Family Resource Centre National Forum
Supporting • Strengthening • Empowering

Health & Wellbeing Community Referral

The Health and Wellbeing Community Referral Programme

Cork/Kerry Social Prescribing Service Annual Report 2022

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Incorporating an External Review of Service Quality & Impact

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Family Resource Centre
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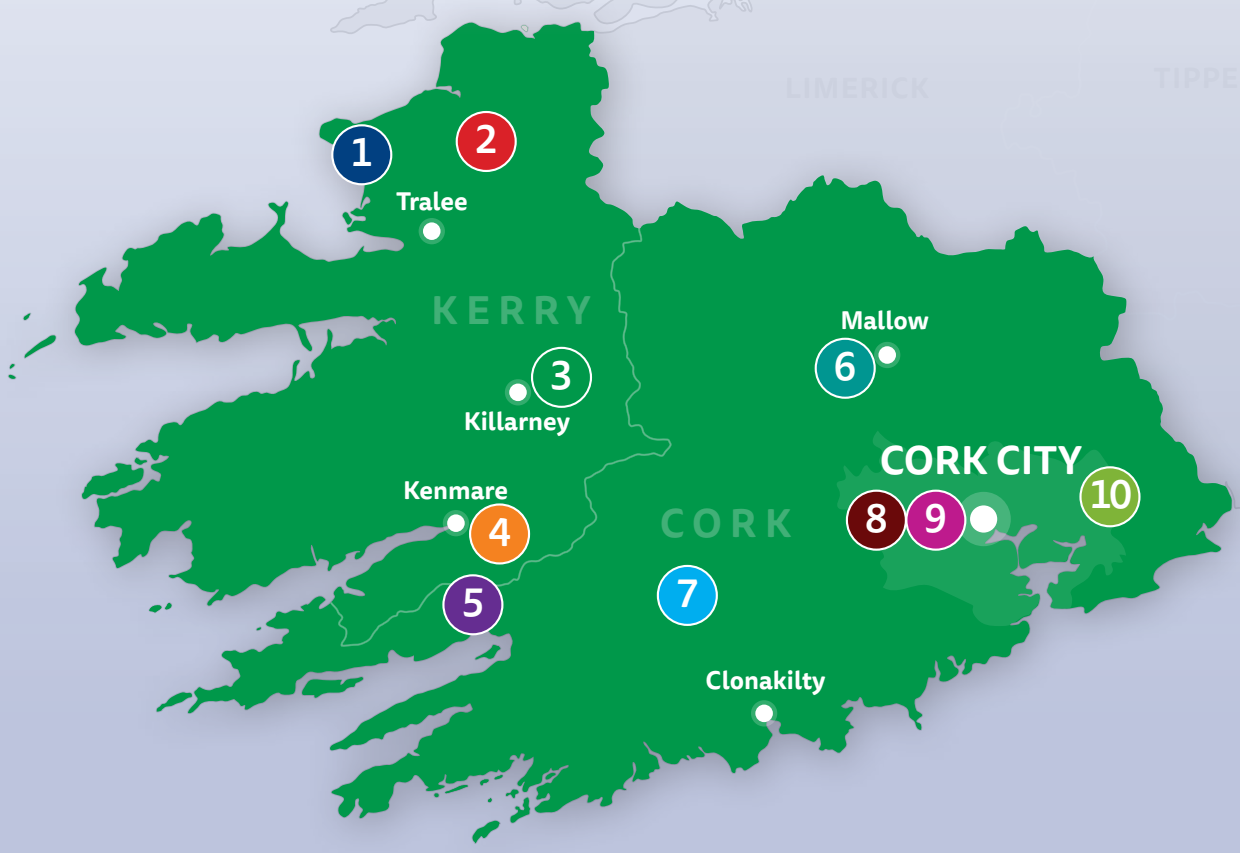
Community Referral

Map of HWBCR Program



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Foreword

The Health and Wellbeing Community Referral Programme - Social Prescribing Service Cork/Kerry and social prescribing more generally are key flagship developments for the Family Resource Centre National Forum.

Jackie Landers
CEO, Listowel FRC

Fergal Landy
CEO

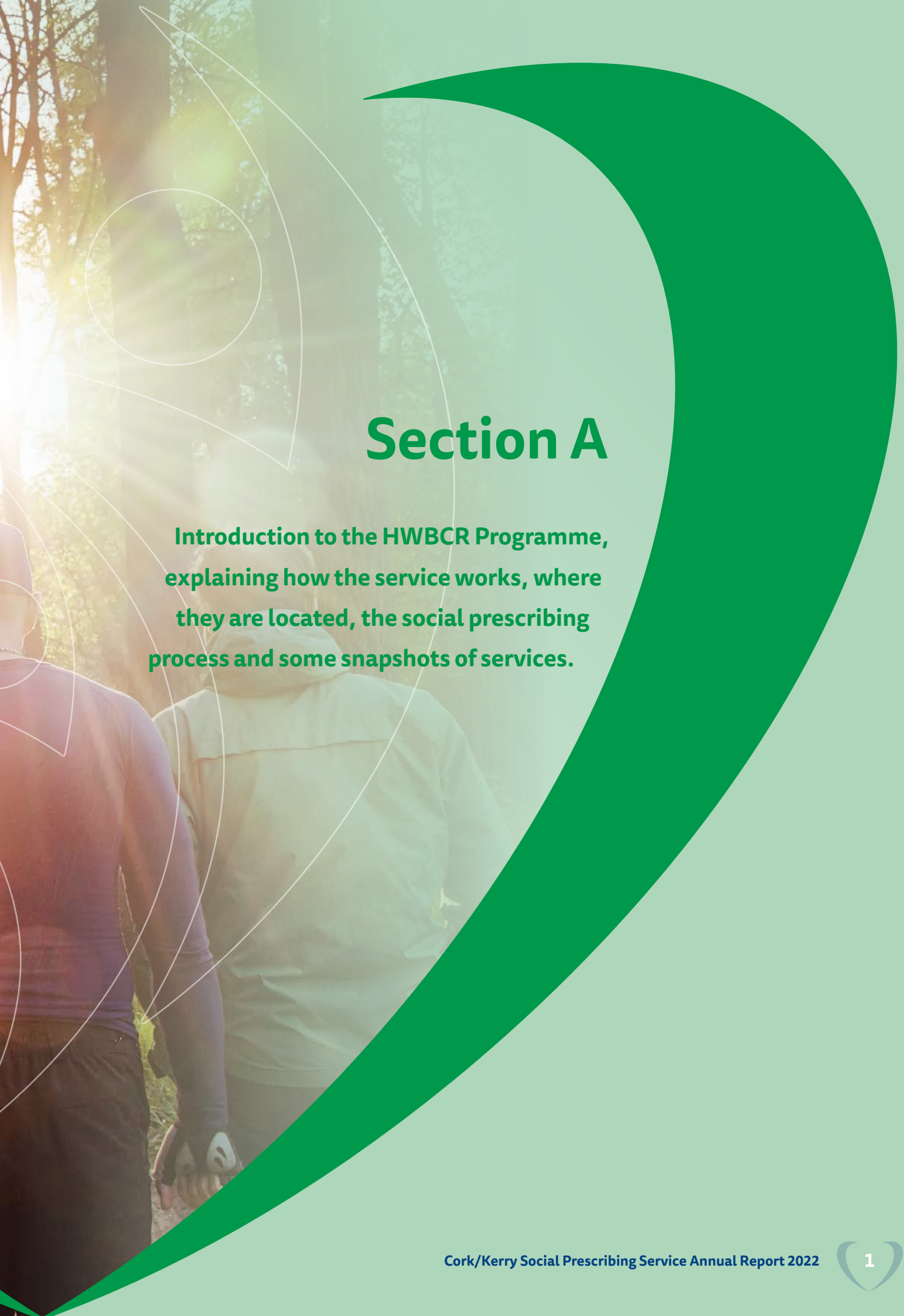
Established in 1998, the Family Resource Centres (FRC) National Forum is the national representative and peer support body of the 121 Family Resource Centres (FRCs) throughout Ireland and collectively we implement the FRC National Programme. The Family Resource Centre Programme is core funded by Tusla - The Child and Family Agency, which provides funding to all 121 Family Resource Centres in Ireland. It is Ireland's largest programme delivering a human rights-based approach to community development and family support programme across the life-course. The principal objective of the FRC programme is to combat disadvantage and to strengthen and empower children, individuals, families, and communities.

Our vision is that all children, families, individuals, and communities will actively participate and be included in a society that is equal, equitable, inclusive, and non-discriminatory and which will enable their optimal wellbeing, and our mission is to support, empower and represent Family Resource Centres so that collectively we can deliver our FRC Programme that creates and influences positive change in our communities. We are guided by our values in respect of equality and human rights, social inclusion, collective action, participation, and climate change, climate justice and our practice principals around transparency and accountability, collaboration, and autonomy.

This report helps to demonstrate the excellent fit that exists between the FRC National Programme and the concept of social prescribing. The human rights-based approach to community development and family support across the life-course that FRCs operate, represents an ideal context for the delivery of social prescribing. FRCs provide a warm and welcoming local environment, with trusted staff, from which social prescribing activities can be coordinated. FRCs also offer a range of health and wellbeing supports that can complement the delivery of social prescribing. Social prescribing is quickly becoming an essential tool used by FRCs as part of their commitment to social inclusion and participation. The sense of place and community belonging that FRCs foster optimises the delivery of the Health and Wellbeing Community Referral Programme in Cork and Kerry.

At a key point in the strategic development of the FRCNF and the FRC National Programme, this Annual Report 2022 for the Health and Wellbeing Community Referral Programme - Social Prescribing Service Cork/Kerry, inclusive of an external review of service quality and impact, provides tangible evidence of the current and future potential impact of social prescribing delivered through the FRC National Programme. It also points to the potential to further develop the practice of social prescribing, across the country to more FRCs and across our various areas of work with older people, young people, children and families.

Through the work of the FRCNF on behalf of FRCS we look forward to facilitating the further development of social prescribing as a key part of the FRC National Programme.



Section A

Introduction to the HWBCR Programme, explaining how the service works, where they are located, the social prescribing process and some snapshots of services.

Introduction

The Health and Wellbeing Community Referral (HWBCR) was originally a pilot project with six sites, funded through the Slaintecare Integration Fund 2019-2021. This model of social prescribing was based on the approach in Listowel Family Resource Centre.

The pilot initiative has now grown, achieving mainstream funding for 10 social prescribing services situated in 9 Family Resource Centres and one Community Development Project (CDP), across the geographical area of HSE CHO4 in Cork/Kerry. These sites are aligned with various community healthcare networks.

The programme aims to address health and wellbeing needs through engagement in meaningful social activities and community participation. It also endeavours to support people with issues such as social isolation, anxiety, loneliness, and inactivity, which negatively affect health and wellbeing. While these issues can particularly impact older age groups, they can also affect those that endure chronic health problems, people with mental health difficulties and psychosocial needs, the bereaved, carers, single parents, migrants and immigrants and people from ethnic minorities or disadvantaged backgrounds. Social prescribing aspires to work holistically, using a resource-based approach to empower participants to improve their wellbeing.

Link workers with specialised training provide a warm welcome to the service user, and they have the capacity to give several one-to-one social prescribing sessions. Here the social prescribing link worker facilitates people to reflect on their wellbeing and situation in life and identify what they see as difficulties. They work together, and the person is enabled to learn about and be supported to engage with local opportunities. Using a strengths-based approach, they work with the social prescriber to design personalised solutions that fit their needs, abilities and situation.

Social prescribing is just one response in Ireland's collective actions to address poor mental health and wellbeing. As an emerging area of practice in mental health promotion, prevention, and primary care provision, social prescribing enables healthcare and other professionals to refer people to a range of local, non-clinical services primarily provided by the voluntary and community sector. The expansion of social prescribing in Ireland became a key component of the 2021 Programme for Government and is an action in many recent strategies and policies, including the HSE Mental Health Promotion Plan 'Stronger Together' 2022–2027, Sharing the Vision 2020-2030, the Sláintecare Implementation Strategy and Action Plan 2021-2023, and also the Healthy Ireland Action Plan 2021-2025.

This report will focus on the manifold impacts of the mainstream rollout of the Health & Wellbeing Community Referral Programme in Cork/Kerry, delivered through the Family Resource Centre National Forum and funded locally through HSE Health and Wellbeing in Cork and Kerry.

The research section was led by the Department of Occupational Science & Occupational Therapy in UCC, by Yvonne Pennisi and Joy Kelleher. This report aims to give an insight into the delivery of services across the programme and identify the associated health outcomes for service users for the period January to December 2022. This will be illustrated using service user outcome measures and supported by qualitative data, along with link worker and service user feedback.

Background

The Health and Wellbeing Community Referral Programme (HWBCR) is rooted in the concept of social prescribing. Social prescribing is an alternative or complementary support to tackle health and wellbeing limiting factors in a person's life.

It is based on a collaboration between key stakeholders - HSE Health and Wellbeing, Family Resource Centre National Forum, FRCs, CDP, GPs, Primary Care Teams, and Mental Health Services, and continues the successful partnership between the National Forum of Family Resource Centres and HSE Health and Wellbeing in Cork and Kerry, as evidenced in the evaluation conducted by UCC in 2021.

The mainstream rollout is led by the National Forum of FRCs, through a local service arrangement with HSE Cork and Kerry. The recruitment of a regional coordinator has ensured that the services is streamlined and delivered to the highest quality. The National Forum takes a lead on the administrations of funding to all 10 sites, KPI reporting, monitoring of outputs and service provision, while developing best practice in relation to social prescribing. The regional coordinator who is line managed by the National Mental health Programme Manager through the National Forum is responsible for ensuring all sites are supported to meet the demands of their service. They also take a lead role in sourcing professional development for link workers, including reflective practice and WRAP training. The role of the regional coordinator is fundamental to the success of the service across the 10 sites. They provide cohesion, leadership, support and ensure accountability.

Reflective Practice and Peer Support Structuring session

This implementation of mainstreaming takes into consideration the essential criteria outlined in the Social Prescribing Framework 2021, such as data collection methods, evaluation tools, link worker targets/KPIs and exploring the expansion of referral pathways with those in the allied healthcare professions and engagement from more GP practices.

Partnership with key areas in the HSE is an essential focus of the mainstream rollout in Cork and Kerry. The National Forum, through the employment of a regional coordinator, supports link workers to engage with supports and services provided by the HSE self-management, health and wellbeing programmes such as Living Well along with healthy eating and smoking cessation programmes. This collaborative approach is fundamental to the programme's success, for both the service user and the service providers, maximising a more cohesive understanding of what social prescribing is and how it can benefit everyone.

What is social prescribing?

Social prescribing is a holistic approach to healthcare that brings together the social and medical models of health and wellbeing. Social prescribing recognises that health is heavily determined by social factors such as poverty, employment, housing and childhood experiences.

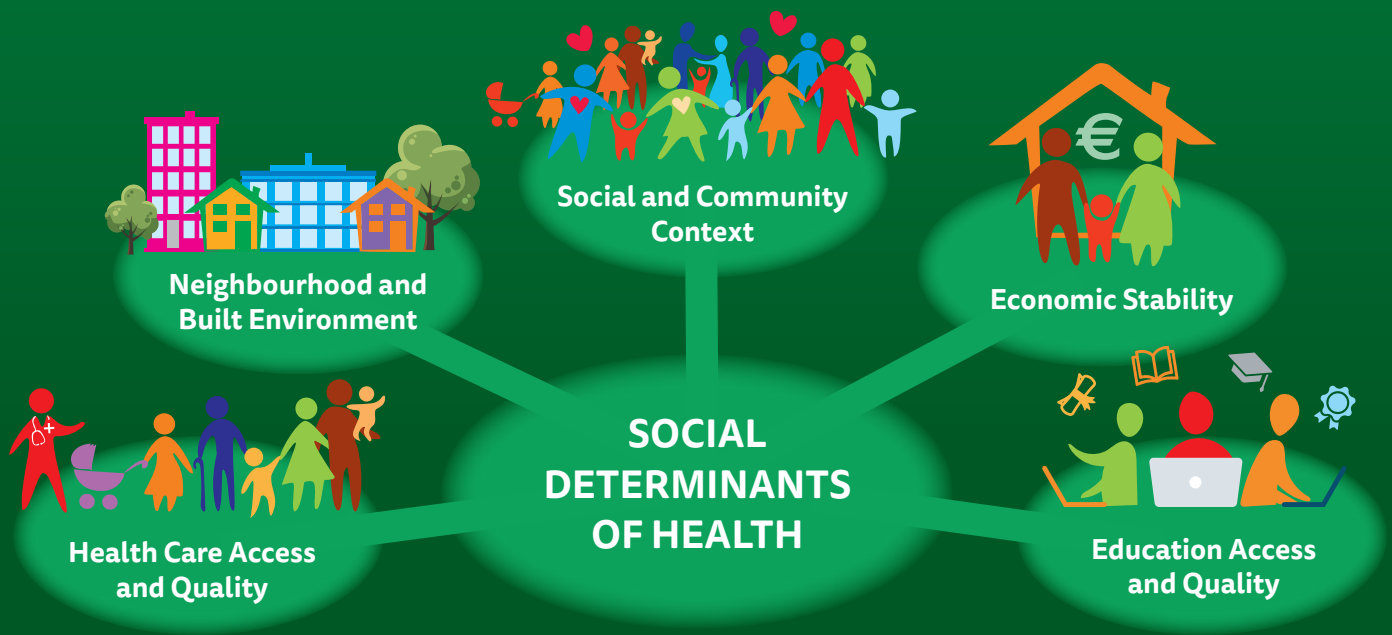
Social Prescribing offers GPs and other health professionals a means of referring people to a range of local, non-clinical services such as physical activity groups, reading clubs, arts and creativity workshops, stress management programmes, financial advice services, men's sheds, community gardening, and many more.

Social prescribing is not a replacement for adequate clinical services, nor is it a social work or counselling service. It is a complementary service that aims to address the broader determinants of health and wellbeing in a personalised and empowering way.

The following are the principles of social prescribing as adapted from the HSE Social Prescribing Framework, 2021:

- **Focuses on the individual's needs in a holistic way.**
- **Individuals are empowered to become co-producers of their health and wellbeing.**
- **Takes into consideration the broader determinants of health, including environmental, social, and economic factors.**
- **Increased focus on early intervention and prevention**
- **Emphasis is placed on building social connections and forging social capital.**
- **Utilises the support and services provided by community, voluntary and private sectors.**

Social Determinants of Health



How does social prescribing work?

A referral is received from any healthcare professional/other professional, or a potential service user can self-refer to the service.

The social prescriber liaises with the referrer to ensure that the social prescribing service is an appropriate fit for the service users' needs at this time, if it is not, then the link worker may refer to a more suitable service or back to the referring agent.

The Social Prescribing journey

Who can avail of the service?

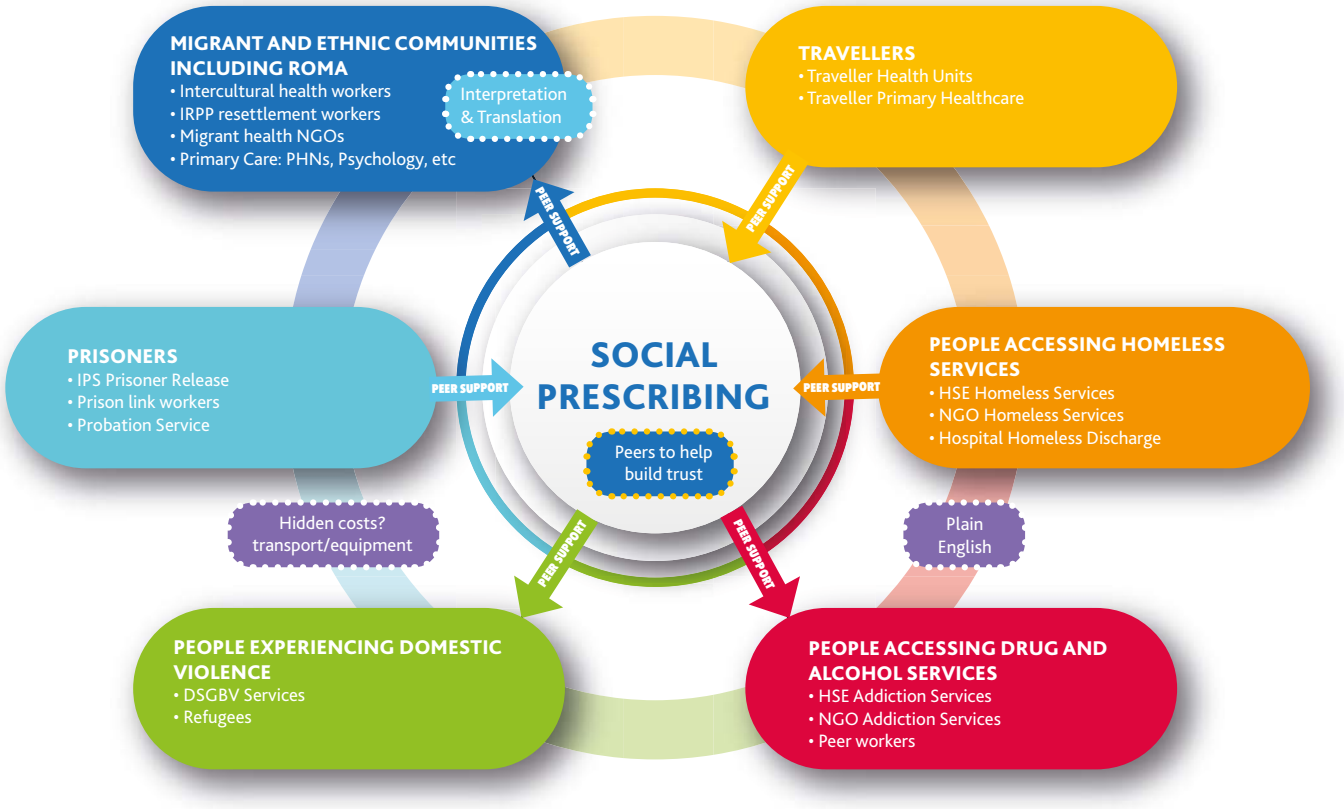
The service is open to anyone who feels they could benefit from using it.

They must be over 18 years of age including (but not exclusively) people who:

- **experience low mood, anxiety, depression and or mental wellbeing issues.**
- **have chronic health issues.**
- **experienced bereavement or loss.**
- **are frequent GP/ED attendees and may benefit from other social supports outside of clinical services.**
- **are members of marginalised groups, e.g., ethnic minorities, Traveller community, asylum seekers, and members of the LGBTQ+ community.**
- **feel disempowered through life experiences, i.e., homelessness, drug/alcohol misuse, contact with the criminal justice system.**

This is not an exhaustive list; link workers will determine with the person if they can benefit from social prescribing at that time.

Routes to social prescribing from social inclusion services



(Source: HSE Social Prescribing Framework, 2021)

The benefits of placing this service within the community

The HWBCR is a community-based service. Family Resource Centres (FRCs) and Community Development Projects (CDPs) work is targeted to support those most disadvantaged and at risk.

They are strategically located in deprived communities across Ireland, where individuals, families and communities struggle daily with many social & economic challenges. Transgenerational issues, barriers of poverty, deprivation, lack of resources, and unemployment are just some of the issues faced by members of these communities. The FRC/ CDP Programme works through community development principles- empowering people to take control of their circumstances by building them up through support.

FRCs view social prescribing as a natural extension of the work they already do, being that gateway to community supports and having trust and established relationships within communities. 9 of the 10 sites in Cork/Kerry are located in FRCs, with Ballyphehane/Togher within an established CDP. The benefits of locating the social prescribing link workers and services within a community-based organisation are manifold. FRCs and CDPs provide wrap-around services and have been instrumental in the work's success to date. The range of supports and activities that can be referred to and from, is considerable.

For example:

- **Counselling**
- **Family support**
- **Wellbeing focused activities/classes**
- **Parent & toddler groups**
- **Community meals**
- **Men's sheds and women's groups**
- **Training and educational opportunities**
- **Volunteering opportunities**

Social prescribing services

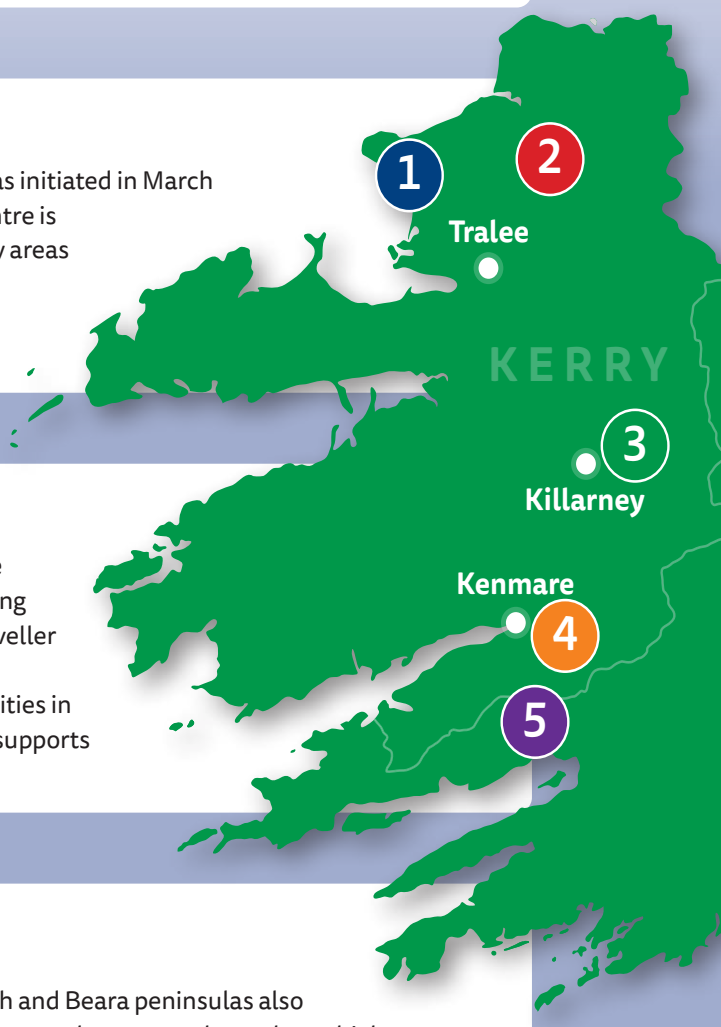
Health and Wellbeing Community Referral Programme Cork/Kerry

1 Kerryhead/Ballyheigue FRC

Kerryhead/ Ballyheigue Family Resource Centre is located just outside the North Kerry town of Ballyheigue. It also supports Ardfert, Tralee, Fenit and Causeway. This part of Kerry and specifically the Kerryhead region has shown to be an area of rural isolation. The Kerryhead/ Ballyheigue area also has a high level of one parent families as well as carers and individuals with disabilities.

2 Listowel FRC

The Listowel Health and Wellbeing Referral Programme was initiated in March 2018. The catchment area of Listowel Family Resource Centre is Listowel urban, Listowel rural and surrounding North Kerry areas with a population of over 15,000 people. The primary focus of Listowel Family Resource Centre is to provide family support in an inclusive and empowering way.



3 Ballyspillane FRC, Killarney

Ballyspillane FRC is situated in Ballyspillane housing estate on the outskirts of Killarney. There is a large number of young families including a high population of ethnic minority /Traveller families compared to other areas of Kerry. The FRC focuses specifically on supporting vulnerable families and communities in need of early intervention, preventative and other specific supports and programmes.

4 Kenmare FRC

Greater Kenmare's location at the conjunction of the Iveragh and Beara peninsulas also covers Kilgarvan, Bonane, Sneem, Lauragh and Tuosist. Kenmare has an age dependency higher than the national average and a relatively lower level of residents in the economically active age cohort. A direct provision centre has been located in the town since 2018.

5 The Caha Centre FRC: Adrigole/Beara

The catchment area served by the Caha Family Resource Centre is vast and sparsely populated and this has an impact on the approach to, and delivery of, services and supports. The decline in local economic activity has led to the closure of much infrastructure - several local shops, pubs, Garda Stations, and post offices. The increase in marginalisation and peripheralisation of the area has also impacted psychologically and emotionally on those living here.

Health & Wellbeing Community Referral

Social prescribing Services (continued)

Le Cheile FRC Mallow

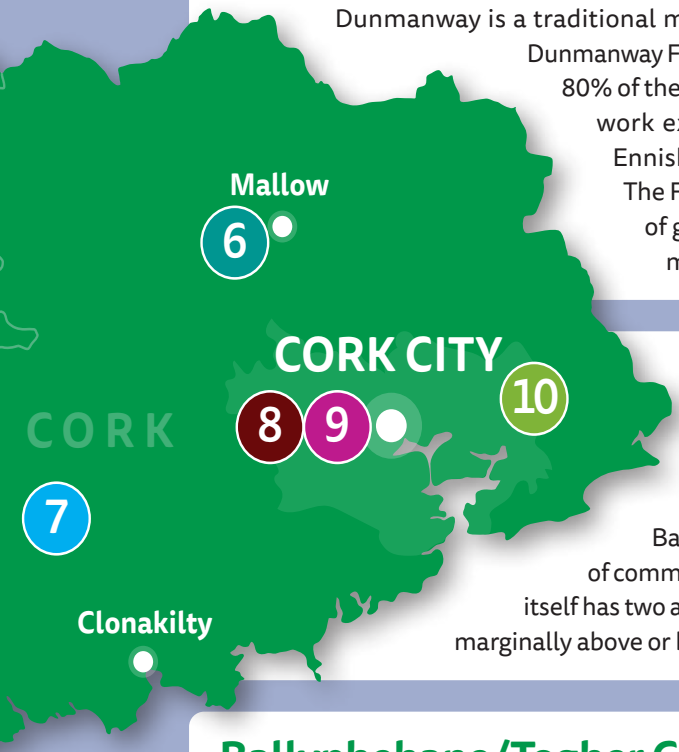
6

Mallow is known as the Crossroads of Munster; it has a population of approx. 13,500 people. Compared to national or county average, Mallow has a higher proportion of ethnic minorities, with the largest being "white non-Irish" – other minorities that are represented include Black Irish and members of the Irish Traveller community. Mallow has a dependency ratio that is higher than national average and higher than the Cork average. Of the 51 small areas in Mallow, 11 have a deprivation score which indicates that are disadvantaged or very disadvantaged.

Dunmanway FRC

7

Dunmanway is a traditional market town in the valley of the Bandon River in West Cork. Dunmanway Family Resource Centre covers a wide geographical area, with over 80% of the population living in the rural hinterland. The social prescribing work extends out beyond this including areas around Clonakilty, Enniskean, Ballineen, Drimoleague, Roscarberry and Skibbereen. The FRC provides family support services, low-cost therapy, a range of group activities throughout the year, a community garden and meals on wheels.



Ballincollig FRC

8

Ballincollig area is considered an affluent town which recently amalgamated with Cork city council. Ballincollig is a centre of industry which brings people to live in Ballincollig but unfortunately there is very little available in terms of community resources despite its growing population. Ballincollig town itself has two areas that are considered to be disadvantaged with the rest being marginally above or below average.

Ballyphehane/Togher CDP

9

Ballyphehane/Togher Community Development Project is a community anchor project linking residents, groups, and public services. It is managed by a local voluntary committee and offers programmes in community childcare, health, development, arts, education, administration, and support. As a CDP, it works to challenge the causes of poverty and disadvantage and to promote equality and inclusion. Togher and Ballyphehane are both suburbs on the southside of Cork City.

Midleton FRC

10

Midleton has seen a rapid expansion of the area with a 16% increase over 5 years. The demographic of Midleton community changed somewhat in the last few years with an influx of new communities being welcomed. The centre provides information, advice and support to target groups and families through the provision of parenting courses, counselling, ansd workshops with an emphasis on mental health and wellness.

1

CHN 01

Kerryhead/Ballyheigue FRC

Based in:

Kerryhead/Ballyheigue Family Resource Centre

Service area:

Abbeydorney, Ardfert, Ballyheigue, Castleisland, Causeway, Lixnaw and Tralee.

Hours of operation:

Part-time 18.5 hours per week

Sources of referral:

Mental Health Team, Self-referral, Primary Care, Family Resource Centre

2020	2021	2022
67	44	55

Most common presenting issues:

Anxiety, isolation, depression, lack of transport

Some of the referral options utilised:

Men's shed, women's shed, yoga and exercise groups, social groups.

Social prescribing process – case study:

- **Referral source:** Mental Health Team.
- **Presenting issues:** Anxiety and depression as well as family issues.
- **Work done together:** Supported person in finding a training course so that she could begin to get back to employment.
- **Outcome:** Person also joined a walking group and the women's shed

Service User Quote:

The service user said that the experience of working with me ***"really helped her to find herself again"***.

What do you see as the benefits of social prescribing?

"Giving a person's time and support so they can actively engage and be part of their communities and wider society."

Link worker

How has SP added value to the FRC?

"By adding a vital service to support our community and the surrounding areas."

What is the impact of SP on the community?

"It has supported isolated and vulnerable members of the community to reengage and therefore improve their wellbeing and mental health."

Manager

2

CHN 01

Listowel FRC

Based in:

Listowel Family Resource Centre
(since March 2018)

Service area:

Providing service to the North Kerry catchment area of the Family Resource Centre

Hours of operation:

Part-time 18.5 hours per week

Sources of referral:

GPs, Community Mental Health Team, self-referrals

2020	2021	2022
39	54	67
& Drop ins	& Drop ins	
197	155	

What do you see as the benefits of social prescribing?

"Social Prescribing is a brief intervention that can have a massive impact. Social Prescribing gives the person time to breathe and facilitates them to identify for themselves that they hold the answers."

Link worker

Most common presenting issues:

- Loneliness
- Mental Health issues
- Anxiety and Depression
- Lack of transport
- Isolation
- Financial issues
- Trauma
- Don't know where to go for support
- Housing issues
- Bereavement

Some of the referral options utilised:

- Counselling
- Addiction services
- MABS
- Kerry Co Council
- ALONE
- KETB classes
- Walking group
- Various Exercise groups
- Volunteering
- Support groups
- Returning to education
- Employability Services

continued ...

2

CHN 01

Listowel FRC (continued)

Social prescribing process:

Female aged 22, living at home with mom and nana. Bullied in primary school and had to transfer schools in secondary due to bullying. Socially isolated.

- **Referral source:** CMHT
- **Presenting issues:** high anxiety, severe paranoia that everyone is looking at her, isolates herself, doesn't have a friend group or support system, depends on Mom and goes everywhere with her. Currently waiting diagnosis from CMHT.
- **Work done together:** 1st meeting wanted Mom present, Assessment forms completed and general chit chat. 2nd meeting happy for Mom to leave and be on her own. Identified what interests and disinterests service user had and route to take to best support her.
- **Referral option selected:** Exercise class with social prescriber, yoga with Mom, Art 4 Wellbeing on her own. Volunteering. Guidance counsellor.
- **Support to access/engage:** Attended exercise with service user. Attended 1st few mins Of Art 4 Wellbeing with client and Secured volunteering with occupation that interested her.
- **Follow up:** weekly WhatsApp message and call.
- **Outcomes:** Enrolling in course in September, as a result of work experience option above.
- **Confidence building:** Now able to walk into exercise class in the gym on her own. Has built a small friend base with people who are like-minded, colleagues from volunteering and friends from her art class. Mom does not worry as much about her as she is now leaving the house.
- **Feedback:** ***"I had absolutely no one only my Mom, I had no friends, no messages on my phone, you changed that I'm excited what's ahead for me now."***

How has SP added value to the FRC?

"The Social Prescribing service is a human rights-based community development approach, actively participating with the FRC, to support our vision that all individuals take part and be included in a society that is equal."

What is the impact of SP on the community?

"The impact of social prescribing on the community includes outcomes such as new and more volunteers in the community, social groups increasing in numbers, links between services, new groups being formed etc."

Manager

3

CHN 01

Ballyspillane FRC, Killarney

Based in:

Ballyspillane Community and Family Resource Centre, Ballyspillane, Killarney, Co. Kerry
(since 30 August 2022)

Service area:

South Kerry

Hours of operation:

Part-time 18.5 hours per week

Sources of referral:

Mental Health Team, Public Health Team and Occupational Therapist.

Most common presenting issues:

Social isolation, loneliness, grief, self-esteem

Social prescribing process – case study:

A female was referred by mental health team to social prescribing service. The person has a history of eating disorders but was stable with the same and wished to engage more in the community and make friends due to working from home, living with a partner and having no outlet for herself. She did not have peer support in the area. She was referred due to social isolation and low self-esteem. The link worker spoke with her mental health team to ensure there were no restrictions on exercise or any activities etc., due to her history of an eating disorder. She stated she had no friends in the area to go out and have coffee with or talk to. All her life was within her home. In the initial meeting, she was unsure what she would like to try or what her interests were. She wanted to be able "to go for a coffee" with someone. Next meeting arranged for local café. Informed link worker of a particular interest that she had.

The person was referred to a social meet-up group that had her interest as a focus. This group that met monthly in the locality. The person has made friends and does not need as much support from SP, check-ins by phone are done every few weeks at the person's request. She regularly goes out for coffee and dinner with a friend group, usually one night per week. She states that her relationship with her family dramatically improved, now she has friends she can meet with regularly and make plans.

What do you see as the benefits of social prescribing?

"Social prescribing has the ability to change lives dramatically. It gives people choice and control over their lives and provides an improved sense of belonging."

Link worker

How has SP added value to the FRC?

"By adding a vital service to support our community and the surrounding areas."

What is the impact of SP on the community?

"Social prescribing service is a good fit within the FRC model as it complements the other services within the centre and they co-exist very strongly."

Manager

4

CHN 03

Kenmare FRC

Based in:

Kenmare FRC

Service area:

South and Southwest Kerry (from Loos Bridge to Kenmare, Sneem and along the coast to Cahersiveen)

Hours of operation:

Part-time 18.5 hours per week

Sources of referral:

Public Health Nurses, Community Mental Health Teams, GPs, Community workers, Home-help workers, Carers and Self-referral

2020	2021	2022
12	24	44

Most common presenting issues:

High levels of social isolation, loneliness, poor mobility, grief, dementia/alzheimer's, acute mental and social issues, poor health

Some of the referral options utilised:

Taobh Linn, Better Balance Bones, knitting group, cooking group, walking group, KETB, Rockmount day services, befriending services, art group, social group, rural social isolation worker.

Social prescribing process – case study:

Male mid-twenties diagnosed as neurotypical and also minimal speaking skills. He lives in sheltered accommodation. This service user had not left his accommodation in 2 years over Covid, and his mother was very worried about him. He was also unemployed with nothing to do during the day. By working with this young man over an eight-week period, the link worker set him up with cooking classes in the centre, he also joined a peer support group with their help, which opened up his social circle. The link worker discovered that he is a very talented musician, and it was arranged for him to play with another musician at the local community event, which he thoroughly enjoyed. The link worker also worked in partnership with the local employability service, and this service user is working. His job has allowed him to gain more confidence in himself, and also he is aware that we are here to help him going forward if he needs any help to join new activities.

What do you see as the benefits of social prescribing?

"Individuals who may have complex health and social care needs can be met and helped in a relaxed non-judgemental, empathic safe space and helped with breaking down the barriers towards social connections. It is worth remembering the role is not as simple as just referring the service user on. The relationship with the service user is key."

Link worker

How has SP added value to the FRC?

"It is an asset to have a community link worker who can take the time to help clients link back into the community. To encourage them to step outside their door and join groups of their choice, meet friends etc."

Manager

5

CHN 10

The Caha Centre FRC, West Cork

Based in:

The Caha FRC – Adrigole, The Beara peninsula.
(since March 2020 - position vacant during 2021)

Service area:

Providing service in Beara, Bantry, Sheeps head and surrounding areas in West Cork.

Hours of operation:

Part-time 18.5 hours per week

Sources of referral:

GPs and Public Health Nurses

2020	2021	2022
9	6	44

Most common presenting issues:

Isolation, loneliness, depression/low mood, isolation due to illness / health issues

Some of the referral options utilised:

FRC services, social walking groups, exercise classes, volunteering, community gardening, ETB or FRC education/classes, Alone services, services run by Carer's & Older Person's Support Workers

Social prescribing process – case study:

A service user was referred by her GP. She had recently moved to the area and English was not her first language. She wanted to improve her English speaking skills and get to know more people in her community also. She felt that she may also be dyslexic as she struggled with school work when she was younger. The link worker met a number of times and discussed her interests, hobbies and what she might like to get involved in. The process of meeting regularly and chatting helped raise her confidence in her language skills as well as helping her to focus on what activities she wanted to be linked into. She linked in with conversational English classes in the local ETB and really enjoyed them and felt her confidence building. She is now planning on doing a DIY class there in the Autumn. The link worker also supported this service user to access services such as Citizen's Information Service regarding entitlements, assisted her with paperwork for applying for her Irish Driver's licence and gave her information regarding options for volunteering in the future when she is ready.

What do you see as the benefits of social prescribing?

"Social prescribing provides a safe space for people to talk and explore their situation and helps them to prioritise their goals and make plans around linking in more with their communities or activities that will improve their overall health and wellbeing."

"The empathy and regular support they receive through social prescribing can be a real catalyst for them to initiate a change in their lives."

Link worker

How has SP added value to the FRC?

"SP has added a positive value to our work by providing an opportunity for the members of our community to avail of a professional, safe, one-to-one support in identifying the possibilities for them to engage and make connections within their locality, which they otherwise would find extremely difficult. SP also promotes all of the existing activities and services that the FRC provides and hosts."

SP impacts our community by improving social connection and interaction, thus helping in reducing social isolation and loneliness, providing important support for hard-to-reach people to have the opportunity to be involved in the process of identifying their social, emotional and mental health needs and support in finding the right connections and linking into the right activities and resources available to them in their own community."

Manager

6

CHN 04

Le Cheile FRC, Mallow, North Cork

Based in:

Le Chéile Family Resource Centre, Mallow (since January 2020)

Service area:

Mallow, Buttevant, Charleville, Kanturk, Millstreet, Newmarket and surrounding areas

Hours of operation:

Full time 37 hours per week (since April 2022)

Sources of referral:

GPs, self-referrals, public health nurses, mental health teams and occupational therapists.

2020	2021	2022
30	52	95

Most common presenting issues:

Social isolation, depression, anxiety, grief, addiction, pain.

Some of the referral options utilised:

Walking group, chair yoga, mindfulness, activator poles, befriending, volunteering, education, social groups, men's shed.

Social prescribing process – case study:

- **Referral source:** Mental Health services
- **Presenting issues:** depression, past suicidal attempts.
- **Work done together:** Listening to the person and facilitating a safe space for him to talk about his depression and sense of loss of the life he had.
- **Referral option selected:** Support in applying for social housing, encouragement and information about returning to education to return to work.
- **Outcomes:** the person has now applied for social housing and is actively job-seeking.
- **Quote from service user:** I never realised how much talking helps. Between [another service] and coming here, it has made a huge difference. I feel different. Like I have a future.

What do you see as the benefits of social prescribing?

"I believe that social prescribing can make a significant difference in people's lives. The first benefit is that individuals can receive the compassionate and supportive listening they need to explore their hopes and fears without any judgment. Secondly, social prescribing provides active guidance on the various resources that are accessible locally, nationally, or online. Persons often express amazement at the range of options available to them after their first consultation. This newfound knowledge can fill them with hope and a sense of empowerment."

Link worker

How has SP added value to the FRC?

"The presence of a social prescribing service at Le Chéile Family Resource Centre has had numerous benefits, as the link worker connects people into FRC services and activities, such as counselling or social groups, thereby expanding the reach of the centre and impacting the communities' wellbeing and social connectedness.

The link worker also helps people seeking support by providing guidance on available and appropriate resources, making social prescribing an essential service in building stronger communities, a primary goal of FRCs."

Manager

7

CHN 10

Dunmanway FRC, West Cork

Based in:

Dunmanway Family Resource Centre
(since June 2022)

Service area:

West Cork area.

Hours of operation:

Part-time 18.5 hours per week

Sources of referral:

- Self-referral – 25%
- GP – 15%
- Family – 15%

2022
22

Most common presenting issues:

Loneliness, isolation, mental health issues, health concerns/limited mobility

Some of the referral options utilised:

Community garden, ETB classes at Dunmanway FRC Employability services, Alone support group, daycare centre, exercise groups, counselling & addiction counselling,

What do you see as the benefits of social prescribing?

"It gives people the opportunity to have the time and space to talk about the issues that are affecting them without pressure. Person-centred and based on what they identify as their needs. It's great to link people with services and activities/groups they may not know about."

Link worker

Social prescribing process – case study:

- **Referral source:** self- referral
- **Presenting issues:** Living alone, new to the community, previous support from mental health services and anxious about accessing activities in the community.
- **Work done together:** Looked at the impact of negative experiences and isolation this had created. Identified interests and what was available in the community. Offered NLN course but unable to access this due to lack of transport and no one available to enable the person to get to National Learning Network (NLN).
- **Outcome:** Linked in with activities in the FRC, including aromatherapy and dancing. Ongoing work re anxieties which previously had stopped the person from attending activities/groups/courses. Linked in with ETB course at the local centre and a community garden.

8

CHN 12

Ballincollig FRC

Based in:

Ballincollig FRC (since 2021)

Service area:

Bishopstown, Ballincollig, Macroom, Ballyvourney

Hours of operation:

Full time 37 hours per week

Sources of referral:

Self-Referral, Family support, Alone, Primary Care (Podiatrist, OT, Social worker) Mental health services.

2020	2021	2022
5	17	64

Most common presenting issues:

High levels of social isolation, loneliness, poor mobility, grief, dementia/alzheimer's, acute mental and social issues, poor health

Some of the referral options utilised:

Employability, West Gate Foundation, Active retirement groups in Sector 12, ETB, Alone and local sports clubs.

The FRC provide personal effectiveness, parenting support, mindfulness, yoga, ASD parent's group, craft groups, Smart Recovery, men's shed and cork pride.

Social prescribing process – case study:

- **Referral source:** PHC mental health service
- **Presenting issues:** Anxiety
- **Work done together:** Met four times, the decision was made to try to get a job
- **Referred option selected:** to social welfare with regards to eligibility for employability. Accompanied to social welfare appointments. Referred to Employability for support in getting a job
- **Outcomes:** Is happy to go to Employability now as the route is planned, is aware of how to get there and has met the staff. Without the support of a link worker, this person would not have taken the steps to move forward.

What do you see as the benefits of social prescribing?

"Most persons report the personal attention and the more personal relationship as the most valuable part of the service. They feel heard, wanted, valued, encouraged, and supported. A link worker can have a professional relationship with the person but with a lower boundary threshold than medical staff. This is because the link workers are accessible and work more on the social side, bridging the gap between the medical and the social, helping people to find their way in the world."

Link worker

How has SP added value to the FRC?

"Social prescribing services in Ballincollig have supported improvement in the overall health of referred persons in both mental and physical health and reduced social isolation and loneliness through access to community resources such as walking groups/personal effectiveness workshops/community gardening/ community art/ along with referral to the local community and voluntary partners."

Manager

Ballyphehane/Togher CDP

9

CHN 14

Based in:

Ballyphehane/Togher CDP, providing service to Ballyphehane, Togher, Greenmount, Turners Cross, The Lough, Glasheen and adjacent communities. Also including two direct provision centres at Kinsale road area, a drug treatment centre and a homeless hostel in the locality. Significant coverage of CHN 14

Hours of operation:

25 hours per week (initially 18 hours per week)

Sources of referral:*

PHN Teams, Occupational Therapists, GP Practices, Primary Care Teams, Family referrals and Self-referral, Hospital Multi-disciplinary teams, Community Mental Health Teams.

2020	2021	2022
122	55	64
referrals, covid response, once-off support	referrals 25 once-off support 30	referrals 35 once-off support 28

Most common presenting issues:

Mental health difficulties, social isolation, dementia and carer support, older people with limited mobility and connectivity

Some of the referral options utilised:

Singing for the brain, green prescriptions – community gardens, tidy towns, men's sheds, walking groups, and CDP community education.

Social prescribing process – case study:

Male Client, aged 68, who availed of Social Prescribing – Service User telling his experience of the service:

When I came to the CDP first, it was somebody in the community who told me I should come here. I was introduced to the link worker. We started meeting every week. We had a very long meeting the first week and then for an hour or so every week after that. It was a place I could say out loud, all that was going on in my head. And I have a lot going on in my head, so much hurt and pain and stress and trauma from my life, my family and especially from my childhood. It was good to just let it out of my head in our safe space. And myself and the link worker would sit, with our tea, light the candle and just let me clear my mind. We did that for a few months and our goal was to go for a coffee together before Christmas, to actually go into a café and we did it. And that was the start of it. Next time I went into a café by myself. I am now in the Tidy Towns Group, the Community Garden, a local walking group and a computer class, I have friends and somewhere to be every day. It's a whole new world, to have a life, not just to be existing, but to be living and I am very grateful.

What do you see as the benefits of social prescribing?

"To work in partnership with people, to enable them to be the driving force of change in their own lives. To support people to identify areas of their lives where they need to make changes, and to accompany them on the journey as they implement these changes. To be part of an overall community approach to helping all members of our community, to offer opportunities for people to lead more fulfilling lives and to feel part of the community."

Link worker

How has SP added value to the CDP?

"Has brought a really valuable addition to CDP supports for the community, allows for one to one work with individuals as well as our regular group activities and programmes. Also provides participation and engagement opportunities for those availing of Social Prescribing. The impact of SP on the community - Ballyphehane Togher CDP has long track record within the community and a network of relationships established over two decades : social prescribing thus was able to be inserted seamlessly into CDP programmes and readily accepted by project participants. Community oriented supports, client centred and very relaxed and accessible in comparison to medical model of community health supports."

Manager

* This doesn't capture events/programmes at community level and community based responses to issues. Once-off cases can mean once-off enquiry but multiple contacts to assist an individual with an issue or follow on.

10

CHN 03

Midleton FRC, East Cork

Based in:

Midleton Family Resource Centre (since Jan 2020 - Position became vacant in 2020/21, New worker from July 2021)

Service area:

Midleton, Youghal, KIlleagh, Cobh, Carrigtwohill

Hours of Operation:

Part-time 20 hours per week
Full time 37 hours (since April 2022)

Referrals – most common sources of referral:

GPs, Public health nurse, Occupational therapist, Community worker, Primary care team

2020/21	2022
22	94

(July to December)

Most common presenting issues:

Health conditions, lonely, isolated, depression and anxiety

Some of the referral options utilised:

Tai chi, chair yoga, creative stress reduction programme, men's shed, mindfulness programme, craft groups, educational groups like CETB or reskilling through National Learning Network, befriending services through Alone or friendly call.

Social prescribing Process – Case study:

The journey of each service user is quite similar, and yet individually different as each social prescribing intervention is tailored to meet the specific needs of the person referred in. In this case, it is mostly GPs who refer a person to the service. The GP will use the community referral form, explaining why they think SP would be a good fit for this person. For example, when a person (referred to the link worker by her GP) presents issues (low mood, anxiety and social isolation). During the first session, the link worker will share a little bit about who they are and how SP works as an intervention, and then the conversation opens up to how they would like to use the session, which usually unveils the reason why they are seeking extra support. Using open-ended questions guided by Pillars of Positive Health, they are able to determine that the person's mental health and well-being had deteriorated as a result of having to cocoon during the pandemic and that her anxiety had increased around social gatherings. To regain a sense of balance in her life, the person was socially prescribed to a Positive Aging Group and Tai Chi.

What do you see as the benefits of social prescribing?

"Social prescribing has the power to transform people's lives as it supports the individual to reflect on what matters to them and to take the necessary steps to better one's health and wellbeing. It is a person-centred approach that serves to empower people."

Link worker

How has SP added value to the FRC?

"SP compliments the ethos of the FRC Programme and supports MFRC in fulfilling one of its primary objectives, which is the expansion of community services within the East Cork Area. SP has introduced the service to a broader person/ service base and has facilitated in introducing the FRC to a wider range of referral stakeholders (GP's, Community/Primary Health care teams). The most significant benefit for MFRC is in 4 key areas (1) it promotes social connectivity (2) it continues to be a meaningful, professional, and consistent conduit to care (3) It promotes individual and community resilience (4) it has a proven capability to combat stigma and create a positive narrative around positive mental health."

What is the impact of SP on the community?

"Although it has been a relatively short time, SP has had a massive impact not only for the individuals participating in the programme and their families but for all community groups and medical interventions locally - SP is valued not only for its promotion of positive mental and physical health initiatives but for its collaborative approach to health and wellbeing in general. Indications are that SP potentially has provided considerable savings to health care professional services in the area because of SPs early intervention measures."

Manager

Section B

External Review of Service Quality & Impact

Yvonne Pennisi and Joy Kelleher

UCC Occupational Therapy Department

Overview

The quality assurance study utilised a mixed methods approach, using quantitative measures, in the changes of the Pillars of Positive Health and the Short Warwick Edinburgh Mental Wellbeing Scale and qualitative measures, in the lived experience of the service users who are either currently engaging in, or have previously participated in the HWBCR Programme.

This evaluation was designed based on a research project conducted with UCC Occupational Science and Occupational Therapy department and service users of the existing Listowel HWBCR Programme. The results indicated the lived experience of the service users was most closely aligned with service provision outcomes, and that the Pillars of Positive Health was the preferred method of gathering quantitative data.

Data entry of demographics was completed by the link workers to provide an overview of service users. Each link worker is required to submit a monthly report to the regional social prescribing coordinator. There is a fixed template for this report that all organisations must use. Qualitative data was gathered and analysed by an external researcher and research assistant (University College Cork). Interviews were used to gather rich and in-depth data about the experience of the service users, health care professionals and link workers within the HWBCR Programme. Thematic analysis was completed, in accordance with qualitative methods, to provide rigorous and trustworthy data about the experience of the programme.

Purpose

The Health & Wellbeing, Cork & Kerry Community Healthcare and the National Forum of Family Resource Centres initiated eight of the 10 Health and Wellbeing Community Referral projects across Cork and Kerry to address health and wellbeing through engagement in meaningful social activities and community participation. Although these projects can and have been described as a social prescribing initiative, the emphasis is on the concept of community referral to avoid being limited by the medical model of prescription. The focus of these projects is to develop community linkage with vulnerable persons and community supports, enriching and developing the community at large in these often under-resourced areas.

The purpose of this external review is to examine the health and wellbeing outcomes of the programme, beyond mental health symptoms, and address the person in a holistic way in measuring the impact of the Health and Wellbeing Community Referral Projects in Cork and Kerry.

Quantitative data

The quantitative data was gathered by the link workers, who have been trained in the use and understanding of data gathering tools, including standard demographics, referral pathways, service usage and outcome measures of the Pillars of Positive Health and the Short Warwick Edinburgh Mental Wellbeing Scale. Quantitative data was gathered during the initial interview stages of the service user engaging in the HWBCR Programme by the link workers. This data was then entered into an excel spreadsheet for data analysis and funding reports.

Qualitative data

Purposive sampling was used for recruitment.

Service users

Service users are individuals who have engaged with the HWBCR Programme. Service users were recruited through the programme, using link workers as gatekeepers. A participant information sheet was provided to all potential participants and if interested, service users were contacted by the researcher who discussed the research in more detail, answered any questions and provided a consent form. Written consent was obtained before the interview and also confirmed during the recording of the interview. During the evaluation period, six service users responded within the evaluation time frame. Three service users were interviewed for the evaluation project.

Link workers

Link workers were contacted through email by the researcher with information about the study and invited to participate in an online interview. Potential participants were provided with an information and consent form. Consent was gathered either online during the interview or via an electronic consent form. During the evaluation period, three link workers responded within the time frame and data collection completed. One link worker responded outside the evaluation project time frame.

Family Resource Centre (FRC) managers

FRC managers are the people who directly manage the link worker and funding. FRC managers were contacted through email by the researcher with information about the study and invited to participate in an online interview. Potential participants were provided with an information and consent form. During the evaluation period, no FRC managers responded or participated in the evaluation process.

Healthcare professionals

Health professionals who have referred service users to the HWBCR Programme were contacted by the link worker and invited to participate in an online interview. Potential participants were provided with an information and consent form by the researcher and written consent obtained before the online interview. One GP who is practicing in a rural area participated in the evaluation.

Data collection

Quantitative data

Demographic, referral and service usage data was gathered as part of the standard initial interview and referral process by the link workers. This was then entered into a prepopulated database by the link workers.

Qualitative data

Individual interviews were conducted by the external researchers with the participant groups of service users, link workers and referrers. Participants chose whether the interview was conducted over the phone or online via MS Teams. All interviews were recorded (audio or video) and then transcribed verbatim.

Data analysis

Quantitative

Descriptive statistical analysis was used to examine any patterns emerging from the data. This is important to see whether the programme is addressing the purpose of the programme as set out by the funding bodies.

Qualitative

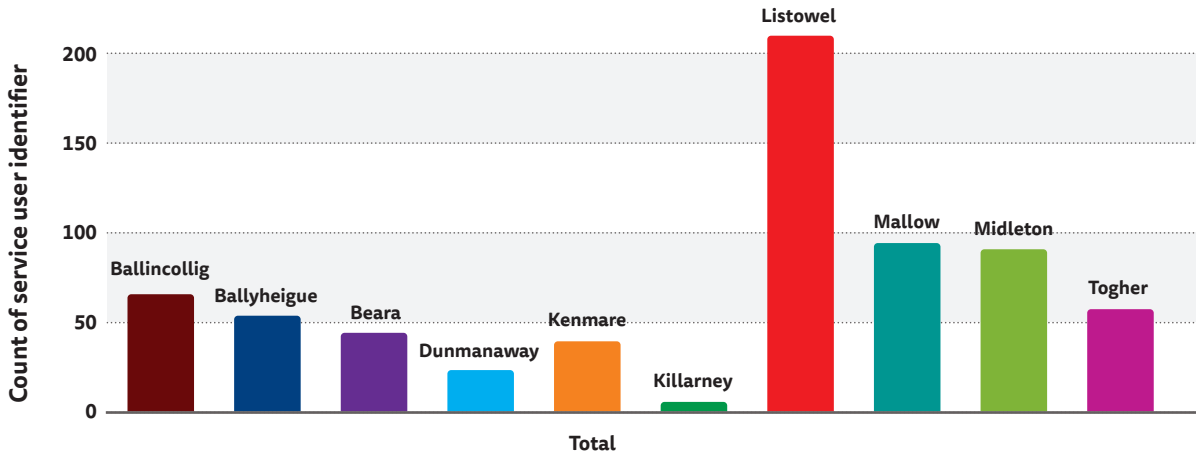
Thematic analysis, using Braun and Clarke (2021) six step process (1) familiariing oneself with the data, (2) generating codes, (3) constructing themes, (4) reviewing potential themes, (5) defining and naming themes, and (6) producing the report.

Project progress

Please note some projects have a full time worker and some projects are .5 or .68 of a full time worker position.

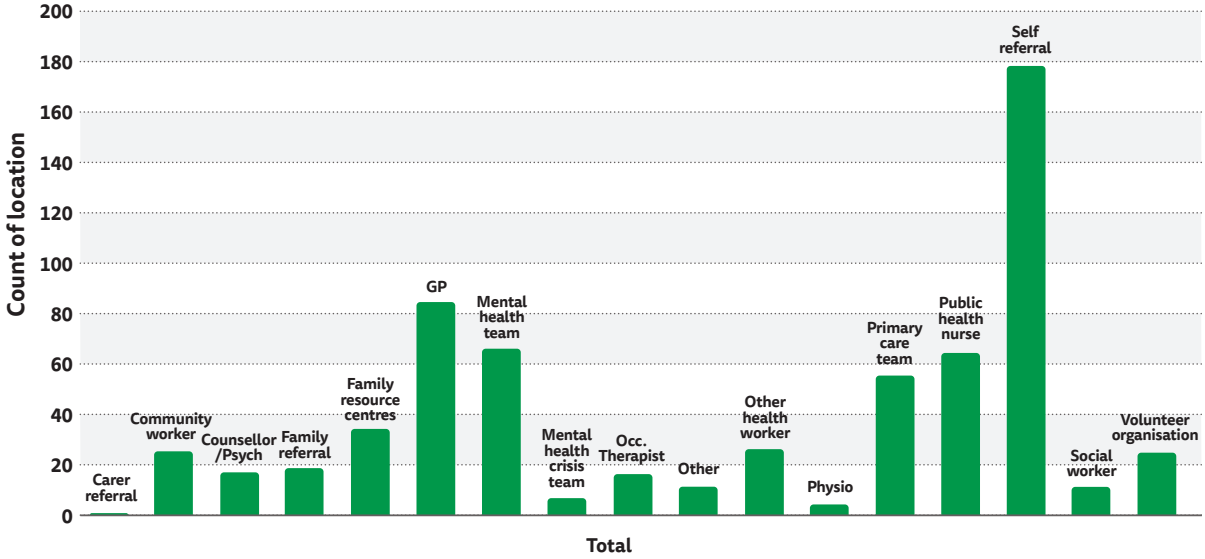
Referrals received

Figure 1: Number of referrals



A total of 692 referrals were received across the 10 sites. The largest number of referrals (211) were received in Listowel which is the longest established site. The lowest number of referrals (6) were received in Killarney, as this is the newest site to be established. The mean number of referrals received per site is 69 referrals.

Figure 2: Referral sources



As portrayed in the above chart, the most common type of referral received was self-referrals, with 178 self-referrals received or 26% of the total referrals. GP referrals have increased significantly from last year, with 85 referrals received across the 10 sites. Mental health professionals accounted for 73 referrals, or around 11% of total referrals received.

Service user demographics

Adults aged 60 years old and older, were the largest population to access the service, making up 46% of service users. Women made up 66% of service users with males 34%.

Nationality

Most service users reported to be Irish (87%). The next largest group to access the service was EU citizens (6%). 11 refugees/ asylum seekers accessed the service, despite the influx of Ukrainian refugees across the country. Potential areas of further research include assessing the accessibility and reach of the service to minority groups like refugees and members of the Traveller community.

Despite, the majority of service users living with family members (54%), a large number of service users reported to be living alone (39%).

Regarding service user relationship status, the majority were single, including those who are widowed or separated (58%). This highlights how the service is meeting target populations that may be at a higher risk of isolation.

Employment status

Retired individuals accounted for the largest group of service users at 39%. Individuals currently unable to work account for 28% of service users, reasons for being unable to work may include physical or mental illness. The majority of participants were unemployed or in part-time work, with 8% of participants reported to be in full-time employment.

Figure 3: Living situation

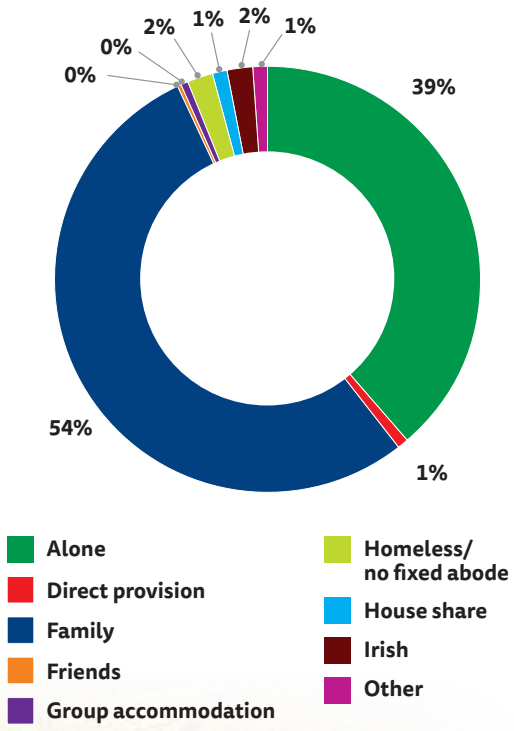
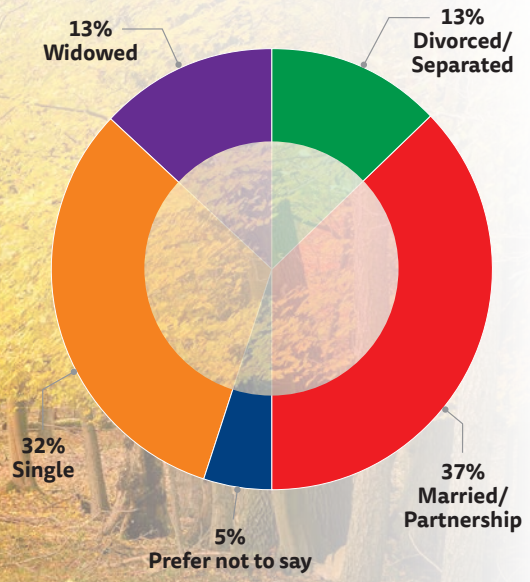
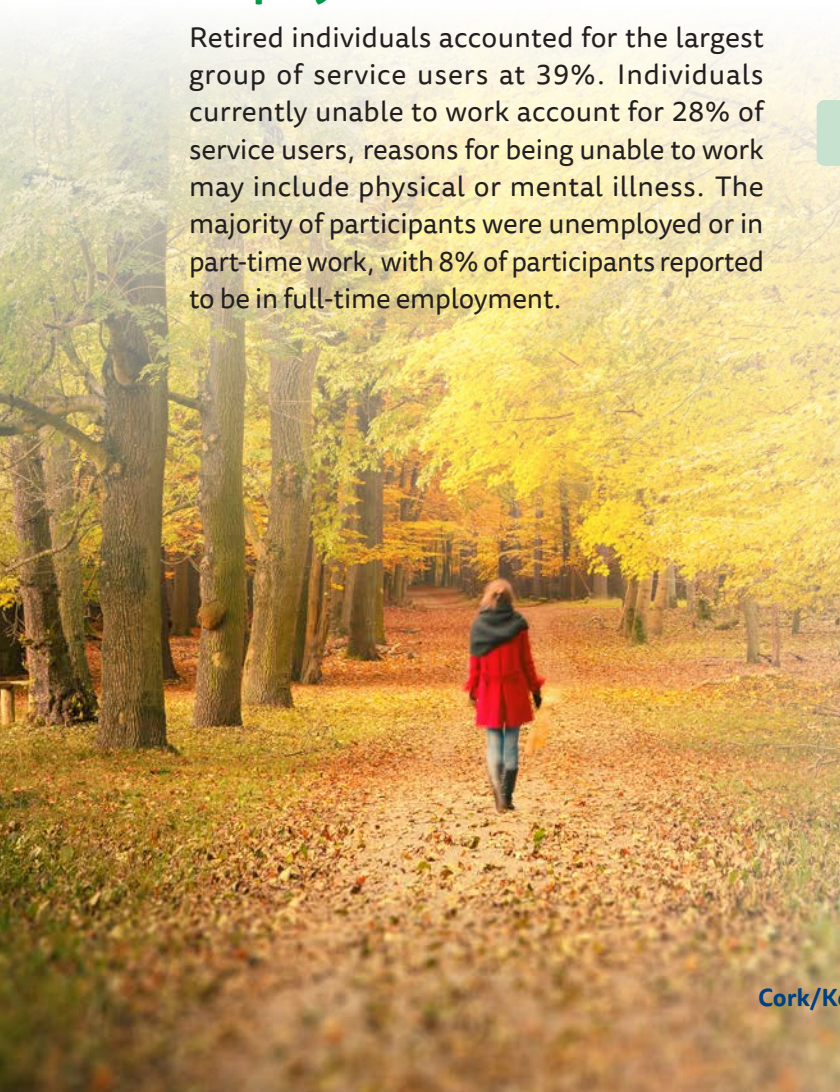


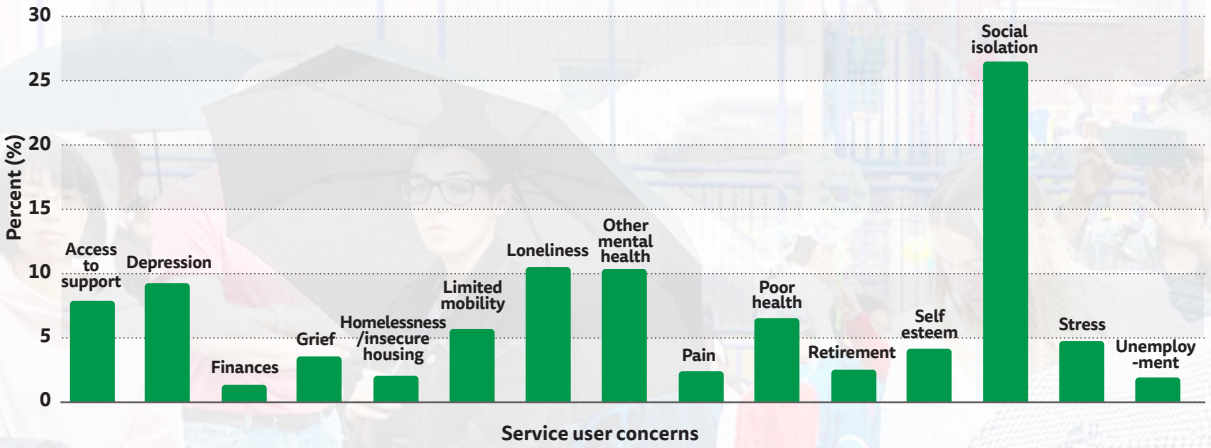
Figure 4: Relationship status





Service user concerns

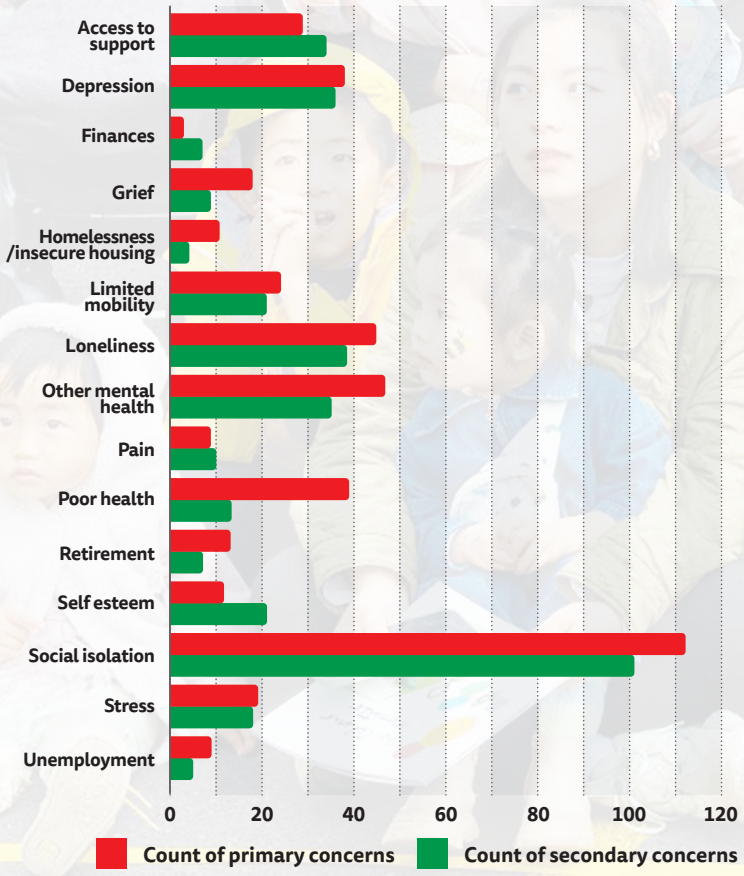
Figure 5: Service user concerns



Service users report at least one concern upon entering the service, however space is provided for service users to provide concerns if needed. A total of 428 primary concerns were reported and 376 secondary concerns were reported by service users.

Combined concerns

Figure 6: Combined service users concerns



Social isolation was the most common reported primary and secondary concern among service users.

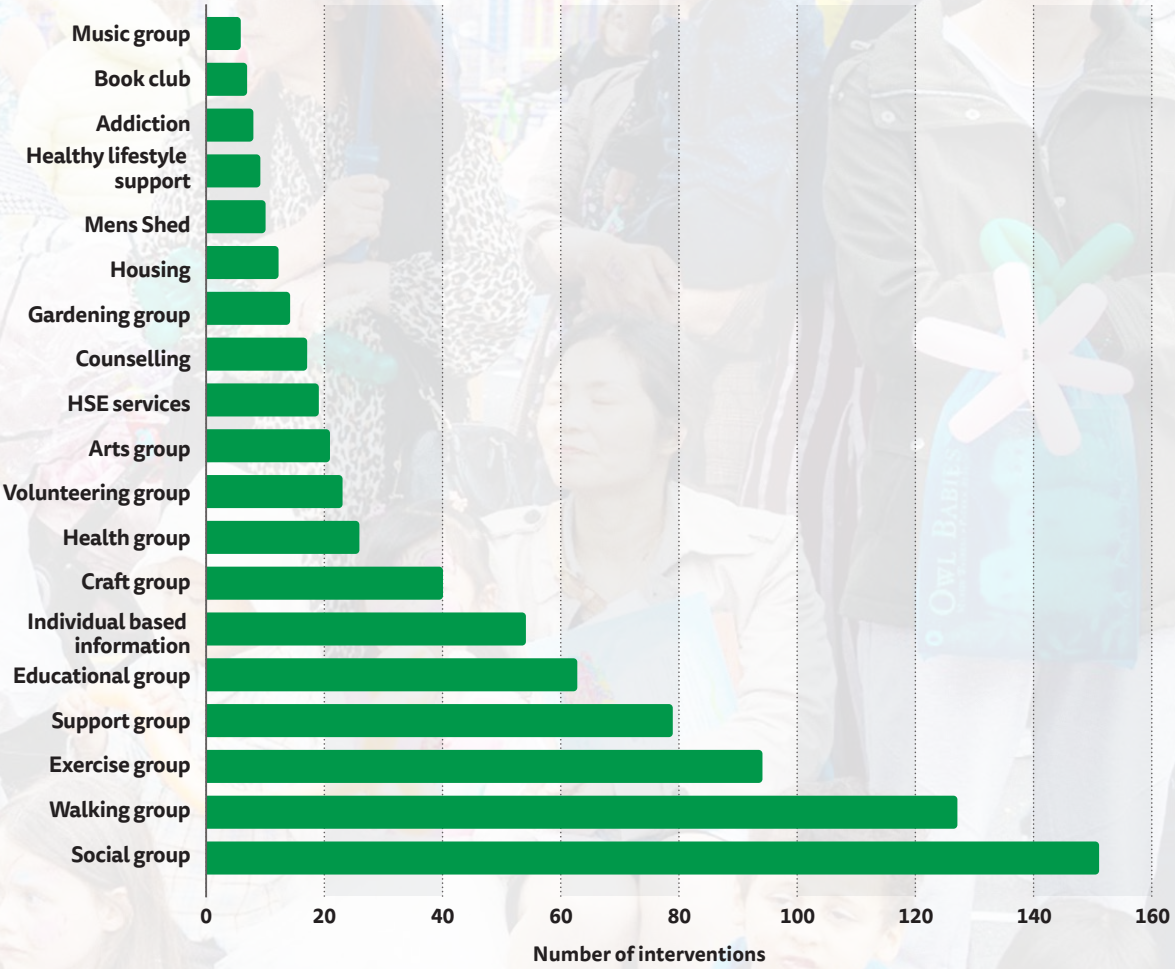
A total of 213 service users (26%) reported social isolation as a concern. Loneliness was reported by 84 service users (10%) and other mental health problems were reported by 83 service users (10%). In total mental health difficulties made up 67% of concerns reported by service users.

Types of supports provided

Link workers provide various services and complete actions to meet the specific needs of the service users. Referrals to community-based groups or activities was the most common action taken by the link worker at 37%. Followed by once-off information or advice which made up 31% of actions taken by link workers.

Interventions

Figure 7: Types of intervention



80% of interventions provided were group-based, which demonstrates the social focus of the service. The most common intervention type was referral to a social group, with 18% of service users. Walking groups (15%), exercise groups (11%) and support groups (10%) were also popular types of referrals.

Number of sessions

Almost half (49%) of the number of sessions provided to service users were once-off sessions. 24% of service users attended 2-4 sessions and 16% of service users attended more than 4 sessions.

Findings of this research

The quality review of the Health and Wellbeing Community Referral Programme aimed to determine the principal benefits associated with participating in this programme such as mental health supports, improved functioning, being more active, being healthier, more socially connected, and improved quality of life. These findings were identified from the analysis of both the quantitative data in the form of outcome measures and qualitative data from interviews with link workers, service users, and healthcare professionals.

Quantitative data – outcome measures

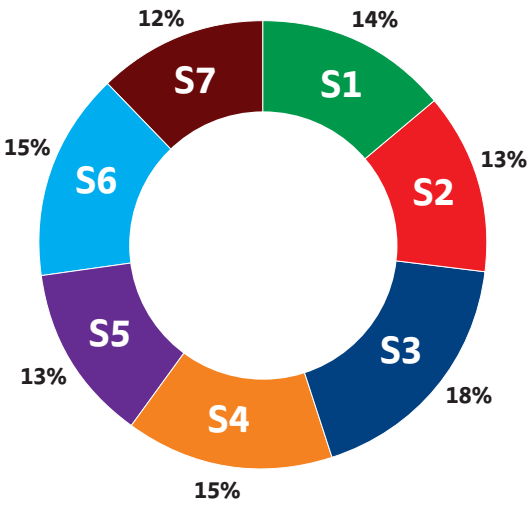
Short Warwick Edinburgh Mental Wellbeing Scale (SWEMWBS)

The SWEMWBS was developed to enable the monitoring of mental wellbeing in the general population and the evaluation of projects, programmes and policies which aim to improve mental wellbeing. The SWEMWBS uses seven statements about thoughts and feelings, which relate more to functioning than feelings and so offer a slightly different perspective on mental wellbeing.

A total of 48 pre and post SWEMWBS were recorded by the link workers across the 10 sites. Given that a total of 692 service users attended the service, 48 is not a significant sample of this population. Despite this, 98% of service users assessed reported an improvement across one or more of the 7 statements.

Improvements were demonstrated across all areas of wellbeing. Most improved areas included statement 3, which looks at relaxation (18%), statement 6, which assesses how close one feels to other people (15%), and statement 4, which measures how well one is dealing with problems (15%). Therefore, improvements in mental wellbeing after engaging with the HWBCR include improved feelings of relaxation, closeness to others and dealing with problems well.

Figure 8: SWEMWBS: Improvements in wellbeing reported



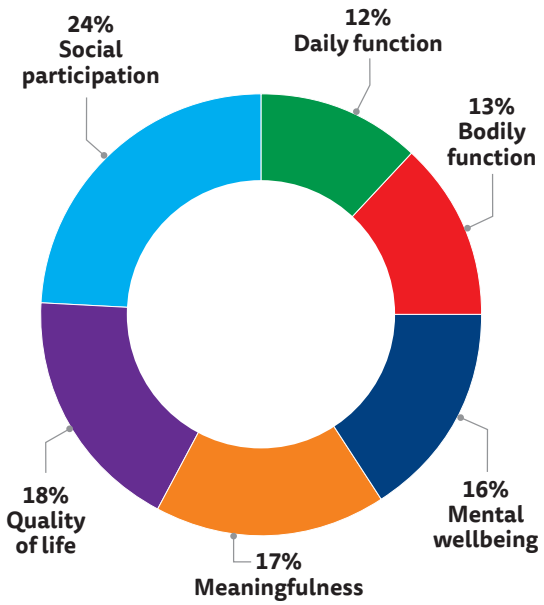
Pillars of Positive Health (POPH)

A total of 98 pre & post outcome measures were recorded. Therefore, the POPH figures represent 14% of the total number of service users referred.

The largest improvement was observed in the Social Participation domain, with a 24% improvement recorded in service user scores across this domain. Quality of life demonstrated an 18% improvement following participation in the service. 17% of service users reported a 17% improvement in meaningfulness. Service user mental wellbeing was reported to have improved by 16% after engaging with the service.

For further information please see the Institute for Positive Health website at https://www.iph.nl/en/

Figure 9: Pillars of Positive Health: Improvement in wellbeing reported



Improvement across 6 domains of health and wellbeing

Figure 10: Improvement across 6 domains of health and wellbeing

	Daily functioning	Bodily functioning	Mental wellbeing	Meaningfulness	Quality of life	Social participation
2022	**62%**	**65%**	**74%**	**67%**	**72%**	**74%**
2021	40%	64%	72%	66%	70%	75%

The above table demonstrates the proportion of service users to report an improvement across the 6 domains of health and wellbeing. The most common improvements made were in the domains of social participation (74% of service users) and mental wellbeing (74% of service users).

In 2021, 40% of service users reported improvement in the area of daily functioning. There is a marked improvement in this domain with 62% of service users reporting improvement in 2022.

Qualitative data

The following findings have been developed from the qualitative data gathered in interviews with stakeholders including service users, referrers and link workers. The qualitative findings illustrate the benefits and the strengths of the HWCRP and also the barriers to the delivery and expansion of the programme.

Theme 1: Benefits of the HWBCR

In addition to the benefits identified through the use of outcome measures, further benefits of participating in the HWBCR were revealed through the qualitative data. Benefits included support with psychosocial issues, improved health and wellbeing, as well as access to improved systems of integrated care.

Subtheme 1: Support with psychosocial issues

Types of support provided by the link workers to the service users included listening, social support, providing individualised and localised advice or information and linking service users with community groups or resources as well as, supporting them to access these resources. The variety of types of support offered resulted in improved outcomes for service users.

> *"It has been very useful in helping me to find different activities that are going on and I find that also, on top of that, the link worker is a very, very good listener. I have been, you know in different, and kind of crisis point over the last, you know, since I've been going to her, and I find that talking to her has been very beneficial" (P2)*

> *"I think the best part would be we'll go for coffees and a quick chat. I think that helps a lot. I think that was the best part was just chatting away about all kinds of different things rather than just my problems and stuff like that. It was like, you know, it was just like having a friend basically over coffee." (P3)*

Link workers assisted service users to cope with their mental health difficulties and facilitated service users in making friends, who in turn would help to support each other.

> *"I live with bipolar, and I have a lot of physical illness as well so sometimes my ability to participate in what's going on depends on you know how I'm feeling at a particular time or how things are going for me. But I have found that being in touch with the link worker has really helped. I have been able to talk very openly to her, and I find that she listens" (P2)*

> *"She actually helped me with my depression because I ended up being referred for my depression, which stopped me from going into town, stopped me from leaving the house and then she actually got me involved with a few services and got me out of the house. So, she did very well" (P3)*

> *"And they'll just start doing other things by themselves and like friendships are starting to farm and they're going off and, you know, having coffee together" (LW2)*

The support provided by the link workers was reported to be beneficial in the lives of their service users. This support enabled service users to improve their social connectedness and community participation, in turn improving their health and wellbeing.

Subtheme 2: Improved health and wellbeing

Participants reported that participation in the HWBCR resulted in improved health and wellbeing outcomes. These included improved mental and emotional health, physical health, social connectedness, and community participation. Improvements in the management of one's own health and an associated sense of empowerment were also noted in the interviews.

> *"It was just nice just to work alongside though and she was like, oh, I'm not doing the work you're doing the work. You're the one that's going out to these places I'm just there as support so. It was kind of like her pushing me to help myself rather than her doing all the work all the time. So we kind of worked together to make myself better. Do you know what I mean, it's. It was really good." (P3)*

> *"…they're building social contacts, they're building friendships, they're building confidence, they're building capabilities, they're building capacity and they're starting to move on and do their own thing. And they're starting to manage their own lives" (LW2)*

Increased participation in healthy activities such as mindfulness, exercise groups and health education groups resulted in service users being able to make more informed decision regarding their health and wellbeing.

> *"The walking was great, you know, we met people through the walking, and we learned different things. There were nature walks and things about nutrition and there's just so much available. It's incredible, you know." (P2)*

> *"If you wasn't for the link worker getting me out, I wouldn't be getting out as much as I am doing. Because I do the women's sheds. I go out every day for a walk now and I'm being encouraged to get back up my motorbike by the people in the women's shed. I also volunteer for the women's shed now so I do a lot for them … It's just improved everything. I'm eating better, I'm sleeping better. I've got a purpose to get up in the morning I've got a purpose in my lifestyle now for getting up and about. It's great. She's really helped me." (P3)*

Participation in the HWBCR resulted in improved mood and health habits reported by service users. Increased participation in social and community activities resulted in improved mental and physical health outcomes for service users.

Subtheme 3: Community Integration/ Integrated care

The benefits of the HWBCR clearly go beyond the individual service user level and have had a positive impact on the communities in which they serve. The service has developed community infrastructure through identifying and addressing gaps, unique to their communities. The HWBCR addresses a gap in community knowledge and services currently in Cork and Kerry. The ability of the link workers to provide individualised and location specific information to the members of their communities was highlighted to benefit both service users and the community as a whole.

> *"I wouldn't have known about it if it wasn't for the link worker. She's put me onto a lot of stuff like you know" (P1)*

> *"(I) do think it (social prescribing) does fill a gap and fits in really nicely in a gap that I can see there" (LW3)*

More specifically, participants discussed the development of community-based activities by the service users themselves, specifically addressing their own and wider community needs. The flexibility and supportive nature of the service has resulted in co-production between link workers and participants, which has increased the number of activities and groups that meet the needs of the community.

> *"So they have kind of started they've kind of moved lot of them have moved on now to kind of doing their own thing doing their own and if step form their own kind of arts and crafts group just before Christmas." (LW2)*

> *"The link worker was absolutely fantastic. I mean we, we talked about all kinds, not just like you know it wasn't just a clinical thing about my depression talking about stuff like that all the time. We talked about so much other stuff. It was just like talking to friends rather than talking to a clinician". (P3)*

Zumba Fun at Middleton FRC, Social Prescribing Project

The social support provided by link workers was identified as a gap within current community mental health teams by one service user. The importance of access to non-clinical or non-medicalised support is highlighted as another benefit of the HWBCR. The importance of providing social support to aid individuals in managing their health and wellbeing was also stressed by healthcare professionals, as their practice is focused on health and not on social issues. It is highlighted that there is improved access to this service when compared to other alternatives offered.

> *"… there's a good few problems we deal with in general practice that aren't medical and I suppose I'd be very anti-medicalizing social problems … like that's the aspect of it that I really like, you know, like it gives me something that I can offer to a patient that's tangible that I know there is good access to as well … people can be waiting months and months and months, whereas I know that if I refer to the link worker, she's probably going to be onto them in the next two or three weeks, you know, which is perfect, like, you know, so it's great from that point of view, really." (GP referrer)*

Theme 2: Strengths of the HWBCR

The HWBCR was reported to have various strengths by stakeholders, including meeting service user needs and meeting community needs through enhancing social integration and community participation.

Subtheme 1: Meets service user needs

Service users who participated in interviews identified several qualities belonging to the service that enabled the link worker to meet their needs, including accessibility, flexibility, community-based, person-centred and non-judgmental.

> *"Well I think the service is doing a good job for me, it certainly is very beneficial. I think the link worker is a great advertisement for it. She's very friendly, very easy going, very diligent and as I said non-judgmental and very welcoming and you know she does what it says on the tin sort of thing." (P2)*

> *"The feedback that I'm getting from people is initially just having space that they can just talk to somebody a little bit more …who isn't pressured for time … And to feel heard and listened to in a way that they've not really felt" (LW3)*

Eithne Foley, Social Prescribing Link Worker at Le Cheile FRC promotional event

The adaptability and flexibility of the service were highlighted as particular strengths of the service, making it more accessible to members of the community. This included the link workers' ability to adjust their input and interventions to match the service users' needs as their situations changed over time.

> *"we met every so often, every couple of weeks, at one stage it was even every week. And then we phased out to once every couple of weeks or once every month … at different stages, there were different things going on that suited me at the time, you know. At the moment I'm not doing the walking because there's something else on at the time of the walking group that I was is doing." (P2)*

The person-centred approach of the link workers enabled service users to access support and increase their participation in their community. link workers were described by the service users as being friendly, diligent, welcoming and non-judgmental, which made the service easy to access.

> *"she understood that one thing might not have worked for me, but another thing might have done … we went through a lot of like what could work for me and what might not work for me and all that kind of stuff on the first visit so. You know, we just worked together, and it just worked really well." (P3)*

> *"It becomes their journey rather than you know me telling them what to do. It becomes it becomes their journey and they come to me with ideas" (LW2)*

The accessibility of the HWBCR is illustrated in the quotations above, which highlight the service's strengths in meeting service user needs.

Activity at the Men's Shed

Social Prescribing arts group

Subtheme 2: Meets community needs

The HWBCR provides integrated care for service users by linking health and social care services with community services and resources. The majority of link workers are based in FRCs. However, some link workers provide outreach in primary care centres, which places them in an ideal position to address the gap between health and community services.

> *"I find that when I talk to the link worker, I feel okay leaving the room you know. I can't commend her enough, but I find the resource centre amazing as well. It's there for me you know and my depression and anxiety and everything." (P1)*

> *"I don't know what they might need, but it's not medical and you're kind of going, I don't even know where to send them. And that, I think is an ideal scenario where you're kind of going like, OK, you know, maybe they can sit down with the link worker and then maybe she can research it as part of her role, like to see where, we could send them and stuff like that." (GP referrer)*

> *"I think it's (length of time) absolutely huge for people and you can just relax. People like take off their coat and put out their bag and it's just it's just completely different feel" (LW1)*

Social and community participation was reported to have increased by service users. By supporting service users to participate in community groups and activities, link workers were able to increase service users' social participation. This enabled service users to make friends and develop support networks in the community.

> *"The link worker got me onto the friends forever and now I have a man ringing me every night at 7 o'clock to see how I'm getting on … So that was a fantastic Programme that she put me on, you know and I love it … She got me into the group for the walking … She's helped me to get out of the flat and go for a walk. And she's got me on to mindfulness as well." (P1)*

> *"The socialisation and getting involved and participating in the different activities helped and I made some friends out of it. Like I'm thinking of one particular person who you know I met her through the walking and then she did the yoga as well and we have become friends. So that has become an important part of my life because she has in turn introduced me to new things." (P2)*

The HWBCR has demonstrated strengths in enhancing social integration and community participation through social prescribing services. Strengths reported include accessibility, flexibility, person-centred, non-judgmental, and the ability to link health and community services in an integrated way.

Social Prescribing Service – Creativity and connection is fostered

Minister Frank Feighan at the launch of Middleton FRC Social Prescribing Service

Theme 3: Barriers to the delivery and expansion of the HWBCR

The HWBCR was reported to have various barriers impacting its rollout. Barriers to the service described by stakeholders included limited community infrastructure in rural areas, consisting of limited access to transport, limited activities in some communities, and limited community spaces to hold groups and events. Other barriers outlined demonstrate how the concept of social prescribing is new in an Irish context and further work is needed to raise awareness among health professionals and service users.

Subtheme 1: Limited community infrastructure

Service users and link workers reported that the limited availability of activities and groups in the community was a barrier to the HWBCR. The cost of groups and activities was also an issue for some individuals and may deter others from participating.

> *"At the beginning the funding, a lot of the yoga and the different things were funded by the government, you know, healthy Ireland, and all that kind of thing. And then they changed it a bit you know to where you have to pay a certain amount of money you know, and I think the whole dynamic changed then that less people were doing it. Because of less funding being available." (P2)*

> *"I'd love to see a Programme where you can go over in the morning and sit down with a group and it's like AA and just get stuff off my chest, just talk, sit down and talk to people you know. That's what I would like to see, you know. I could go out in the morning, meet people and talk out my troubles, you know." (P1)*

One potential reason for a lack of activities and groups is a lack of suitable spaces large enough to facilitate group activities in the community. Rural areas with smaller populations may only have access to one community hall or one large room to hold group activities. This limits the number and types of group activities that can be facilitated in a certain area.

> *"It's a shame, in a way not to have a bit of space to be able to do more group stuff." (LW3)*

> *"it's a rural community and they have no transport, and I can't provide transport." (LW3)*

> *"I suppose that was the biggest challenge I was getting is that not having anywhere to link people in to" (LW2)*

Subtheme 2: Social Prescribing as a New Concept

Participants acknowledged that the concept of social prescribing is new in an Irish context and further work is needed to raise awareness among health professionals and members of the public. The service is at risk of being misunderstood and is limited in terms of expansion, due to a lack of awareness and understanding of social prescribing.

> *"The more that the service is offering and the more people you'll get in contact with through the years and stuff like that, like you know. You make contact with one person who might refer you to somewhere else who might refer to somewhere else. It's all about networking, so maybe a bit more networking if anything." (P3)*

> *"I think just constant visibility like the thing is you can send out emails and leaflets and stuff, but at the end of the day, if a GP picks up an email they forget about it by tomorrow, you know, if it's not kind of constantly visible or you know. Like in the kind of in the consciousness then it's not going to be something that people are going to use." (GP referrer)*

Participants suggest further advertisement of the service across a variety of media platforms and reaching out to GP practices to present at CPD days to increase awareness of social prescribing and its associated benefits. Another measure suggested to increase the awareness of the service was to make it accessible through Health Link, the software used by GPs to make referrals.

> *"…in our case, it's still it's either the PDF, they're filling it in and they're emailing it off or a printed referral form, they're filling it in, photocopying it, then either emailing or posting it off and for highly busy people like, like GPs? I think that is definitely a barrier." (LW1)*

> *"That would be the main thing for me, would be the referral pathway if it was easier … if something takes me a bit longer, I might wait till the end of the day or until I have a few minutes to do some paperwork and then it's just getting the can kicked down the road … and you know I think that would that would probably be the best way you could improve it really you know. " (GP referrer)*

> *"you know targeting like that CPD days for GPS or whatever, you know like all the GP's need to get up their CPD points… If you could tap into those meetings. Sure, like you have a captive audience of a number of GPs at once, you know." (GP referrer)*

Another potential barrier discussed was the difficulty to measure and demonstrate the social and community impacts of social prescribing using healthcare outcome measures.

> *"a huge impact on certain people, It's hard to measure on other people." (LW2)*

> *"Everyone's trying to quantify everything. It's very hard to quantify what social prescribing it is really, you know like that's it, it's not as quantifiable, it's not about numbers like it's not like you can try and quantify it … But like ultimately how can you put numbers on how someone is socially engaged or not you know like." (GP referrer)*

In summary, the strengths of the HWBCR included meeting service user needs and meeting the needs of the communities in which they serve. The barriers included limited community infrastructure and a lack of awareness regarding the concept of social prescribing.

Discussion and reflections from research

In the last year there has been significant development of the Cork and Kerry HWBCR, including the expansion of services into new locations, the recruitment and training of two new link workers and the recruitment and establishment of a regional coordinator to oversee the programme. This has been a direct result of the permanent funding gained by the Family Resource Centre National Forum from HSE Cork/Kerry. In addition, perpetuation funding for link worker positions has translated into increased staffing stability providing opportunities for staff to develop both their individual skills set for social prescribing as well as the development of specific local knowledge and community linkages.

Development of the service and expansion into new areas

Findings demonstrate that the sites that are established longer receive more referrals annually, potentially indicating better community knowledge of social prescribing and better knowledge of community options and service. The addition of some locations into Primary Care facilities is bridging the gap between community services and health and social care services, providing integrated care options.

Each location has specific needs and demographics that require the development of bespoke services and resources.

There has been an increase in referrals in 2022, when compared to 2021. Although with an increase in site locations, an overall increase in referral numbers is expected, individually most specific sites, have also increased the referrals their sites received. This indicates that the knowledge and impact of the programme is growing.

The programme aims to reach those people who are socially isolated. The referrals indicate that the programme is reaching the populations of people at higher risk of social isolation, with 40% of service users identifying as living alone. In addition, other populations at risk of isolation, loneliness and mental health problems include the unemployed and retired populations. Again, the referral data from the programme indicates the service is reaching these at-risk populations. More specifically the data indicates that concerns identified by the service users were social isolation 27%, loneliness 10%, and other mental health issues 30%. This illustrates how the service is designed to sufficiently address the concerns identified by the target population.

The HWBCR data appears to align well with the indicators and needs demonstrating that service user needs were met. The findings indicate that there has been an increased number of service users who report improved health and wellbeing outcomes, compared to the 2021 data. The non-medical or social interventions reflected the needs of the service users with referrals to community-based group activities being the highest, then once-off information and signposting. Social groups, walking groups, exercise groups, support groups, and educational groups. Again, this data indicates that the HWBCR is meeting the overall programme purpose and aims.

The quantitative data is reinforced by the qualitative data obtained through the interviews, highlighting the importance of linking and integrating the service users into the community. The local knowledge and individual skills of the link workers are reported to aid in providing opportunities for service users to develop their own confidence and skills, thereby empowering them to address not only their own needs, but the identified gaps in their local community. The flexibility in the duration and frequency of sessions, is important, with the majority of service users needing only between one and three sessions. Additionally, the person-centred and community-based aspect of this programme was also highlighted as the key to its success.

Conclusion: Service Review – Quality and Impacts

The quantitative and qualitative findings of this report demonstrate the powerful impact that social prescribing can have on one's overall sense of wellbeing.

Benefits associated with participation in the project include improved social participation, quality of life, meaningfulness and mental wellbeing, as well as increased feelings of relaxation, closeness and improvements in dealing with problems. Overall, the HWBCR design continues to allow link workers to be flexible in adapting to the unique needs of each community. The reach of the initiative has increased resulting in increased referrals from healthcare professionals as well as community organisations. The findings outline areas to focus on going forward such as increased efforts to engage minority populations, such as refugees and asylum seekers.

The evidence highlighted in this report demonstrates the individual and community benefits of the Health and Wellbeing Community Referral Programme in 2022. There are additional unanticipated positive benefits accruing for those experiencing disadvantage, their families, and their community. Continuous evaluation and collaboration with other HCPs are encouraged to strengthen the evidence supporting the efficacy of the social prescribing approach for population health and wellbeing from an Irish context. Health promotion services such as the Health and Wellbeing Community Referral Programme have the potential to improve population health and wellbeing and to alleviate the increasing pressure on the Irish healthcare system.

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Section C

Learnings and future development of the service

Learnings and future development of the service

The final section on the report draws upon the positive developments of the service, taking into consideration the challenges and opportunities that are presenting. The service is still very much in its developmental stage with ongoing reviews of practice. This section will highlight some of the challenges to service delivery within Cork/Kerry but will also identify some of the wider benefits of this service.

Promotion of service

Continuing to promote the understanding of Social Prescribing within the community and amongst healthcare professionals is essential to continued expansion. Although developments have been reported, there is still a perceived lack of full understanding and knowledge around the role of social prescribing within the healthcare community and in society at large. Further work, on a local, national, and international level, is needed through evaluation and building up an evidence base of what works in social prescribing.

More than just signposting or referring on

Social prescribing is so much more than signposting. The connection and positive relationship that is experienced by the service user with the link worker very often is a real positive enabler in improving their situation. People experience empowerment through the services and support of the programme. While the role of the link worker is not to be a therapist, many link workers report, that within the sessions the service user can develop a new awareness and strategies to improve their situation, and this can support a significant shift in their health and wellbeing. The connection that the link worker builds with the service user, the sense of being valued, accepted, and cared for experienced by the service user is often a real catalyst to enabling real positive changes in their lives, supporting their health and wellbeing.

Infrastructure and transport

Identifying and accessing transport and community resources is an ongoing issue, especially in rural locations. This is outside the realm of control for link workers but has detrimental impacts on individuals and the community, as well as the delivery and outcomes of the HWBCR Programme. The scarcity of community programmes in many areas and particularly rural areas for link workers, to refer the person to, and some with long waiting lists, is a barrier to particpation. The low funding levels for tutors/facilitators to run activities and other training programs is challenging, but link workers endeavour always to be resourceful by accessing other funding streams where possible.

Increased complexity of presenting issues

There has been a shift in the complexity of presenting issues of service users. There has been a considerable increase in the number of referrals from mental health services, which has been fantastic; supporting people on the recovery journey is a vital part of social prescribing. Ensuring referrals are appropriate and the person is ready to engage is an integral part of any referral of the more complex cases. The recovery colleges and peer workers have been identified as a potential key partner in the supporting of these individuals in their social prescribing journey.

Stigma

In society and particularly in rural Ireland, there is still a fear and a sense of stigma for some people in coming forward for support. People may fear that other people will know and judge someone who is seen as seeking or needing help, particularly around mental health challenges. Marketing social prescribing beyond being a mental health support could potentially remove the stigma associated, and encourage people to utilise the service. This is something the HWBCR will be working on in 2023.

Training and support needs of link workers

Link workers continue to complete professional development, this supports them in the quality of the intervention they can provide. There is a need for additional funds to continue this training in order to meet new and emerging needs of the service users. Reflective practice, peer support structures and external one to one support and supervision, have all been identified as essential for link workers.

Outreach work

Outreach is an important part of the delivery of the mainstreaming of social prescribing across Cork and Kerry. Sourcing a suitable base for providing outreach to meet service users, with the expansion across CHNs has proven to be challenging. In some areas the primary care centres have worked really well, the link worker has forged strong referral pathways through this outreach centre. In some of the more rural areas this has yet to occur, with work actively being done to source suitable premises.

Additional benefits to wider society

At all times, the programme is committed to finding opportunities to maximise the reach and quality of service the person receives. It has been identified that there are many by-products due to the provision of this social prescribing service for the area in which the service operates, that benefit the wider community, for example:

Identifying gaps in services

Many different gaps in resources and services, in different areas have been identified and, in some cases, remedies initiated, e.g., in one area, where the link worker found there were no supports for older persons to refer into, this FRC proactively worked to remedy this issue by working to apply for and host an older person's support worker. This would provide a kaleidoscope of new opportunities and supports for older persons in the area and facilitate the link worker, in having appropriate and quality resources into which to refer.

Presentation to Oncology, CUH to promote referrals to Social Prescribing Service

Targeted promotion and outreach

The service aims to increase awareness of the programme and improve the reach and accessibility of the service to individuals/referral agents to target those who are experiencing significant challenges in life e.g., presentations given to community mental health teams, the organisations - Alone, and the oncology department at CUH – to promote the service of social prescribing to the staff, whose service users or family members of service-users might derive benefits. There have been launches, information sessions at libraries, and service promotional visits to multi-disciplinary teams, to increase awareness of the programme, leading to increased referrals particularly those most disadvantaged or at-risk.

Impacts on families and communities

By availing of social prescribing, the service users are potentially in a better place to support their wellbeing and the wellbeing of other family members, their children, their spouses, their parents, and people in their care. Through involvement in the community, the community becomes a better place, e.g., the development of a community garden, befriending services, and volunteering. This helps to promote a culture of active health promotion, healthy choices focused on the health of body, mind, and spirit, linking with supports and learning to build resilience and self-empowerment.

Cohesion

There is improved communication with potential partners, who can provide supports for potential service users. In the experience of this programme, there is a real improvement, starting with agencies working together in a more real and person-centred way and extending to the voluntary and the statutory sector working in cohesion. It is expected that this will continue through improved communication and collaboration between link workers and local HSE health promotion, self-management, and wellbeing programmes. It is also expected that the programme will help HSE health promotion services highlight areas where these services are not available and support the rollout and take up of these services in those areas.

Recording, reviewing and evaluation

Identifying the challenges and planning mitigations informs service provision. As the programme evolves, continuous reflection, adaptation, and development is necessary to maximise the reach and quality of the service. Developing an evidence base of what works in social prescribing will be advanced in 2023, linking with academic partners to explore validated tools and to ensure the data we collect is relevant and utilised to improve the service.

Ballyphehane Togher: Sinéad, the Social Prescribing Link Worker was part of a group, who worked to establish a Community Garden in Togher in 2020.

Summary

In summary, the benefits of the HWBCR include.

- Improvements in mental wellbeing, in particular improved feelings of relaxation, closeness to others and dealing with problems well.
- Improvements in daily functioning, bodily functioning, mental wellbeing, meaningfulness, quality of life, and social participation.
- Improved support systems for service users, increasing social connectedness and community participation.
- Feeling empowered and an improved sense of control over one's health and wellbeing.
- Increased participation in healthy activities and improved health habits and coping mechanisms.
- Improved community integration by linking service users to healthcare and community services.
- Identified and addressed gaps in community infrastructure and community-based health and social care services.
- Greater opportunities in the community that support the health and wellbeing, of service users and the broader community, through the work of the social prescriber and the FRC/CDP.

Conclusion

The benefits to members of our society, particularly those who are disadvantaged or going through a challenging period in their lives, through the provision and engagement with the HWBCR programme are significant, as can be seen from the feedback and analysis within this report.

All persons should be afforded the opportunity to thrive. Life can pose may obstacles which can lead to a downward spiral in people's health and wellbeing. The provision of timely and accessible support, such as social prescribing, can have a life-changing impact on a service user.

Social prescribing goes further than other services have the capacity to, it can provide real multifaceted support to help the service user to take those first steps, providing "scaffolding around the person" as they navigate and embark upon that road towards improved health and wellbeing, remaining as a point of contact and support throughout the individuals social prescription.

The HWBCR has made great progress towards becoming a thriving service across Cork/Kerry, its rollout through the National Forum of Family Resource Centres, has confirmed that social prescribing benefits greatly from a coordinated community approach that demonstrates leadership, cohesion and accountability in order to flourish.

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