# An Evaluation of the Health and Wellbeing Community Referral Project in Cork and Kerry

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Health & Wellbeing
Community Referral

Sláintecare.

family resource centre
national forum

National FRC
Mental Health
Promotion Project

CORCAIGH CIARRAÍ
CORK KERRY

pobal
government supporting communities

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# 1. Foreword

The Health and Wellbeing Community Referral Project (H&WBCR) has initiated eight Health and Wellbeing Community Referral projects across Cork and Kerry, to address health and wellbeing through engagement in meaningful social activities and community participation. The project is based on the concept of social prescribing commonly used in the U.K. Although these projects can be 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 purpose of this evaluation is to examine the health and wellbeing outcomes of the project. The H&WBCR project was evaluated using a mixed methods approach. Surveys and interviews were used to gather data. Participant demographics and data from the outcome measure was recorded by the Link Workers. The evaluation's findings suggest that the project had an overall positive influence on service-users and their communities particularly in terms of mental health and social participation.

# 2. Executive Summary

This pilot project for Cork Kerry Health & Wellbeing Community Referral (CKH&WBCR) service is based within six Family Resource Centres (FRC) and builds upon the experience of the Listowel and Togher services. The H&WBCR project was designed to be responsive to the local needs of people and to use local resources, enabling GPs and other healthcare practitioners to refer individuals to the service. The Link Worker explores issues limiting participation, and highlights possibilities and options available to them. The purpose is to explore activities available and support service-users in attending these activities. This empowers people with social, emotional or practical needs to find practical solutions. The H&WBCR sites focus particularly on socially excluded groups who have complex health needs and experience poor health outcomes across a range of indicators like chronic disease, morbidity, mortality and self-reported ill health. This includes people who are homeless, people with substance use disorders, Travellers, asylum- seekers, prisoners and survivors of institutional abuse.

Due to COVID-19, people were unable to visit their GP, and therefore could not be referred, which was a challenge to the referral pathway. Also due to COVID-19 and social distancing restrictions community groups, supports and resources are still not operating at pre-COVID levels. Moreover, the lockdowns and social distancing restrictions made the use of the Pillars of Positive Health Self-Report more difficult, due to issues around building rapport over the phone and online. To address these issues, Link Workers developed alternatives to traditional face to face such as online consultation, Zoom Cafes, and WhatsApp chat groups. The provision of online and mobile services has also highlighted the issues around digital poverty and limited education or exposure to digital technology. Considering the program is targeted at areas of socioeconomic disadvantage, the risk that potential service-users are not accessing the program due to digital poverty is high.

# 3. Background

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### 3.1 Family Resource Centres

Family Resource Centres (FRCs) are based in some of the most marginalised communities across Ireland. In these areas, poverty, social isolation, deprivation, and unemployment are weaved into the everyday lives of the communities. There are 121 Family Resource Centres across the Republic of Ireland. FRCs work by involving communities and representatives of those in need of support. FRCs also work closely with a range of voluntary organisations and statutory agencies to develop co-ordinated responses to community issues. This wrap-around support aims to create and sustain resilient children, families, and communities.

FRCs are ideally placed to facilitate community-based responses around mental health promotion, resilience building, and suicide prevention. The national network offers an infrastructure that can support the delivery of national strategies including 'Connecting for Life' and 'Sharing the Vision' along with mental health promotion campaigns, as well as provide a platform for mainstreaming the promotion of positive mental health in existing services. As FRCs already offer a drop-in service to the public, they are presented with a wide range of social issues, including mental health difficulties. FRCs are often the first point of call for individuals in distress and supports are available across the life course. The National Forum of FRCs has a dedicated National Mental Health Promotion Project, which provides training, support and best practice guidance on mental health promotion and suicide prevention, to staff and volunteers. The Mental Health Promotion Project currently supports the delivery and development of social prescribing within the FRC network.

### 3.2 Mental Health Promotion Project

The National FRC Mental Health Promotion Project provides education, training, support and best practice guidance to staff, volunteers, and voluntary boards of all 121 Family Resource Centres.

The Mental Health Promotion Project strives to meet the training needs of 250+ core staff funded by Tusla, 121 Voluntary boards, Tus, Childcare, CE workers. Along with other funded posts, including Social Prescribing Link Workers and over 3000 volunteers. The network is large, with potential for positive mental health impacts for each member of staff. This in turn has a ripple effect on the communities these people work and belong to.

Between 2015 and 2016 a Framework 'Building Resilient Communities' was completed by key stakeholders including the National Forum of FRCs, NOSP, Tusla, Mental Health Ireland, HSE Mental Health, Primary care and Health and Wellbeing. This ambitious piece of work identified four key priorities for the promotion of positive mental health within communities through the FRC program. It included twelve recommendations for collaboration across services to provide pathways to care, build community resilience, promote social connectedness, and combat stigma.

These four key areas are the foundations to the work of the Mental Health Project since 2017:

- Promoting Social Connectedness
- Building Community Resilience
- Providing Pathways to Care
- Combating Stigma

As part of the area of work relating to Promoting Social Connectedness, the Mental Health Project is tasked with assessing opportunities focusing the FRC infrastructure to facilitate a national rollout of social prescribing. FRCs already 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.

### 3.3 Social Prescribing- Health and Wellbeing Community Referral

The Mental Health Project is the lead and support organisation for 6 new Health and Wellbeing Community Referral Sites in Cork and Kerry. This is in partnership with the HSE Health and Wellbeing and Cork/Kerry Community Healthcare. Social prescribing is a way of linking people with sources of support within their communities and is commonly used across the U.K. Although these projects can be 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 service provides GPs and other healthcare professionals with non-medical referral options to improve health and wellbeing. This project is funded through Sláintecare Integration Fund 2019-2021. This also provides an avenue for empowering citizens in actively engaging in their own health and wellbeing, with the provision of self referral. In addition, this approach encourages communities to identify and develop services attuned to local needs, in alignment with Sláintecare Action Plan (2019).

### 3.4 Resources to promote positive Mental Health

FRCs were ideally placed to facilitate community-based responses around mental health promotion, resilience building, suicide prevention and social prescribing. The national FRC network supports the delivery of national strategies including 'Connecting for Life' and 'Sharing the Vision', as well as providing a platform for the promotion of positive mental health and wellbeing in existing services. FRCs offer a wide range of health and wellbeing supports and services including:

- Provide information on mental health issues, this may involve signposting individuals to appropriate services, handing out information material, and in some cases directly facilitating access to activities and supports.
- Promote social inclusion and connectedness e.g., by providing a 'safe space' for vulnerable groups and individuals, facilitating befriending services, and establishing community groups etc.
- Deliver mental health promotion programmes, including bereavement supports, and mental health awareness training.
- Facilitate affordable counselling and play therapy services.
- Support active learning and resilience building e.g., in relation to mindfulness, meditation, stress management, and alternative therapies.
- In alignment with the Sláintecare Action Plan 2019, providing an avenue for joined-up service delivery between public, private and voluntary health care services.

### 3.5 Social Prescribing and FRCs

Family resource centres offer a non-stigmatising safe space that is used by the wider community, while also being accessible to individuals who are at higher risk of experiencing poor mental health. As a result, FRC's already have experience identifying and responding to individuals at risk, thereby ensuring timely referrals to specialist services or voluntary supports. FRC's also offer support groups and activities that can be utilised by the referred individual and a host of other resources to promote positive mental health.

The suitability of FRCs to provide social prescribing services on a national level is illustrated by the fact that they are tactically located in areas where there are higher levels of socioeconomic disadvantage, in which mental health difficulties are commonly reported. Within these FRCs are staff and volunteers who are familiar with mental health services, legislation, and policy, who have experience working closely and collaboratively with individuals, families, and communities. The aims of the FRCs align well with the principles of social prescribing. Both services aim to combat stigma, improve social connectedness, provide pathways to healthcare services (as well as, providing alternative services and activities), all while empowering service-users and their communities. The community based FRC, is designed to be a "safe space", free from judgement and stigma, which is important for those who may not access traditional health services due to fears of encountering mental health stigma.

# 4. Methodology

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## 4.1. Overview

The project evaluation utilised a mixed methods approach, using both quantitative measures, in the changes of the Pillars of Positive Health and qualitative, in the lived experience of the service-users who are either currently engaging in, or have previously participated in the H&WBCR program. 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 H&WBCR program. 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 (see Appendix A for further information).

The Pillars of Positive Health was used alone, not in conjunction with the SF36 as initially envisaged, as the SF36 was found by link workers to deter some potential service users, therefore, decreasing the access to a potentially beneficial service. The SF36 was discontinued due to potential ethical and inequity issues.
The Pillars of Positive Health is a service user led self-report/interview tool which asks the participant to rate six categories of health and wellbeing: daily function/self-care; bodily function/physical health; mental wellbeing/health; meaningfulness; quality of life and social participation. This was used as a pre and post assessment, however, due to COVID19 the number of traditional engagements and face to face engagements inhibited the completion of pre and post self-rating on the PoPH.

Data entry of demographics was completed by the Link Workers to provide an overview of service-users. 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 H&WBCR program. Thematic analysis was completed, in accordance with qualitative methods, to provide rigorous and trustworthy data about the experience of the program. An online survey of healthcare workers was also conducted.

**Purpose**

The Health & Wellbeing, Cork & Kerry Community Healthcare and the National Family Resource Centre Mental Health Promotion Project initiated eight 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 evaluation is to examine the health and wellbeing outcomes of each project, beyond mental health symptoms, addressing the person in a holistic way and measuring the true nature of the Health and Wellbeing Community Referral Projects in Cork and Kerry.

## 4.2. Aims

The Cork Kerry Health & Wellbeing Community Referral Project aimed to demonstrate partnerships and cross sectoral work specifically with Health Care Practitioners, address the determinants of health and social problems in the local catchment areas and identify strategies needed to enhance social connectedness across the life course and to connect people most in need.

Proposed target outputs for the project included:

1. Better quality of life
2. Improved health behaviours
3. Reduced healthcare resources

### 4.2.1. Evaluation Questions

- What were the impacts on the different aspects of health and wellbeing from a service-users' perspective?
- What referral pathways are being used to access the program?
- What are the demographics of the service-users accessing the program?
- What strengths and limitations have been identified in the local areas, for the delivery of the H&WBCR programs?
    - Link workers' perspectives
    - Health Care providers' perspectives
- How has the COVID-19 pandemic impacted the set up and delivery of the programs?

## 4.3. Evaluation Methods

### 4.3.1. Data Collection Methods

Qualitative data was gathered through individual interviews conducted with service-users, by an independent evaluator, regarding their feedback and experience of the program. Quantitative data was gathered by the Link workers, who have been trained in the use and understanding of the Pillars of Positive Health. Previously the evaluation intended to use the SF36, in addition to the Pillars of Positive Health, as the SF36 is an internationally recognised and reliable measure. This was discontinued, as the Link Workers have reported negative impact from attempting to administer the SF36, causing discomfort from the service-users and possible disengagement from the program. Other standardised assessments, such as the SF12 or the WHO5 have been disregarded, as it was decided that the categories are too broad to capture the changes to the social and occupational engagement of the service-users. Additionally, other quantitative tools were disregarded, as the focus of the program is not solely on mental health, but on overall health and wellbeing.

***a. Quantitative Methods***

- **Referrals & referral pathways:**
  Quantitative data was gathered during the initial interview stages of the servic- user engaging in the H&WBCR program by the Link Workers. Descriptive statistical analysis was used to examine any patterns emerging from the data.
- **Service-user demographics:**
  Quantitative data was gathered during the initial interview stages of the service-user engaging in the H&WBCR

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

- **Healthcare service use:**
  Self-reported use of health care providers was reported by the service-users to the Link Workers. This data outlines self-reported GP attendance and attendance at other healthcare services.

- **Strengths and limitations – Health Care Providers**
  Quantitative data was gathered using a purpose-built survey to identify awareness of the programs, ease of use and concerns. Descriptive statistical analysis was used to examine any patterns emerging from the data. Currently insufficient data is available from the online survey, continued circulation and increased advertisement is planned. Depending on the survey response, focus groups or interviews may be conducted in the future.

***b. Qualitative Methods:***

- **Service-users' impact:**
  Semi-structured interviews were conducted with service-users at each site, to examine the lived experience of participating with the H&WBCR program. Two to three service-users from each program will be recruited using Gatekeepers to explore the experiences of the service-users.

- **Strengths and limitations / Impact of COVID-19 – Link workers**
  Semi- structured interviews on the experience (facilitators and barriers and impact) were conducted with link workers at each site. Thematic analysis was used to analyse the transcribed data.

**Outcome Measure Selection – Pillars of Positive Health**

Social prescribing has been in practice in the United Kingdom, for several years, and in limited areas in Ireland since 2013. A recent systematic review of the NHS social prescribing system (Bickerdike et al, 2017) reported non-systematic use of outcome measures, with little clear strategy or impact. Some of the scales reported included the following: Warwick-Edinburgh Mental Well-being Scale (WEMWBS), Hospital Anxiety and Depression Scale (HADS), General Anxiety Disorder-7 (GAD), Patient Health Questionnaire-9 (PHQ), Clinical Outcomes in Routine Evaluation-Outcome Measure (CORE-OM), Work and Social Adjustment Scale (WSAS), General Health Questionnaire (GHQ). It is noted that these scales do not measure all areas associated with wellbeing.

As a result, the outcome measure used in the evaluation of this project, the Pillars of Positive Health (POPH), takes a broad view of health and wellbeing. The definition of positive health is defined by Huber et al. (2015) as "the ability of an individual to adapt and self-manage in the face of social, physical and emotional challenges."

### 4.3.2. Participants

- **Service-users:** The impact on the service-users has been designed based on a student research study conducted with the participants in Listowel Health and Wellbeing Community Referral Project. The service-

users identified the Pillars of Positive Health to be a tool that would identify the change to the individuals' areas of health. In addition, the service-users identified the importance of their personal stories to be a factor they wished to include in the evaluation. The participants highlighted that each personal story was the most effective way to communicate the impact of the program on their health and wellbeing.

- **Stakeholders:** Members of the steering committees for the Family Resource Centres and the overall steering committee for the entire project were also consulted and feedback to the project provided. This included:
  - Link workers
  - Local health service providers from the HSE (including mental health services and public health nurses)
  - Health Promotion officers
  - Representatives from the local GP practices
  - Local charities and non-governmental organisations
  - Representatives from the Family Resource Centres

# 5. Overview of the Project

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## 5.1. Site Selection

**Expression of Interest Process:**

The National Forum in conjunction with the National FRC Mental Health Project designed a robust expression of interest process for the selection of Health and Wellbeing Community Referral sites in Cork and Kerry. This process was established to ensure a fair and transparent application selection and to ensure the Health and Wellbeing Community Referral Project was targeting areas that supported key priority groups.

As part of the expression of interest, an information session was held in Killarney where all interested FRCs were invited along to find out the details of the Slaintecare funding, along with the aims and objectives of the project and the benefits of having a link worker within their service. This was led by the Manager of the FRC Mental Health Promotion Project and the Chair of the National Forum of FRCs.

The expression of interest captured the following information and a marking scheme

- Demographic details
- Governance
- Planning
- Staff readiness and engagement
- Systems and process
- Health Outcomes


The chosen FRCs and CDP demonstrated a strong passion for mental wellbeing within the communities they serve. Each one has strong connections already made with primary care teams, GPs, suicide prevention resource officers and have multiple supports and groups established in their centres. Highlighted below are some of the key features demonstrated by each FRC location.

**Kenmare FRC**

Greater Kenmare's location at the conjunction of the Iveragh and Beara peninsulas also covers Kilgarvan, Bonane, Sneem, Lauragh and Tuosist. The town is situated 75km distant from Tralee the county town, 32km distant from Killarney. City centres of Cork, Limerick and Dublin are 96km, 140km and 331km distant by road. Kenmare's resident population is comprised of predominantly white, Irish nationals (73.7%). Of those within the 65+ age-band, 217 of the town's resident population are aged 75 years or older with almost one fifth of the resident population aged 65 year or older. An age dependency higher than the national average and a relatively lower level of residents in the economically active age cohort. Direct provision centre located in the town since 2018. Limited facilities and social outlets for all age groups specifically younger people, Multiple suicides each year, rural isolation and long distance from services and facilities located in larger towns; poor or non-existent transport options to access these. Comparatively low levels of community or social activity within the town.

**Mallow**

Mallow, known as the Crossroads of Munster, has a population of approx. 13,500 people, and is made up of 3 electoral divisions, Mallow north urban, Mallow rural, Mallow south urban. Within those 3 electoral divisions lie 51 small areas. Mallow is approx. 45km North of Cork city and lies on the Blackwater River. Mallow has a dependency ratio that is higher than national average and higher than Cork average. Mallow south urban has a high proportion of people over the age of 65 and Mallow rural has a high proportion of young people. 27.5% of families with children are one parent families, predominantly headed by women. 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. Of the 51 small areas in Mallow, 11 have a depravation score which indicates that are disadvantaged or very disadvantaged.

**Kerryhead/ Ballyheigue FRC**

Kerryhead/ Ballyheigue Family Resource is located just outside the north Kerry town of Ballyheigue. It also supports the areas Ardfert, Tralee, Fenit and Causeway. This area and specifically the Kerryhead area has shown to be an area of rural isolation. The Kerryhead/ Ballyheigue area is also an area that has a high level of one parent families as well as carers and individuals with disabilities. In terms of education this area has a low level of members of the community who have been able to secure higher levels of education. In turn the area experiences high levels of unemployment especially male unemployment.

**Ballincollig FRC**

Ballincollig area is considered an affluent town which recently amalgamated with cork city council. The population was recorded in the 2016 census at 18,621 and is now over 22,000. It consists of six town lands some of which surround the town itself and are affluent to very affluent. Ballincollig town land itself has two areas that are considered to be disadvantaged with the rest being marginally above or below average. There is a population of 1462 EU citizens 730 of which are from the polish community and 902 from the rest of the world. Ballincollig has a population of 2,321 that are Disabled and have 14,433 in employment. Ballincollig would have a lot of industry including a population of Tech companies. This brings people to live in Ballincollig but unfortunately there is very little available in the line of support for this size population.

**Adrigole FRC**

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. It covers more than 345 sq. km. 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. This has an impact on people in terms of their own sense of self-worth and identity and often manifests in experience of real or perceived loneliness, depression and disconnectedness. The Health & Wellbeing Community Link worker being situated within the established and rooted, Family Resource Centre has been extremely mutually beneficial. The FRC can provide many of the services that the Health and Wellbeing worker

can directly link the client with such as low-cost counselling, Men's Shed, Women's wellbeing groups, recreational activities, further learning, various health promoting activities, craft groups, community activitation groups, volunteering opportunities and so much more.

**Listowel FRC**

The Listowel Health and Wellbeing referral programme was initiated in March 2018, before the initiation of the H&WBCR project. 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. Listowel alone has a relatively high unemployment rate at 27.7% compared with a National Average rate of 19.0% (C.S.O 2011). The primary focus of Listowel Family Resource Centre is to provide family support in an inclusive and empowering way. This is achieved by the provision of many services such as adult education, counselling service, support groups, parent and family programmes and supports, centre for Outreach Programmes, children's centre, partner with Tusla in Creative Community Alternatives to Care, training hub, and a meeting space for community organisations and private businesses. It is noted that the Listowel project was the prototype for how the H&WBCR project would be operated. This was evaluated separately by UCC OSOT students.

**Midleton FRC**

Midleton has seen a rapid expansion of the area with a 16% increase over 5 years. A satellite town of Cork City, Midleton is part of Metropolitan Cork. It is the central hub of business for the East Cork Area. Population of Midleton currently stands at 12,803 taken from CSO (2016). The demographic of Midelton community changed somewhat in the last few years with an influx of new communities being welcomed. The doubling of the population between 1996 and 2016 has brought a greater need for a diverse range of community-based services like that which the Midelton Family Resource Centre provides. Midelton FRC provides a range of childcare facilities including preschool, creche and an afterschool activities club. On site there is 1 family support worker, a Community Health and Well-being Link worker, as well as childcare staff. Typically, the centre provides information, advice and support to target groups and families through the provision of parenting courses, as well as counselling, workshops with an emphasis on mental health and wellness. Other groups that use the service include Toastmasters, the Men's Shed, Women's Shed etc.

**Togher/ Ballyphehane Community Development Project**

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 & to promote equality and inclusion. Togher and Ballyphehane are both suburbs on the southside of Cork City. Togher has a population of 2,765 people and Ballyphehane has a population of 1,443. Ballyphehane is one of the areas with the highest number of 40–64-year-olds in Cork and Togher is one of the areas with the highest number of 65+ (Cork City Council, 2018).

## 5.2. Service Description

**Recruitment process:**

Once areas had been selected, the recruitment process began for each site. This process included developing standardised job descriptions and person specifications. A recruitment panel for each site was chosen and this was led by the National FRC Mental Health Promotion Project with the support of the FRC managers of each area.

**Induction Process:**

Each Link worker and their managers received specific training on social prescribing. The initial induction training was provided by an external provider "DNA Insight", through a full-day training (See learning outcomes Appendix B) delivered to both staff and managers in Oriel House Ballincollig. Further training has been provided in the form of continuing professional development (CPD) using online training sessions provided through the Mental Health Project. Support and supervision are provided regularly by managers, and other forms of CPD training received include reflective practice session, suicide prevention, and self-care training.

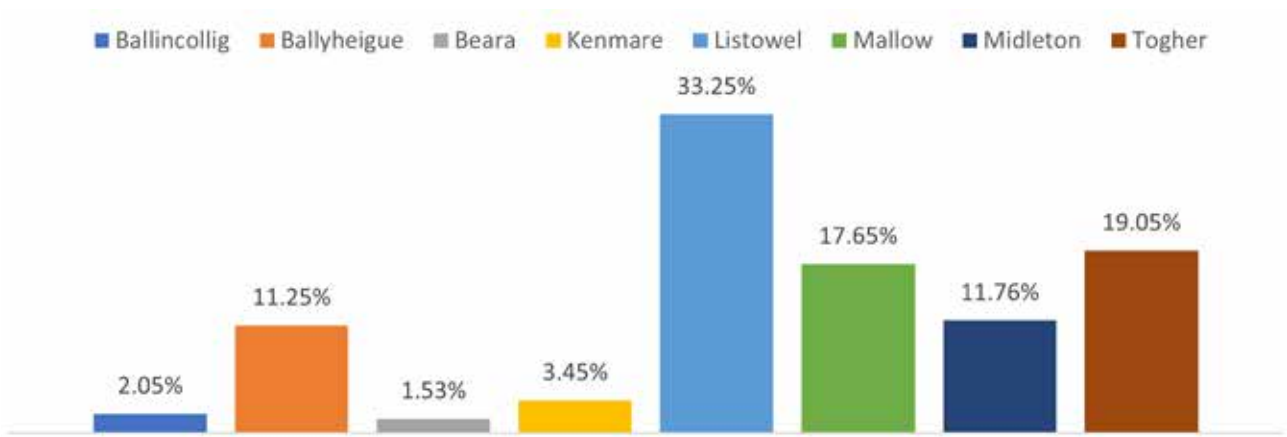
**Evaluation Induction:**

One full day of face-to-face induction training on quantitative research methods was provided by a UCC representative, as well as two online sessions. This training provided an overview of OT, community based participatory research and the development of the evaluation project, evaluation on the existing Listowel project, different quantitative measures, and discussed how qualitative data and case studies would be collected.Ongoing support is provided from both the Mental Health Project (Operational Manager Shauna Diamond) and the Evaluation Lead (Yvonne Penisi), with check in meetings being provided on a regular basis during the project rollout.

### 5.2.1. Referral pathways

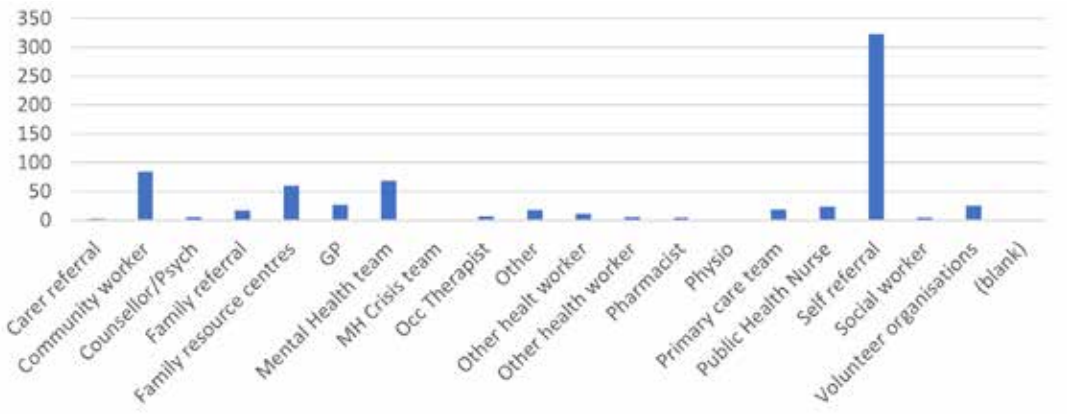
As of the 1st of September 2021, 782 referrals have been received across the Cork and Kerry H&WBCR Project. As demonstrated on the chart below, the number of referrals varied among each location. 33% of the overall referrals were received in Listowel, this may be due to the fact that the Listowel Community Referral Project was established before the other projects and before the COVID-19 pandemic.. This service had developed its referral pathways through meeting face-to-face with community organisations and healthcare professionals, which is thought to have increased the number of referrals received.

**Figure 5.2.1.1 Referrals received**



Self-referrals accounted for 45% of referral sources. 24% of referrals received came from community organisations such as Family Resource Centres and voluntary organisations. Referrals from health care professionals accounted for approximately 25% of the total overall referrals. COVID-19 has undoubtedly impacted on referrals with redeployment of healthcare professionals, limiting access to the public, as well as reducing access to GPs and other healthcare professionals. This has resulted in decreased referrals, however due to the ongoing networking and social media advertising and community information, self-referrals make up almost half of all referrals. This may indicate that service-users are accessing the H&WBCR program as an alternative to limited health care services.

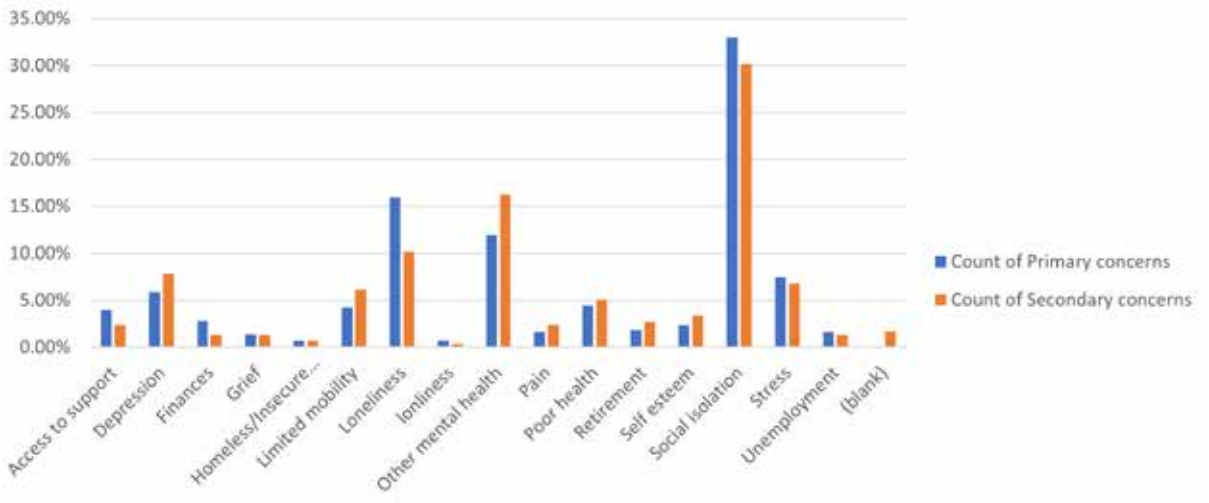
**Figure 5.2.1.2 Referral Pathways**




## 5.2.2. Types of concerns presented

The major mental health difficulty reported was social isolation (accounted for 32% of overall reasons for accessing the service). Loneliness (which accounted for 14% of concerns) and social isolation are major factors and indicators for people experiencing mental health difficulties. In addition, specifically diagnosed mental health conditions (depression (7%), grief (1%), stress (7%) and other mental health difficulties (14%)) were identified as 29% of reasons for referral. In combination this meets the target with 75% of referrals availed of the services for mental health difficulties. Other issues presented by service users include poor physical health (5%), financial difficulties (2%) and unemployment (1.5%).

**Figure 5.2.2. Types of concerns**



### 5.2.3. Consultation process

Initial contact is made with the potential service-user, either through a meeting in person, on the phone, or online, to assess whether or not the service is appropriate. In the initial session the link worker will obtain Informed consent from the service-user and make note of key issues the person is experiencing along with their demographic information.

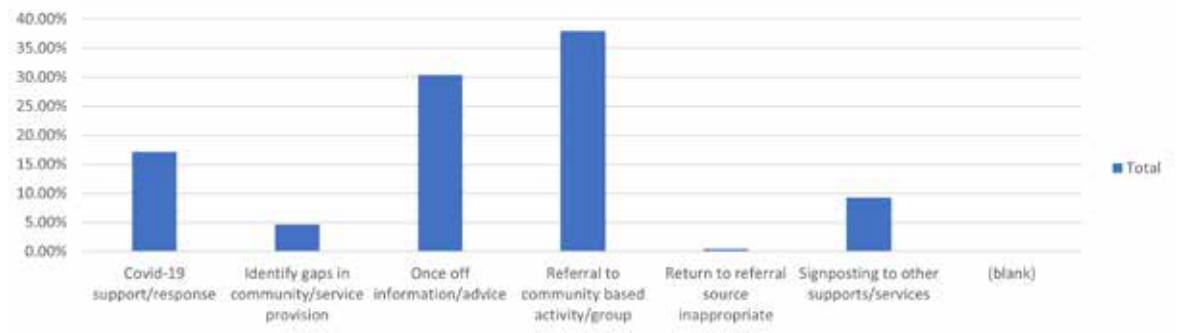
Link Workers use the Pillars of Positive Health to guide their initial interviews and identify issues or gaps in support experienced by service-users. Following the initial session, the Link Worker will either accept or decline the referral. Actions taken following acceptance of a referral depend on the needs of the service-user.

### 5.2.4. Action after referral

Actions taken following acceptance of a referral depend on the needs of the service-user. Care plans are co-produced between the Link Worker and service-user, where social supports, groups, activities and community assets or resources are mapped out.

Examples of the primary types of actions taken are listed below. Referrals to community-based activity/group were the most common form of action at 38%. Furthermore, 30% of service-users received once off information or advice, and 17% of service-users received COVID-19 support from the H&WBCR project. 10% of service-users were signposted to other services and supports, including healthcare and community services. Supports given include intervention sessions where Link Workers help the person to set relevant goals, provide support to service-users to attend groups and signpost to relevant groups, services or resources in the person's local community.

**Figure 5.2.4. Action after referral**



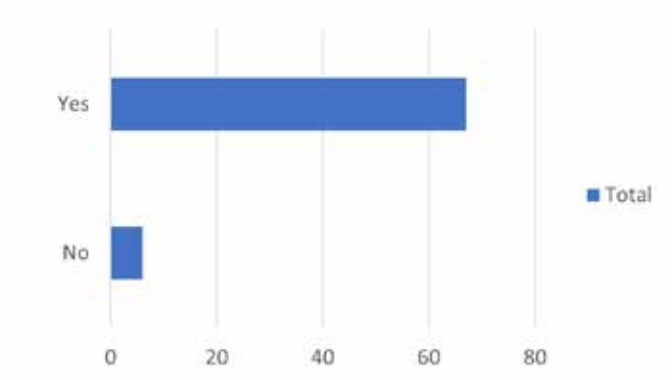

### 5.2.5. Pillars of Positive Health (PoPH)

The Pillars of Positive Health is a service-user led self-report/interview tool which asks the participant to rate six categories of health and wellbeing: daily function/self care; bodily function/physical health; mental wellbeing/health; meaningfulness; quality of life and social participation. Inclusion criteria for the participant PoPH outcome measure within the report are attendance at more than one session and full assessment completed. Participants were excluded when the intervention was identified as COVID-19 response and any cases remaining open as the post assessment has not yet been completed. It should be noted here that not all service-users consented to participate in the PoPH outcome measure, therefore these service-users are not reflected in the data.

The PoPH was carried out before and after the Link worker intervention, however, due to COVID-19 the number of traditional engagements and face to face engagements inhibited the completion of pre and post self-rating on

the PoPH. A total of 67 PoPH assessments were fully completed, of these, 63, or around 94% of service-users showed improvement in at least one area of wellbeing following service attendance.

**Figure 5.2.5. Improvement in PoPH**




### 5.2.6. Types of supports given

The breakdown of sessions is as follows: 1 session - 48% of referrals; 2 to 4 sessions - 26%; 5-6 sessions - 20%. It should be noted here that the majority of service users referred to the programme are engaging with multiple meetings and online support each week. During COVID-19, support was provided online through WhatsApp, Zoom and through telephone conversations. It should be noted here that COVID-19 had a significant impact on the number of sessions. More than 15% of service-users referred received COVID-19 support from the service.

**Figure 5.2.6.1 Number of Sessions per Service-user**

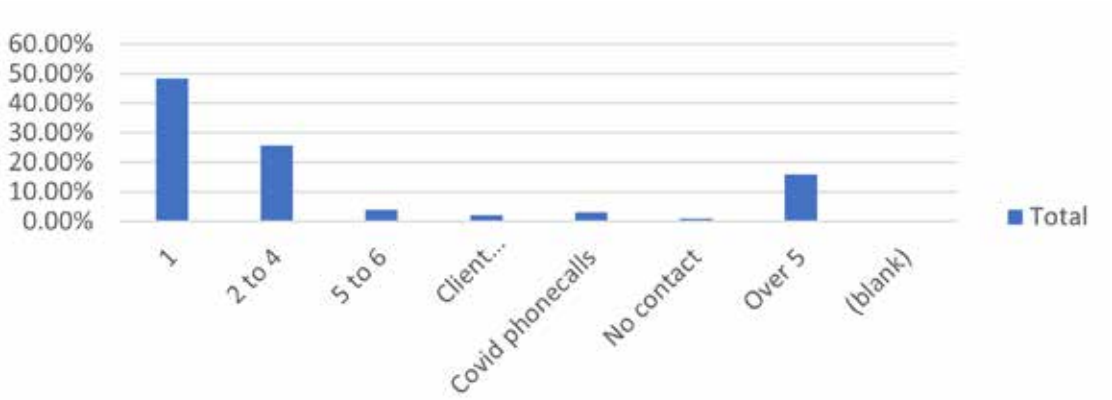
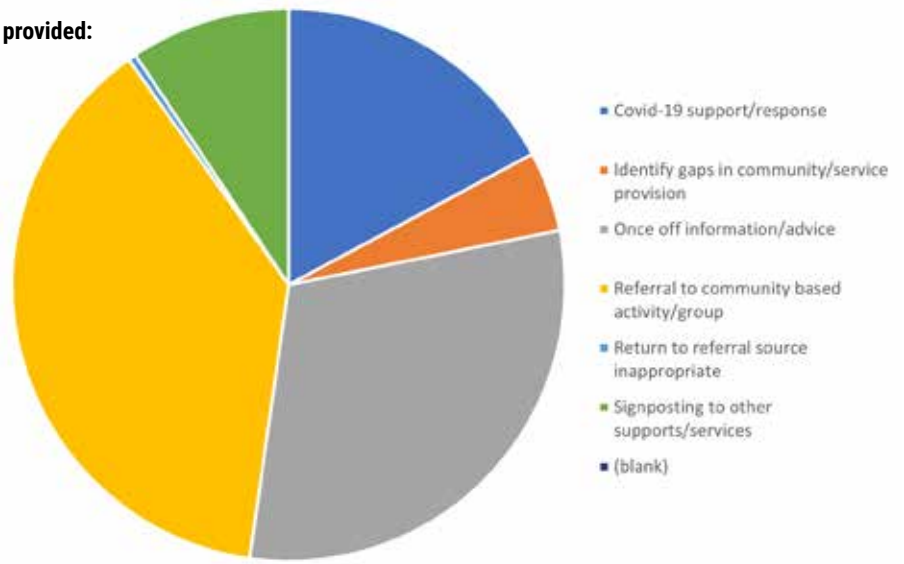
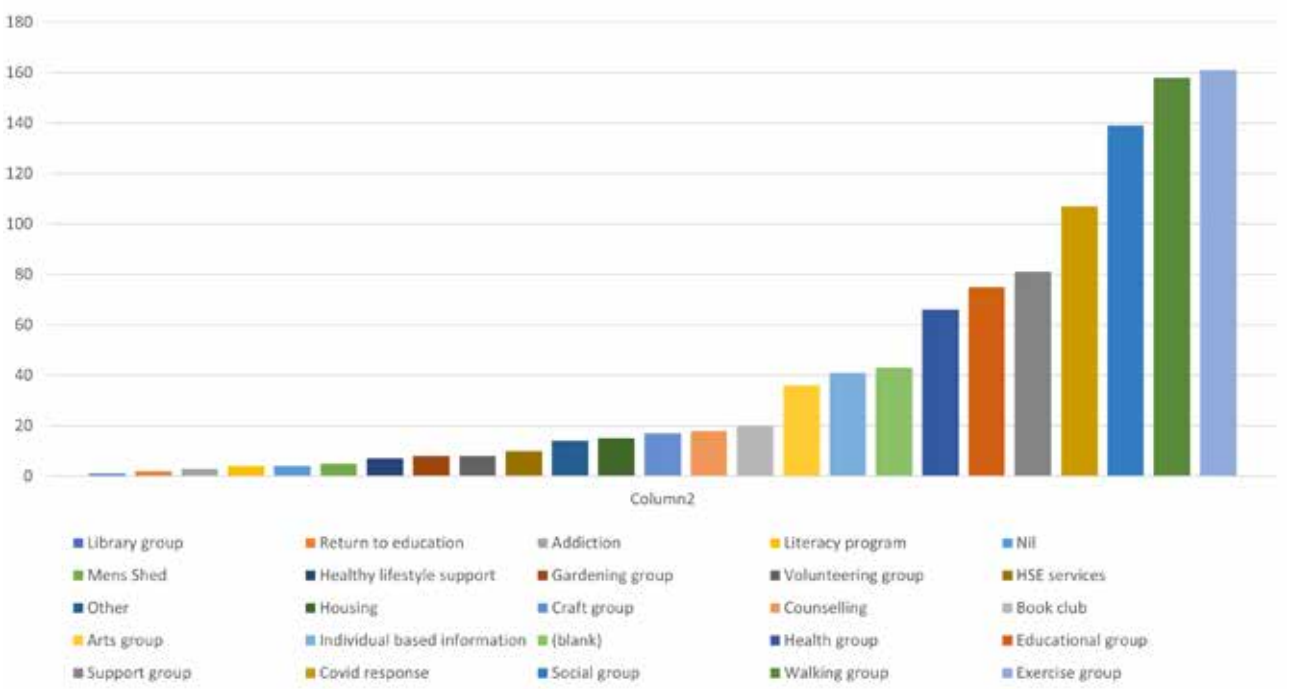



**Figure 5.2.6.2 Types of action/supports provided:**



Due to the COVID-19 pandemic and associated lockdown, Link Workers struggled to identify community groups and resources to refer service-users onwards to. As a result, Link Workers took initiative to establish online groups for their communities during COVID-19. Interventions targeting physical activity were the most popular type of intervention provided, 15% of service-users were referred to an exercise group and 19% were referred to walking groups. 13% of service-users were referred to social groups and 8% were referred to support groups.

**Figure 5.2.6.3 Interventions**



# 6. Findings

# 6. Findings

## 6.1. Overview

The evaluation of the Health and Wellbeing Community Referral Project aimed to determine the principal benefits associated with participating in this project such as mental health supports; more appropriate engagement in healthcare services, improved social functioning, being more active, being healthier, more socially connected, and improved quality of life.

The project's chosen outcome measure, the PoPH, was used to measure participants' improvements across each dimension of health and wellbeing. The dimensions that improved the most, as a result of attending the community referral project, included Social participation (75%), Mental Wellbeing (72%) and Quality of Life (70%).

**PoPH Breakdown:**

- Daily functioning: 40% of service-users reported improvement in this dimension of health
- Bodily functioning: 64% of service-users reported improvement in this dimension of health
- Mental Wellbeing: 72% of service-users reported improvement in this dimension of health
- Meaningfulness: 66% of service-users reported improvement in this dimension of health
- Quality of life: 70% of service-users reported improvement in this dimension of health
- Social participation: 75% of service-users reported improvement in this dimension of health

## 6.2 Findings

### 6.2.1. Output 1: Better Quality of Life

The first target outcome for the project was that 60 % of participants availing of support, will be supported for mental health difficulties. A total of 66% of participants reported a mental health difficulty, such as social isolation, loneliness, depression, grief and other undisclosed mental health issues, as the primary issue facing them when referred. Self-esteem was also highlighted by service-users as an issue impacting on mental health.

Data resulting from the PoPH illustrates the project's positive influence on an individual's self-reported quality of life, with 70% of participants reporting an improvement in their quality of life. Improvements in mental wellbeing reported by 72% and social participation by 75% of participants, demonstrating further the positive impact of the H&WBCR project on service-user quality of life. Furthermore, strong evidence was collected from interviews with service-users, demonstrating a significant positive impact on their quality of life, after engaging with the program.

**Qualitative data: Theme 1: Better Quality of life**

The first major theme was around better quality of life reported by participants. Three subthemes were identified within the qualitative data; improved individual health and wellbeing outcomes, improvements in mental well being and reduced levels of social isolation and loneliness. These will be further explored in the following paragraphs.

***Subtheme 1.1. Improved individual health and well-being outcomes***

Individual health and well-being outcomes were reported to be improved as a result of participation in the H&WBCR programme. Participants reported to notice improvements in their life, as their community and social participation increased. Community and group activities were found to motivate participants and provides some individuals with "a reason to get out of bed in the morning".

> *I felt like I had no future prospects. That filters down to everything. After one session with [link worker] I went from having no idea to having a plan. A direction. I feel excited. I can do this. I haven't felt like that in a long time.* (Service-user)

***Subtheme 1.2. Improvements in mental wellbeing***

The subtheme of mental wellbeing improvement was highlighted within the data. Participants reported that engaging in the community referral project was a positive experience. These improvements in mental wellbeing included experiencing relaxation and developing improved ability to cope with stress. Exercise and social groups were also reported to benefit participants mental health.

> *The walking group has benefited my mental health, as I get to laugh with others, and it does good for my body.* (Service-user)

***Subtheme 1.3. Reduced levels of social isolation and loneliness***

Social isolation and loneliness reduction was identified a subtheme within wellbeing changes. Service users reported participating with the H&WBCR program improved both social connection and participation in community activities.

> *I found this very beneficial as it encouraged me to get back out of the house and back into the community.* (Service-user)

Participants connected the reduced levels of social isolation and loneliness directly with working with the link workers within the program.

> *[Link worker] made it easy for me to get involved in things, and I'm feeling happy in myself with lots of new things to do that I didn't have before I had sessions with [Link worker].* (Service-user)

It was noted within the findings that COVID-19 significantly increases loneliness and social isolation. The positive impact of participation in the program on social isolation and loneliness was illustrated during the interviews, even with the impact of the pandemic.

> *COVID shut down everything. It shut down my world… made it smaller. The program opened up my world again.* (Service-user)

### 6.2.2. Output 2: Improved Health Status

The second aim of the project was that 60% of participants show improved wellbeing and self-care behaviour. Overall, 94% of assessed service-users reported improvement in at least one area of wellbeing following service attendance. Improved bodily functioning was reported by 64% of assessed service-users and improved mental wellbeing was reported by 72% of service-users.

Strong qualitative evidence collected from interviews demonstrated a significant positive impact on service-user self-esteem, ability to self-care, better use of Third Sector services and improved access to non-medical social activities and support.

**Qualitative data: Theme 2: Improved health status**

***Subtheme 2.1: Improvements in confidence levels, self-esteem, and ability to self-care***

Service-users reported improvements in their confidence levels, self-esteem, and self-care abilities as a result of their participation in the H&WBCR program. It was reported by the service-users that working with the link worker improved their sense of control over their health. The knowledge, skill and enthusiasm of link workers are provided as potential reasons for the noted improvements in service-user confidence levels, self-esteem, and self-care.

> *It gave me a sense of being in control of my own health care. You know you can get passed on from one person to another. After working with [link worker] I feel more in control.* (Service-user)

> *It has greatly boosted my confidence and [Link worker] was more than helpful with everything and very enthusiastic.* (Service-user)

***Subtheme 2.2. Improved use of and access to health services***

The second subtheme presented in the interview data demonstrated that engagement with the H&WBCR program improved service-user access to healthcare services and resulted in more appropriate use of health services.

> *You know you can waste a lot of time getting in touch with the wrong person [health care provider].* (Service-user)

It was noted by the Link Workers that some service-users had previously struggled to ask for help and support when needed. Link workers reported to provide support and encouragement to those who found it difficult to ask for help, providing them with the education and confidence to overcome this.

> *There's lots of pride in older Irish people - they don't want to say that they need support. This service gives people the confidence to ask for help.* (Referrer re: service-users)

***Subtheme 2.3. Improved access to non-medical social activities and support***

The qualitative data revealed that service-user engagement with the H&WBCR program, resulted in improved access to social activities and groups in the local community. Furthermore, increased participation in meaningful activities was noted by service-users and link workers.

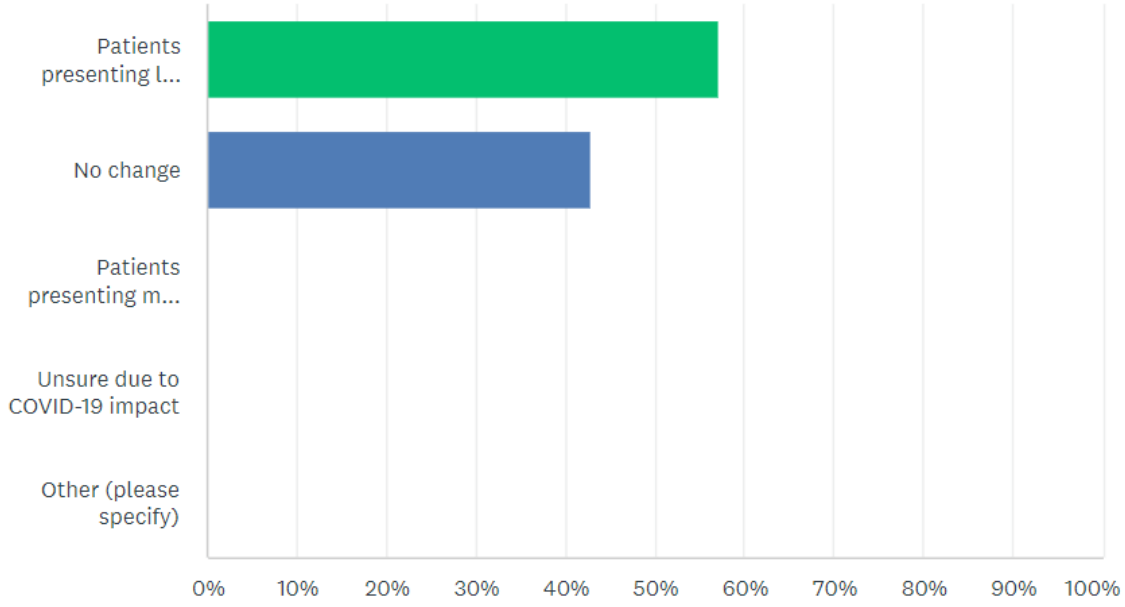
> *I don't know if it was designed to do it, but it hit the cultural support needs as well.* (Service-user)

### 6.2.3. Output 3: Reduced use of healthcare resources

The project aimed for GPs to refer up to 20% of their patients and to report a 10% reduction among patients of cohort in demand for follow up appointments. third outcome was not able to be measured due to a lack of access to GP patient databases. The ongoing COVID-19 pandemic also influenced both the ability to engage the GP practices in the referral process and has inhibited the ability to access GPs for feedback on the program. As there is no national database to access GP attendance for patients, reliance on the self-report of GPs, Health Care Practitioners and service-users/patients is required.

The data obtained from the online survey outlined that over 50% of health professionals who responded, reported that their patients presented less frequently to their service since participation in the H&WBCR program. However, the response to the survey to Health Care Providers was extremely low (seven responses) and is therefore not strong quantitative evidence and was excluded from the overall findings.

**Have you found a change on the frequency of presentation to your service?**




The demographic data collected demonstrates how link workers provided more appropriate referrals to relevant community services rather than referral to acute location. The charts below outline the types of support and interventions provided by link workers across the community referral project sites, with referrals to community-based groups and activities the most common form of action taken by link workers. The most popular type of intervention provided included interventions targeting physical activity where 15% of service-users were referred to an exercise group and 15% were referred to walking groups. 13% of service-users were referred to social groups and 8% were referred to support groups. Physical activity and social participation are both recommended to maintain good physical and mental health. These types of interventions are examples of community-based supports, that GP's and other health professionals in the area may not have knowledge of.

**Figure 6.2.3.1 Types of action/supports provided:**

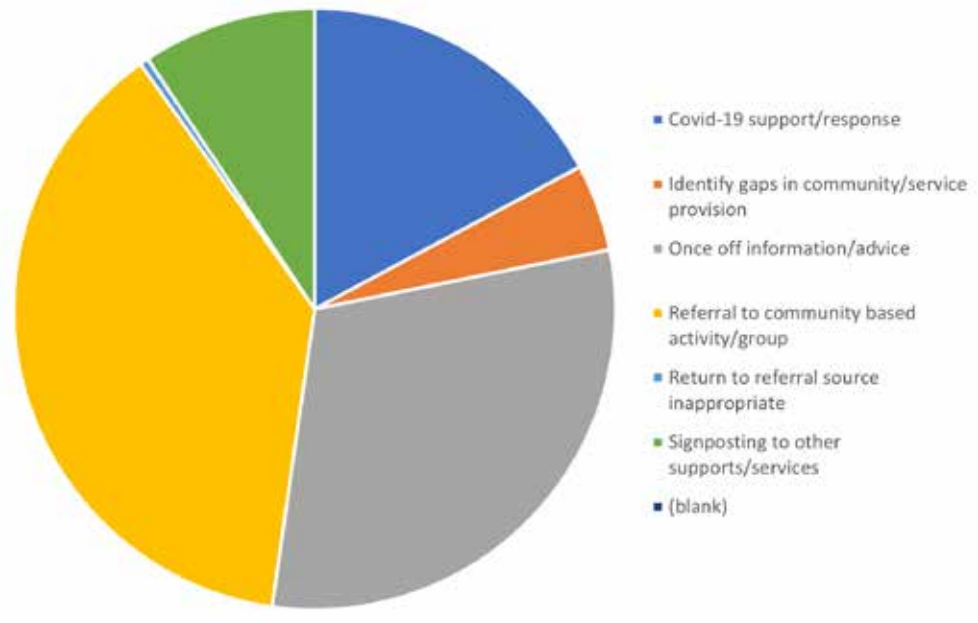
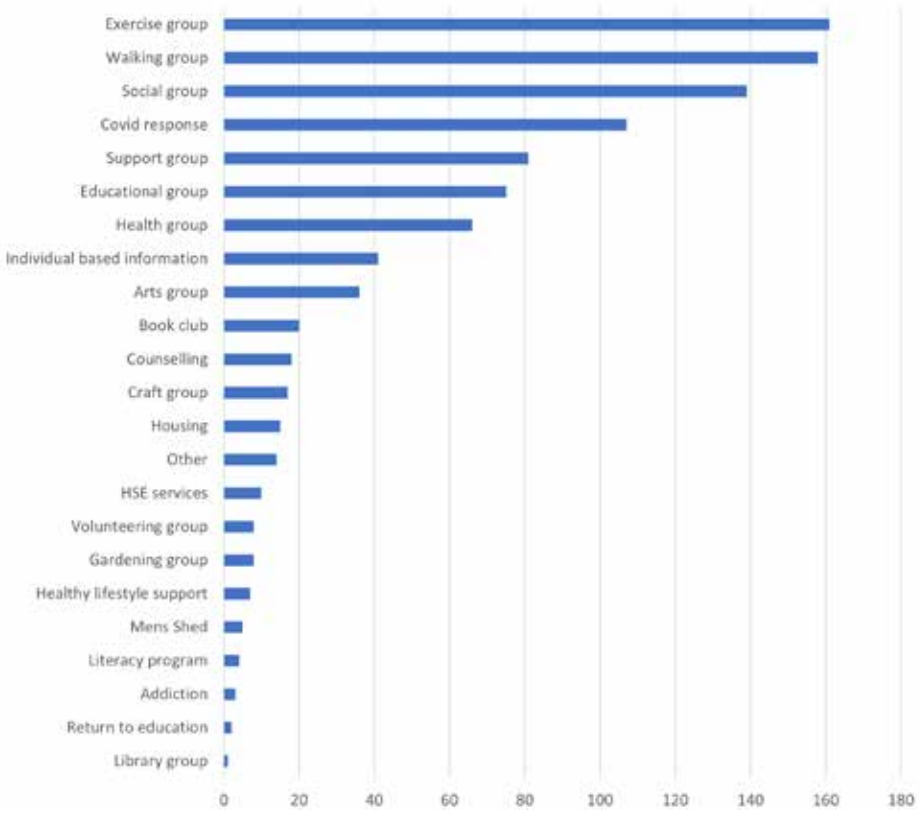


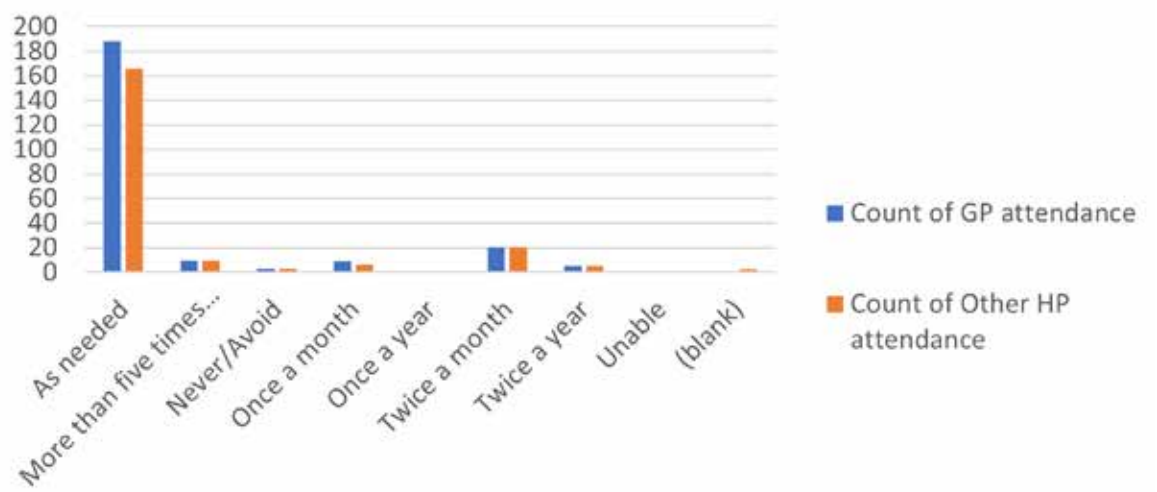

**Figure 6.2.3.2 Interventions**




## Healthcare Service Use

Self-reported use of health care providers was reported by the service-users to the Link Workers. This data outlines self-reported GP attendance and attendance at other healthcare services, however post-intervention data was not collected by the Link Workers. Link workers report that some service-users did not like being asked about their health services attendance, which may have been a barrier to collecting post-intervention data. The majority of participants reported attending healthcare service “as needed”, therefore there remains ambiguity regarding their typical health service attendance. Furthermore, this information was self-reported by the service-users and there is no access to GP patient data to confirm service-user reports.

**Figure 6.2.3.3 GP attendance:**




To support limited quantitative data, qualitative evidence was collected from interviews and demonstrated how service-users reported a reduced demand for GP services, urgent care and secondary care services, as well as an improved patient experience.

**Qualitative data: Theme 3: Healthcare Service Use**

***Subtheme 3.1 Healthcare service access and use***

Service-users reported feeling more in control of their health care, with the ability to access information that GPs would not have knowledge about. The link workers have identified that some service-users were encouraged to access a GP service, to commence promoting self-care of their own health. This was reflected in the interviews with service-users. Some participants reported a reduced need for GP services since engaging with the H&WBCR program.

> *There's a massive gap in their knowledge base. They don't know what is going on in the community. [Link worker] had all the links as well. I didn't need to go through my GP.* (Service-user)

However other interview participants, such as referrers, reported no change in GP attendance.

> *I haven't seen any change in GP attendance because GPs still don't know who we are despite all the information being given to them.* (Referrer)

***Subtheme 3.2. Improved patient experience***

The final subtheme, improved patient experience, was reported by the range of participants, including service users, link workers and referrers. Service-users reported that participation in the H&WBCR program, resulted in an improved ability to advocate for ones health and more appropriate engagement with health care services. The support provided to service-users by the link workers was reported to enhance their experience accessing healthcare and community services.

> *When you're feeling low, you don't know who to call. You don't advocate for your own health. [Link worker] outlined what you could expect from a service.* (Service-user)

> *I didn't know who to go to. Who to get in contact with? Now it feels like somebody is looking out for me. I have a plan of action.* (Service-user)

### 6.3. Discussion

The success of the H&WBCR projects is demonstrated in the initiation, establishment, and operation of 6 new Health and wellbeing Community Referral services, in 6 Family Resource Centres, serviced by 6 newly recruited Link workers, during a worldwide pandemic. Despite challenges to service delivery due to COVID-19, Link workers participated in investigating and mapping the community resources and services currently available as well as, identifying and, where possible, addressing the gaps in services, activities, or groups.

The high level of self-referrals throughout the program sites that the information about this service has been provided to people at a "grass roots" level. The H&WBCR program's accessibility to people, enabling them to take control and responsibility for their own health and wellbeing is a key achievement for the program. Service-users reported a feeling of participation in the process and increased sense of "control" over their health and access to health services.

> *After working with [link worker] I have a sense of being in control of my own healthcare. Usually, it feels like the health service is happening to you.* (Service-user)

The Link Workers' ability to be flexible and creative in their approach has facilitated more service-users in accessing the service.

> [Service-user] *now has PEOPLE to meet and talk/walk with during the week.* (Link Worker)

This is a major achievement for many service-users, who previously did not have any social contacts. This is a direct impact of the H&WBCR project on the service-users' skill set and development. Furthermore, Link Workers participated in identifying and addressing gaps in services and activities available in the community. This was a by-product of the work carried out by the Link Workers.

The qualitative data indicates significant positive impacts on the overall wellbeing, social connectedness, and positive impact on self-care (specifically self-care of overall health) for the service users. The quantitative data demonstrates improvements in the areas of daily function, bodily function, mental wellbeing, meaningfulness, quality of life and social participation for service-users. It should be noted that most of the data was collected during the COVID-19 pandemic and associated lockdowns, which have been documented to have significant negative impacts on mental wellbeing and engagement in social and daily life tasks.

COVID-19 has undoubtedly impacted on referrals with redeployment of healthcare professionals, limiting access to the public, as well as reducing access to GPs and other healthcare professionals. This has resulted in decreased referrals, however due to the ongoing networking and social media advertising and community information, self-referrals make up almost half of all referrals. This indicates that service users are accessing the H&WBCR program as an alternative to limited health care services.

# 7. Case studies

# 7. Case studies

Service-user demographics show that individuals with a diverse range of ages and from various backgrounds have participated in the Cork Kerry Health & Wellbeing Community Referral (CKH&WBCR) service.

**Figure 7.1 Age range of service users:**

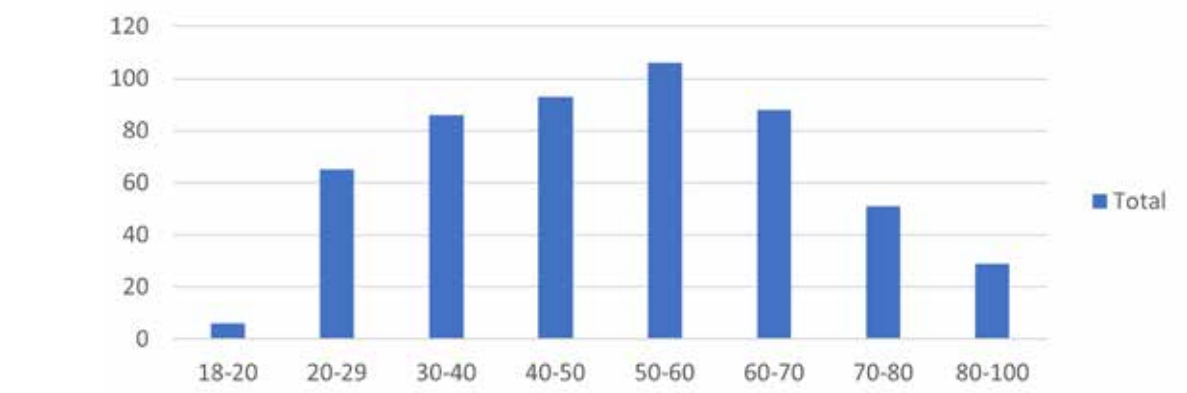
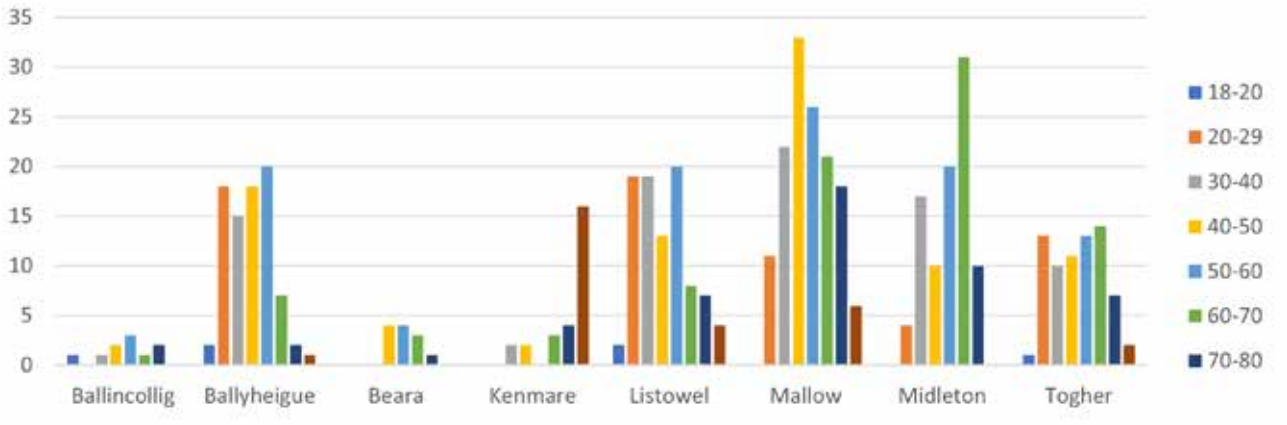



**Figure 7.2 Age ranges by location**




The case studies below demonstrate the different types of service users and the type of interventions provided by link workers.

**Case Study 1:**

This man had moved to [location] in the last two years from the UK and expressed to me that he found it difficult to build meaningful connections since he left the UK and found it difficult to join established common interest groups. I could tell initially that he was withdrawn. He also told me that due to the lockdown and working from home he was not even seeing his work colleagues. This male is married however his wife works shift work as a [profession] and he spends a lot of time on his own. He was attracted to the group as they have a dog and he felt that he was always out walking with the dog by himself. He felt it was a great way to socialise himself and the dog. Since joining the group I can see a real change in this man and moreover because he attended from the first week, I can see his confidence developing in how he interacts with the new members each week.

**Case Study 2:**

MB is an eighty-year-old man. He lives in [location] which is a rural town. He lives on his own. He never married and has no children. His closest family live over 20Km away. He is a retired boatman. MB is a Self- Referral. Although MB had support around him when I took the time to really listen, I realised that MB was worried that he would not be a part of his community again because of COVID restrictions. I worked with MB through telephone at a difficult time and then by encouraging him back out into the community when restrictions were lifted. When MB felt ready, I linked him with local agencies such as the [location]Family Resource Centre and [location] Rural Men's Outreach Office. These two links have given MB an outlet to go and enjoy himself and be part of a group. This will help him feel less lonely. I also linked him with the PHN who has arranged for his clothes to be cleaned and SVP will source furniture and be available if he needs help in the future. MB has said that: 'I now feel much happier as I am not alone, and I have places to go and meet friends'.

**Case Study 3:**

GM, is over eighty years of age. She lives on her own in sheltered accommodation. GM never married and has no children. Her closest relatives live 40 km away. She spent most of her working life in the computer industry. GM was referred by her GP as she was feeling socially isolated and did not have many friends. GM is displaying early symptoms of dementia, but she is still able to live independently with the security of sheltered accommodation. When I first met her, she was not interested in any activities, that meant she never left the apartment. Although, lockdown happened while I was still new to her it turned out to be a blessing, I got to know GM and what her needs were. As I had already met her face to face the telephone conversations allowed me the build on that relationship. I was able to link her with Meals on Wheels, which was very valuable during her time indoors. Now that she knows it exists, she is open to using it again in the future. Linking her to [location] Family Resource Centre will be very beneficial as they have a knitting club that meets once a week, GM has expressed an interest in joining this group which will allow her to be part of a group. GM is also looking forward to being part of a gardening programme within the sheltered accommodation. This will give her the opportunity to have a greater social interaction with her neighbours. GM said: 'I am over 80, I never expected to meet new people or find activities for my age group. I am very happy.'

# 8. Recommendations and Reflections

# 8. Recommendations and Reflections

### 8.1 Overall recommendation

The evaluation team recommends the continuation and expansion of the H&WBCR program. The findings indicate service user engagement and empowerment in their own health and wellbeing increase a direct result of participation in the program. This is in alignment with the Sláintecare Action plan 2019.

### 8.2 Service user engagement and empowerment

The H&WBCR program was based in and delivered services to the local community. The promotion of choice and power over the service user's own health and wellbeing is a welcome outcome. This addresses the citizen and staff engagement and empowerment section of Sláintecare's action plan. Strengthening the community further addresses the identified issues within the social determinants of health.

Furthermore, the program addressed the Social Determinants of Health as published by the World Health Organisation (Sláintecare Action Plan, 2019). In particular this program specifically addressed and reportedly made changes to the social capital, social support, social network and cohesion and developing neighbourhoods.

### 8.3. Link worker expertise

There is a need to identify, recruit and retain highly skilled Link Workers. This is a consistent theme with both the initial, mid-way and final reports. The Link Worker is highlighted by both service-users and referrers to be key to an effective and sustainabe H&WBCR program.

**Issues:**

- Retention in excellent Link Workers due to part time and/or short-term contract leading to insecure employment.
- Ongoing recruitment issues present a severe resource drain on management of the program.
- Geographical locations and infrastructure (i.e. rural link workers) may negatively impact ability to recruit and retain link workers.

**Supports:**

- Increasing job security through pay and conditions, equity to align with the healthy community's rollout.
- Need for external support and supervision, the level of need depending on the communities, to prevent burnt-out or compassion fatigue.
- Additional funding for Continued Professional Development, it is essential to ensure CPD funding is consistent to enable ongoing training needs, to be responsive to the referrals to the service and changing community dynamics.

### 8.2. Referral development & pathways – Health care professionals

The program has not been able to meet the proposed key performance indicator relating to GP referral. There have been many different reasons identified as to why this has not been achieved.

**Issues:**

- COVID-19 pandemic and associated restrictions had a negative impact on the development of referral pathways by Link workers across the community referral sites.
- COVID-19 severely impacted the continuation/ effectiveness of stakeholder committees and disrupted service provision. This included disruption to stakeholder meetings, development of relationships with staff and access to standard working procedures.
- GP and other HCP redeployment and extreme workload during the COVID-19 pandemic impacted the ability to engage with the program.
- A lack of face-to-face communication made it difficult for Link workers to build connections in their community to develop referral pathways.

**Supports:**

- Increased education and awareness regarding Social Prescribing and the Heath & Wellbeing Community Referral Project.
- Option of CPD points to be offered to incentivise attendance by linking with professional organisations, associations, and accreditation bodies.
- Engagement from HSE, Healthcare professional boards/ organisations, developing links between social prescribing network and health professional's bodies or managers including Grade 8's i.e., management in HSE.
- Expansion of focus from GPs to the wider HCP disciplines.
- Participation of HCPs on HWBCR steering committees

### 8.3. KPI/Outcome Change

The evaluation team has identified concerns about the appropriateness of set KPIs of measuring success of the H&WBCR program with a decrease in GP and health care attendance, such as emergency department attendance. The project aimed for GPs to refer up to 20% of their patients and to report a 10% reduction among patients of cohort in demand for follow up appointments.

**Issues:**

- No centralised or national GP database exists to access and measure GP attendance
- GDPR and Privacy laws prevent the access to GP patient records. In addition, GPs are private practices, further impeding access and incentive to provide access to data.

### 8.4. Support for administration and management of the project.

It is acknowledged that no additional funding or support in terms of administration has been provided for the H&WBCR program. This is currently being done under the auspices of the National Mental Health Promotion project. The additional tasks, such as recruitment, training, administration, financial management and reporting have a significant impact. Dedicated funds and personnel are essential for longevity of the program, as the current structure is unsustainable in the long term.

**Issues:**

- Failure to remedy this funding issue as this program continues to expand, means increased pressure on current personnel.

**Supports:**

- Further funding in relation to project administration, oversight and management.

### 8.5. Evaluation and research

Support and funding provided for accurate in-depth evaluations is needed to develop the bank of evidence supporting the efficacy of the social prescribing approach for population health and well-being from an Irish context. Further research into the impact of the interventions provided, and the availability of infrastructure, resources, and support in each community.

**Issues:**

- The lack of face-to-face contact, because of the COVID-19 pandemic and associated restrictions, made it difficult for Link Workers to explain and administer the Pillars of Positive Health outcome measure. This limited the amount of quantitative data available during the evaluation process.

**Supports:**

- Identification and provision of funding to support the evaluation process is required.
- Development of standardised evaluation process nationwide.
- The development of funded postgraduate research opportunities would encourage high quality researchers to engage with the project.
- Continued Data base monitoring and updating on a weekly basis, including reminding Link Workers to update their quantitative data on the spreadsheets.

# 9. Conclusion

# 9. Conclusion

Overall, the project design was flexible to adapt to the unique needs of each community. Evidence suggests that the community referral programme benefited service-users social and community participation, as well as their overall health and wellbeing.

Services utilising a social prescribing approach have the potential to support population health and wellbeing and to reduce the increasing pressure on the healthcare system in Ireland. The success of these services will be hindered if adequate and sustainable funding is not committed. Therefore, it is recommended that national guidelines are developed to ensure a level of consistency between social prescribing services. Furthermore, supporting accurate evaluations, to develop the bank of evidence supporting the efficacy of the social prescribing approach for population health and well-being from an Irish context.

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# Appendices

**Appendix A:**

***Report: The efficacy of the Pillars of Positive Health outcome measure tool to evaluate the impact of social programme on service users in Listowel, Co. Kerry.***

The proposed research project was to address the efficiency of the Pillars of Positive Health measurement tool for the evaluation of the impact of social prescribing in Listowel, Co. Kerry.

Social prescribing is a service that links people through GPs, nurses or other primary health care professionals to local non-medical support agencies in the community that provide activities for social interactions that benefit health (Thew, Bell & Flanagan, 2017). It is a concept that has been recently established but it is lacking in evidence of effectiveness of the programs. The concept of social prescribing has primarily gained support in the NHS in the United Kingdom. This is due to the fact that 20% of people in the UK were visiting their doctor due to social problems.

Engagement in social participation occupations is well documented to show significant increases in overall health and wellbeing. The American Occupational Therapy Association's (AOTA) supports occupational therapists' use of meaningful occupations in order to promote health and wellbeing and increase social participation (AOTA, 2013).

The definition of positive health is defined by Huber et al. (2015) as *"the ability of an individual to adapt and self-manage in the face of social, physical and emotional challenges."* In 2015, Huber founded the Institute for Positive Health which released the Pillars of Positive Health. The Pillars of Positive Health includes social participation as part of its determinants for positive health and wellbeing, which we plan to use in our project.

The Listowel Health and Wellbeing referral program has been initiated by Healthy Ireland a year ago, in combination with Priscilla Lynch (Head of Service, Health & Wellbeing, Cork & Kerry Community Healthcare) to address health and wellbeing through engagement in meaningful occupations. At this point in time, little evidence has been provided to show the impact of social prescribing.

The purpose of this project was to receive feedback on the use of the Pillars of Positive Health tool for evaluating the health and wellbeing referral project in Listowel.
Client feedback was an important aspect to our research as we wanted to gather the client's own personal experiences of the program and how they feel it has impacted on their life, however, this alone is insufficient to demonstrate the effectiveness or ineffectiveness of the program in a standardised way. We wanted to know if this an appropriate tool to show the impact of the social prescribing project, if it is easy for clients to understand and use and if it reflects the changes they have experienced as a result of engaging in the project.

Our methodology was a phenomenological, qualitative descriptive approach on the useability and efficacy of the Pillars of Positive Health tool from the perspectives of clients engaging in the referral program.

As part of our method, we gathered our data through the use of semi-structured, face-to-face interviews in the Family Resource Centre in Listowel as the service users felt comfortable in this setting because they are familiar with it. During the interviews the service users were provided with the tool to complete with our assistance. Then follow up questions were completed in order to determine how the clients felt the measurement tool represented their perception of their health and wellbeing through occupational participation. One interview was held at the beginning of the trial and a second phone call interview was completed after 1 month to follow up with the service users on their experience of using the Pillars of Positive Health tool. Clients were already known to the service and engaging in the program. They were recruited through purposive sampling by the Listowel program coordinator.

We transcribed our interviews verbatim and used thematic analysis to analyse these transcripts. From our analysis we deducted the following themes:

- The positivity of the use of a visual measure: the service users reported that the visual aid of the diagram of the Pillars of Positive Health measurement tool facilitated their completion of the tool, aided their understanding and they enjoyed the visual representation of their health and well-being.

- Completing the diagram with a professional: the service users stated that completing the tool with a professional as opposed to completing it alone was a positive aspect and enjoyed the interaction.

- Being involved: the service users felt that being included while the outcome measure was completed aided their understanding of how the outcome measure is completed and understood how the outcome measure could be completed again in a few weeks time.

- The opportunity to tell their personal stories: during the interviews service users discussed their personal stories while the outcome measure was being completed. They enjoyed discussing how the programme positively influenced their lives and were eager to talk about its impact on their engagement in their occupations.

- Face-to-face interviews: The service users discussed the benefits of completing face-to-face interviews in order to gather information from the client's own perspective of the service as face-to-face interviews are a more client centred approach to gathering people's personal stories.

- Increasing awareness of the programme: Increasing the advertisement of the programme was another theme that service users reported. They highlighted the need to promote the service in order to inform people of the programme opportunities and the positive impact of social prescribing. Some service users reported not being able to access the Internet prevented them from learning about social prescribing sooner and stressed the importance of brochures, advertisements in the local paper and information nights in the local community centre. One service user mentioned a phone hotline would be a useful way for people to contact the service and have their questions answered before meeting with the programme co-ordinator.

In conclusion, it is evident from the findings of this research that the service users found the Pillars of Positive Health outcome measure a positive experience. They could see how the outcome measure could be used at the beginning and end of their social prescribing experience to show a difference in their health and wellbeing as a result of engaging in the programme. Two service users recommended implementing the outcome measure in social prescribing programmes throughout the country. As a result of this pilot study and the service user's preference to discuss their personal experiences of the programme, we have chosen to focus on the participant's lived experience of the social prescribing programme from an occupational perspective for our final year project.

# References

American Association of Occupational Therapy. (2013). *Occupational therapy in the promotion of health and well-being.* American Journal of Occupational Therapy, 67, S47-S59. doi:10.5014/ajot.2013.67S47

Huber, M., Van-Vliet, M., Giezenberg, M., Winkens, B., Heerkens, Y., Dagnelie, P.C., & Knottnerus, J.A. (2015). *Towards a 'patient-centred' operationalisation of the new dynamic concept of health: A mixed methods study.* BMJ Open 2016, 5, 1-11. doi: 10.1136/bmjopen-2015- 010091

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**Appendix B: The Social Prescriber Plus Programme**

The Social Prescriber Plus Programme comprises 3 half day modules, two of which normally take place on the same day and the third which takes place several weeks after the delegates take up their new role. The Programme is delivered online via Zoom.

**Module 1**

The role of the Social Prescribing Team in the PCN, Practice or Community (Half Day).

This module introduces the concept Social Prescribing and helps delegates to understand their role in relation to their patients, the PCN/Practice, the community and the wider health and social system. The module focuses particularly on the soft skills needed by the Social Prescriber to represent the views and needs of their patients to their Practice colleagues and to other service providers in the wider health system. It includes negotiation and advocacy skills, history taking, record keeping, networking and presentation skills, as well as a new focus on telephone consultations and techniques in the age of coronavirus.

**Module 2**

Case Management Skills with the Patient/Client (Half Day).

This module looks at the approaches and techniques central to engaging effectively with the patient. It introduces, explains and provides practice in the skills and techniques by which the Prescriber can encourage the patient to take a more pro-active approach to managing their condition. Using anonymised video case studies, audio clips and practical exercises the module covers the key competencies of Active Listening, Health Coaching.

Making Every Contact Count (MECC) and Motivational Interviewing. It also includes discussion and practise in conversation and meeting models designed to put the patient at ease and to build trust and rapport.

**Module 3**

Active Learning Session (Half Day).

Module 3 takes place a number of weeks after the delegates have started their new role and is hosted by one of the delegates in their own Practice or place of work. In a facilitated learning environment, delegates are invited to present anonymised but actual situations and case studies they have encountered since being trained, that have presented a challenge in their new role. The assembled delegates discuss the challenge and, through a structured and facilitated process, provide feedback and suggestions to help the delegate with the challenge. It is an immensely powerful process and is designed to help delegates with their own challenges, as well as to provide a professional networking forum that will provide regular opportunities for the delegates to meet and discuss current topics and issues.

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