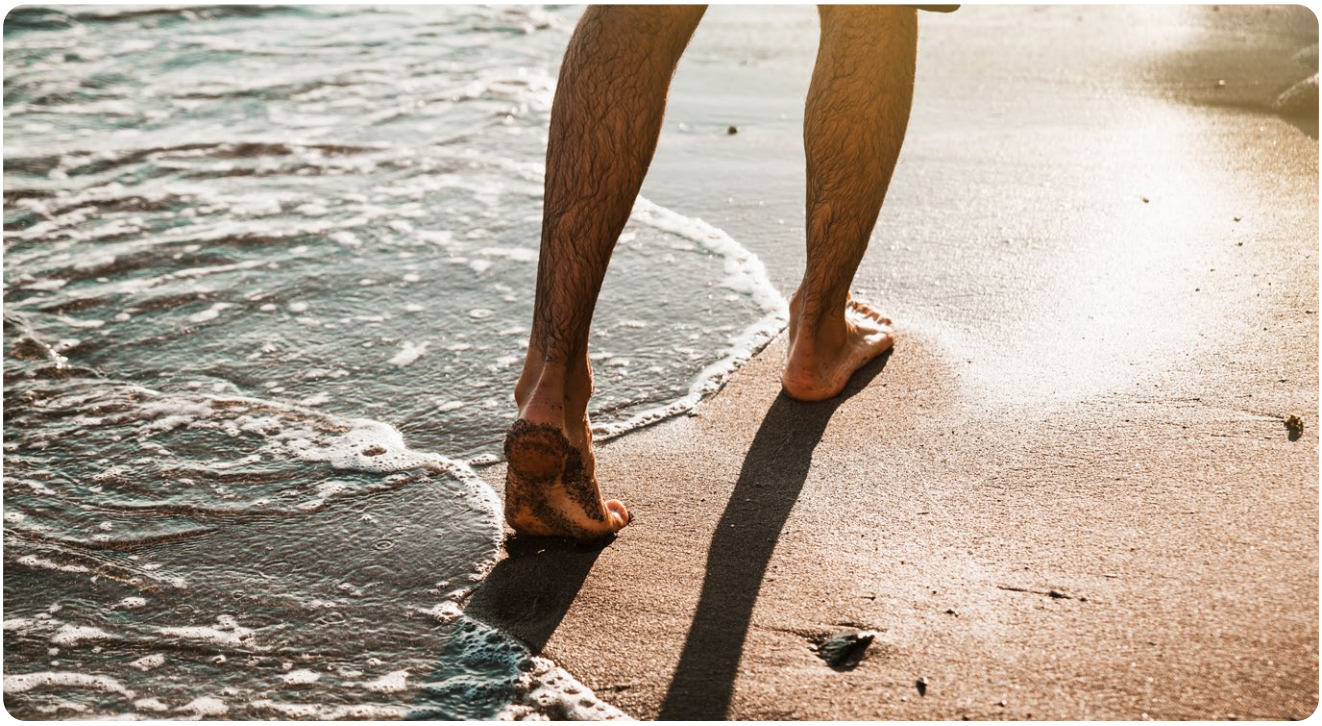
Key resources listed in Section 7.3 Annex III, related to the implementation of social prescribing and NBSP schemes, may be relevant for further reading.

CASE STUDIES

National and regional social prescribing schemes

England: England is a worldwide reference in the social prescribing field. While local schemes have existed since the 1980s, in 2019 social prescribing was formally recognised as a national health policy, part of the NHS Long Term Plan. This policy creates a framework and provides an infrastructure of multidisciplinary teams, mostly in primary care networks, to support personalised care in routine practice, based on individuals' needs and interests, and facilitate social prescribing and the link to community groups and services. As part of the NHS Long Term Plan, the government launched a two-year programme (2021-2023) to specifically embed green social prescribing within mental health pathways and across integrated care systems.

Region of Catalonia, Spain (regional level): The Social Prescribing programme in Catalonia started in 2011 with pilot projects and is currently implemented at regional level. The programme is coordinated by the General Sub-directorate for Drug Dependencies of the Department of Health of Catalonia, and is grounded in the WHO's community mental health care model, promoting person-centred and rights-based approaches.



2) If a prescribing scheme exists but you believe that improvements in the system are needed, you can follow the below recommendations, as relevant. The recommendations focus on making the case and connecting with the people who can decide on the implementation of the below asks. You can do this in partnership with other peers or with a professional advocacy organisation active in the field (for example the national association for primary care or another association that represents your voice as a professional in your field). You can also do this by having a say as part of an institutional expert advisory or working group, or during a public consultation on health strategies.

Some elements that may help improve prescribing schemes are:

- **Introducing or increasing the number of intermediary roles, such as link workers, in health or social care facilities, who can connect patients to social prescriptions.** Link workers play a key role in the prescribing pathway as part of collaborative, multidisciplinary teams, spending time with patients to understand what matters and motivates them, supporting them with a personalised, holistic care plan, and connecting them with community groups and services. Link workers also work with partners to increase community capacity by identifying community needs and connecting these needs with local community groups and organisations. The figure of an intermediary role like a link worker is not a must to make a social prescribing programme. However, the availability of such figures in the referral pathway can alleviate workload pressures of staff in primary care. The authors of this guide, however, recognise the existing pressures that link workers face, managing high workloads and spending a big amount of their time managing complex needs, left sometimes with limited room to take on wider functions defined in their role, such as undertaking community development, NbT providers' outreach, or take the time for training (55,57,58).

CASE STUDY

Co-existence of social prescribing schemes (Portugal)

In Portugal, several social prescribing schemes exist, coordinated by the National School of Public Health in collaboration with health units, municipalities and third-sector organisations. These different schemes involve various professionals who act as intermediary figures in the referral pathway (social worker, community pharmacies, municipal social offices), depending on where the referral was initiated (primary care unit, intermunicipal networks or third sector organisations).

- **Including nature-based social prescribing and NbT prescriptions in electronic health records systems to, on one hand, record and code the activity that prescribers undertake and, on the other hand, to provide a space for follow-up prompts with NbT providers while adhering to privacy restrictions.** Electronic health records provide prescribers access to patients' medical information, including a track of prescriptions, facilitating coordinated multidisciplinary care, decision-making and follow-up. From an equity perspective, such information can also provide information on what groups are receiving these prescriptions and track prescription uptake (linked to the following point on monitoring and evaluation).

CASE STUDY

Social prescriptions recorded by law (England)

In England, it is a contractual requirement for the primary care networks to record the referral to social prescribing services, including noting when social prescribing was declined. This information is accessible to all members of the primary care network multidisciplinary team. Link workers are also encouraged to register information related to the date and reasons for referral, who made the referral, number of appointments and time spent with link worker, where the person is being connected to, outcomes for the person.

- **Establish a monitoring and evaluation system for nature-based social prescribing schemes.** Monitoring helps to assess if targets are achieved on time and within budget, and to identify barriers to the successful implementation of NBSP. Evaluation allows an assessment of whether the objectives have been achieved efficiently and effectively. It generates evidence to show whether NBSP is effective and cost-effective in the given context. As part of this system, it is important to define what are the criteria for success, monitoring indicators, consider the feasibility of conducting an evaluation study, establish timelines for implementation and evaluation, and determine how progress and outcomes will be measured.

RESOURCE

Monitoring and evaluation of social prescribing schemes

Toolkit on how to implement social prescribing, developed by the World Health Organization. Step 7 'Monitoring and evaluation' (pages 38-43), includes suggestions for the monitoring and evaluation stages and how to involve the implementation team members at this stage.

4.2.4 Pillar 4: Shaping policy frameworks

Our healthcare systems tend to focus on treating diseases rather than adopting a more holistic approach to health that emphasises the social determinants of health and health promotion. It is therefore important to establish national/regional frameworks that focus on salutogenic initiatives and non-clinical methods, such as NBSP. These frameworks facilitate NbT prescription through policymaking, partnerships, interdisciplinary collaborations, and integrated care, with shared action plans and goals.

These recommendations are included to provide an idea of how to shape supportive policy frameworks that could help the scaling of NBSP. The authors of this guide realise that in everyday practice they are beyond the remit of most prescribers. However, they may help if prescribers have the opportunity to advocate for policy change with decision-makers, for instance as part of institutional expert advisory or working groups, or wish to provide responses to public consultations on health strategies. They can also support conversations with peers or advocacy organisations active in the field.

- **Advocate for health-related policy frameworks or specific health guidelines to recognise and include nature-based social prescribing strategies.**

  1. First, find out whether a prevention, wellbeing or social prescribing framework already exists in your country or region at the governmental level, and whether NbTs are named in it. If one exists, the fastest route to legitimacy is to use the terminology used in this existing and official

framework and cite it when you make the case for NbTs or when you ask for resources. If the prescription of NbTs is already authorised by an existing strategy or policy framework, you are negotiating from a much stronger position when claiming for more funding or improving the infrastructure for NbT prescription.

2. Second, where relevant national health guidelines exist on physical activity, mental health, loneliness, social connection, etc., approach the professional body or authority that owns them and help to make the case for NbTs to be recognised as a health promoting or healthcare strategy that could support reaching the desired health and wellbeing outcomes defined in these strategies. Physical activity guidelines can reference how outdoor NbTs help people meet activity targets; mental health guidelines can reference wellbeing outcomes; loneliness strategies can reference social connection. A named mention in a guideline is a durable foothold that every prescriber after you can cite.

- **Promote a more holistic approach to health, where prevention and health promotion are embedded in governmental planning and budgeting at different levels and across different sectors.** This can support the shift to a more salutogenic approach to health, that can facilitate the use of NbT prescriptions at community level. This can be achieved by:

  - Presenting, as a prescriber, the evidence to individuals in the decision-making process that hold the levers, with evidence that patients want NbTs (demand) and that prescribing them works in practice (feasibility). The use of evidence, successful case studies, and key resources is essential to make the case. You are welcome to use the content available in this guide, especially in Section 2 and Section 3.

  - Engaging in awareness campaigns (see Section 4.2.1), providing feedback during public consultations on national strategies, new regulations, and budget planning (as an individual or as part of a group), or collaborating with research institutions and advocacy organisations.

CASE STUDIES

Health guidelines that recognise nature-based social prescribing for health promotion

- The report 'From loneliness to social connection. Charting a path to healthier societies', developed by the World Health Organization, recognises social prescribing as an element of broader integrated care and effective community intervention for social connection.

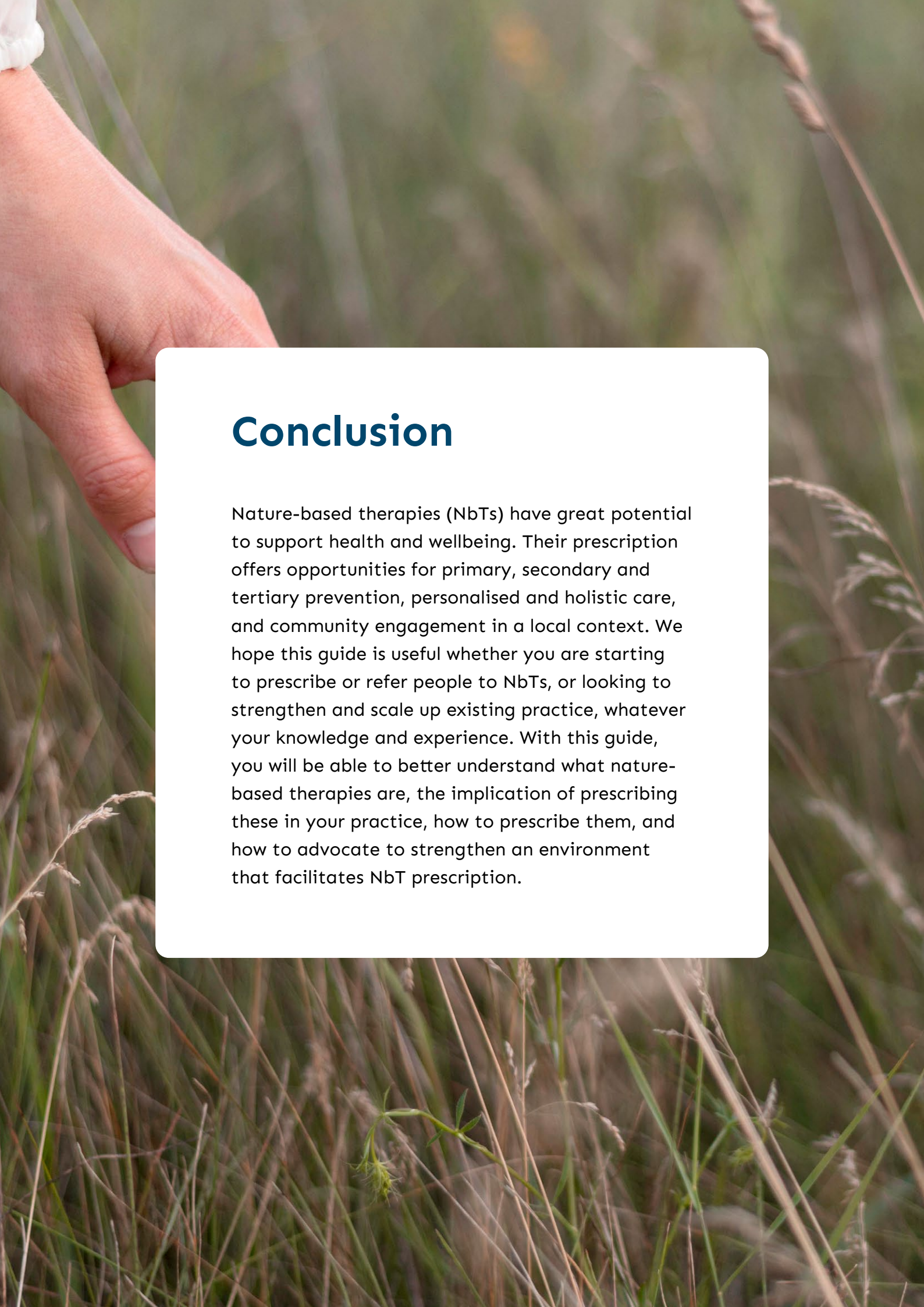
- Norway's 'Healthy Life Centres' are municipal prevention services that support people in making lifestyle changes and managing their health. National guidance suggests that centres make extensive use of outdoor areas for group activities and physical activities, collaborate with local outdoor recreation organisations, and can help people continue outdoor recreation after the programme ends.

CASE STUDIES

Legal frameworks that promote a more holistic approach to health

Germany: The Prevention Act in Germany is a legal framework in force since 2015 to strengthen health promotion and prevention. It represents a coordinated and multi-sector approach that brings together social insurance institutions and actors in the states and municipalities to agree on ways of cooperation for health promotion in schools, companies, day-care centres and other settings.

The Netherlands: The National Prevention Agreement in the Netherlands includes policy measures to improve healthier environments and lifestyles. In addition, as part of this framework, it is foreseen to develop investment models for prevention to improve how preventive actions are financed and evaluated, to better link investments in prevention with measurable outcomes and long-term savings.



Conclusion

Nature-based therapies (NbTs) have great potential to support health and wellbeing. Their prescription offers opportunities for primary, secondary and tertiary prevention, personalised and holistic care, and community engagement in a local context. We hope this guide is useful whether you are starting to prescribe or refer people to NbTs, or looking to strengthen and scale up existing practice, whatever your knowledge and experience. With this guide, you will be able to better understand what nature-based therapies are, the implication of prescribing these in your practice, how to prescribe them, and how to advocate to strengthen an environment that facilitates NbT prescription.

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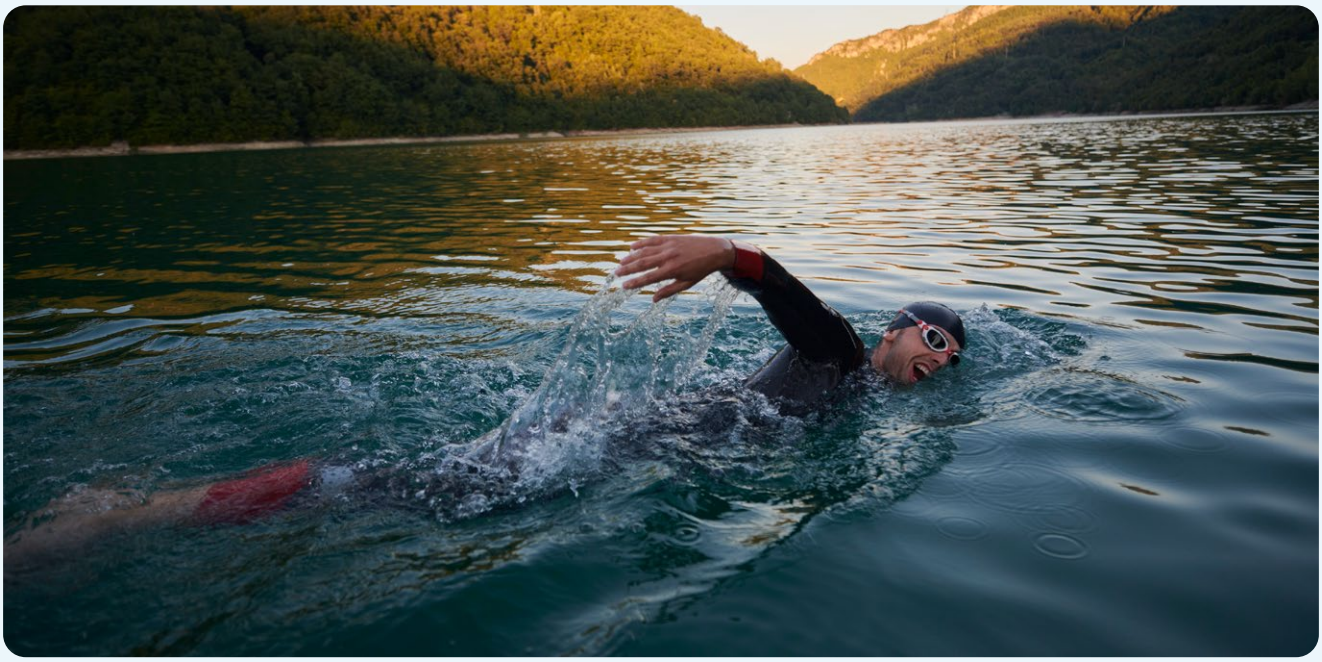

Annex

7.1 Annex I: Clarifications on terminology

There is no consensus among the scientific community on the terminology to use for this new approach to care through nature. A variety of terms are used in the literature related to nature-based therapies (NbTs), such as: 'nature-based activities, 'nature-based interventions', 'nature-based health interventions', 'green care', 'blue care', 'nature on prescription'. Similarly, multiple terms are also used to refer to the prescribing process underlying these activities, such as: 'nature prescribing', 'nature-based social prescribing', 'green social prescribing', among others. In line with the terminology used in the RESONATE Project, in this guide we use the term nature-based therapy. However, in this guide we acknowledge the wide-spread use of these other similar terms.

Similarly, and aligned with the RESONATE project, we chose to use Nature-based Social Prescribing (NBSP) as an umbrella term that captures the different factors that relate to the mechanism of linking individuals through referral approaches to non-medical community resources that include exposure to nature as the core element.

Thus, NBSP is understood as the mechanism in place for referring the individuals to the activities. NbT is understood as the activities where individuals are referred to.

7.2 Annex II: Methodology

This guide was based on a study that aimed at understanding prescribers' views on how to make greater use of NbTs as a form of prescription for health and wellbeing promotion while ensuring equitable outcomes. This study was informed by the Consolidated Framework for Implementation Research (CFIR) (59), commonly used in implementation research, and aimed at responding the question "what are prescribers' perceptions on potential barriers and facilitators influencing NbTs' uptake?". With this research question, we were able to identify barriers and facilitators that are directly linked to the prescribers' use of NbTs' prescriptions, such as the skills for using them, but also barriers and facilitators that are related to the effect of internal and external factors within and beyond health and social care facilities where the prescriptions are provided. These results informed the production of this document and guided the development of the recommendations in the different sections.

The study consisted of a literature review and 30 semi-structured interviews. The interviews were conducted in-person and remotely with health and social care professionals that had the potential to prescribe NbTs based in different European countries and in Canada. Although the RESONATE project has a major European focus, learnings and best practices of NbTs' prescription were explored worldwide (in particular in Canada). This was done in collaboration with Dr. Melissa Lem, Co-founder of PaRx and advisor for the RESONATE project. PaRx, which is Canada's national nature prescription programme, was identified outside Europe as a successful program worth exploring and learning from.

Among the interviewees in Europe and Canada, the level of knowledge and experience with NbTs and prescribing these was very heterogeneous, from almost no experience in prescribing these to some recommending NbTs on a weekly basis. More details of the sample are described in Table 4 The results of the interviews will be published in a separate publication in 2027.

Additional desk research was conducted to develop sections 2 and 3, and identify key resources and case studies showcased in sections 3 and 4.

	Europe	Canada
Total of number interviews	16	14
Gender	Female (6), Male (10)	Female (8), Male (6)
Occupation	General practitioners (4), physiotherapist and occupational therapist (3), pharmacist (3), link worker (2), mental health provider (2), nurse (2)	General practitioners (4), mental health provider (3), physician obstetrician (1), social worker (1), nurse (1), pharmacist (1), physiotherapist and occupational therapist (1), naturopathic doctor (1), paediatrician (1)
Geographic location	By European country: Austria (1), Bulgaria (1), Croatia (1), France (1), Germany (1), Greece (1), Italy (1), Norway (1), Portugal (2), Slovenia (1), Spain (2), Sweden (1), Netherlands (1), United Kingdom (1)	By Canadian province: British Columbia (10), Ontario (3), New Brunswick (1)

Table 4. **Characteristics of prescribers interviewed**

7.3 Annex III: Further resources

For professionals or organisations who are looking to set up social prescribing and nature-based social prescribing schemes in their areas or beyond, we include below four resources that could help further action.

A toolkit on how to implement social prescribing (2022)

Author: World Health Organization (WHO)

This toolkit for managers and staff at health and social care facilities provides simple steps to implementing social prescribing. It includes details on the different implementation steps, checklists and case studies. The guidance and recommendations are adaptable to different healthcare and social systems.

Link: iris.who.int/server/api/core/bitstreams/eeb3a70f-f3dd-4f83-9157-75daede4df49/content

Nature on prescription handbook (2021)

Author: European Centre for Environment and Human Health, part of the University of Exeter Medical School

This guide includes evidence-based suggestions on how to develop and implement nature prescriptions under social prescribing schemes. It is aimed at providers of group, nature-based interventions that target mental health conditions, delivered via social prescribing schemes, but the content can be of interest for all professionals involved in social prescribing (link workers, GPs, commissioners, researchers, etc).

Link: www.ecehh.org/research/nature-prescription-handbook/

Green social prescribing toolkit (2023)

Author: National Academy for Social Prescribing

This guide for implementing green social prescribing is for professionals who are responsible for starting, developing or growing nature-based social prescribing schemes.

Link: socialprescribingacademy.org.uk/media/3ozd3tv2/nhs-green-social-prescribing-toolkit.pdf

An induction guide for social prescribing link workers in primary care networks (2022)

Author: NHS England

This guide provides essential information for link workers who are new to the role. It includes guidance on ways of working and resources to support these professionals in carrying out their responsibilities effectively.

Link: www.england.nhs.uk/wp-content/uploads/2022/12/social-prescribing-link-worker-welcome-pack-web-2.pdf

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This guide was developed by EuroHealthNet, as part of the RESONATE project. RESONATE is funded by the European Union's Horizon Europe Research and Innovation programme under grant agreement No. 101081420 and co-funded by the UK Research and Innovation grant award No. 10063874.

Co-funded by the European Union

UK Research and Innovation