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Healthy
Communities

South Dublin County Partnership: Clondalkin

Social Prescribing Service Evaluation

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Átha Cliath Theas

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List of Abbreviations

A&E	Accident & Emergency
ANOVA	Analysis of Variance
GP	General Practitioner
HSE	Health Service Executive
KPI	Key Performance Indicator
MYCaW	Measure Yourself Concerns and Wellbeing
SDCP	South Dublin County Partnership
SHC	Sláintecare Healthy Communities
SP	Social Prescribing
SPLW	Social Prescribing Link Worker
SWEMWBS	Short Warwick-Edinburgh Mental Wellbeing Scale

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Executive Summary

Executive Summary

Social Prescribing (SP) is a healthcare approach used to address health inequalities by supporting individuals to engage with non-medical activities or services, such as community programmes, social groups, or recreational activities. SP aims to improve individuals' health and well-being and reduce social isolation and mental health issues by connecting people with community resources and activities. SP seeks to empower individuals, promote holistic care, and alleviate pressure on healthcare services by offering tailored support to vulnerable groups. Within the South Dublin County Partnership (SDCP) SP service, link workers offer social prescriptions tailored to participants' needs and goals, connecting them with appropriate sources of support within their communities.

This report evaluates the progress of the SDCP Clondalkin SP Service over its first year. Topics covered include data collection and analysis, programme referrals, and description of participants. The report continues on to investigate emerging trends in the data, client journeys, outcome assessments, and alignment with the national framework.

In particular, the assessment concentrates on participants' experiences and immediate outcomes, measured through wellbeing scores and interviews conducted after programme completion. The research employs a mixed methods approach, combining qualitative interviews and focus groups with clients and staff, alongside quantitative data drawn from programme management software and qualitative data from referrer questionnaires.

Findings suggest that by directly engaging with clients and carefully listening to their needs, SPLWs build trusting relationships that are crucial for the success of the programme. This attentive and personalised approach allows SPLWs to tailor their recommendations effectively, ensuring that both the specific needs of the clients and the concerns of the referrers are addressed. The personal impact of the SP programme is significant and multifaceted. Clients experience a range of benefits, including improved mental and physical health, enhanced social connections, and greater overall well-being.

Additionally, the trust and rapport established between clients and link workers plays a vital role in encouraging ongoing engagement and fostering long-term benefits. **Clients valued the attentive listening, personalised support, and practical resources provided through the SP process.** They expressed satisfaction with social prescriptions that were tailored to their interests and objectives.

SP clients noted reduced feelings of isolation and loneliness, increased wellbeing, and improved social connectedness resulting from participation in community activities. Engaging in diverse community programs provided structure to their routines, contributing to a more positive emotional outlook since beginning the programme. Throughout, the service maintains a person-centred approach, ensuring that the pace aligns with the participant's preferences and needs.

Findings also indicated that the need for SP in the local community is higher than what might be expected. Many clients had complex journeys, needed more interventions to complete the programme, and persisted in the programme for a longer duration than what could be predicted from HSE guidelines.

Lastly, the report puts forward several recommendations for the continued development of SDCP's SP Service. These suggestions aim to enhance the programme's effectiveness, reach, and sustainability, and will help ensure that the programme continues to meet the evolving needs of its participants and stakeholders, ultimately reducing health inequalities for individuals and within communities.

1. Introduction

1. Introduction

1.1. Report Aims

This report seeks to evaluate the first 12 months of the social prescribing (SP) service run by South Dublin County Partnership (SDCP) under Sláintecare Healthy Communities (SHC) in Clondalkin. The Clondalkin SP Service aids adults in accessing services that can help enhance their overall health and wellbeing. This report focuses on three primary objectives:

1. To evaluate the initial project development during its inaugural year
2. To ascertain whether the Clondalkin SP Service employs a sustainable model that fosters positive health behaviours within the local community, ultimately reducing health inequalities
3. To offer recommendations for future service delivery to optimise short- and long-term outcomes for the programme's clients.

The research questions to be addressed include:

1. What is the nature of the referrals received in the first 12 months of the SDCP Clondalkin SP Service?
2. Who is being referred to the SP Service, and are there any emerging demographic trends regarding referrals, completions, duration of time spent on the programme, outcomes, or other elements of programme?
3. How can we describe the journeys of clients engaging with the SP Service and are the variations in client journeys reflected in the monitoring guidelines provided under the SP National Framework provided by the HSE?

In order to meet these aims and shed light on the research questions, the research employs a mixed methods approach, combining qualitative and quantitative data from a variety of sources and stakeholders to evaluate the SDCP SP Service.

1.2. Background

1

Social Determinants of Health

The determinants influencing individuals' health outcomes extend beyond medical factors and encompass various non-medical elements. These include the circumstances of birth, growth, work, living conditions, and ageing, as well as broader forces and systems shaping daily life, such as early childhood experiences,

discrimination, income, education, employment, food security, and housing. Maintaining good physical and mental health is crucial for an individual's wellbeing and quality of life.

1.3. Sláintecare Healthy Communities

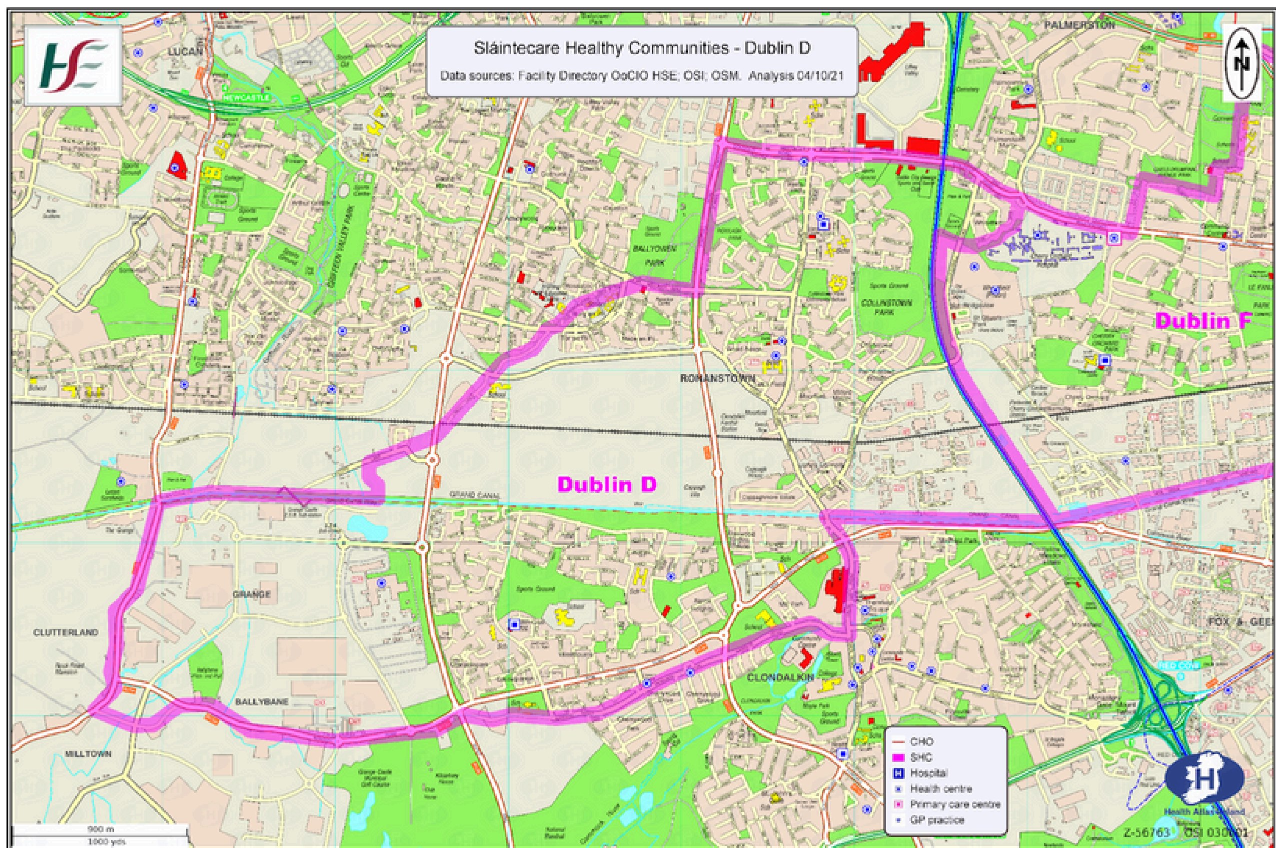
In 2021, the Department of Health, in collaboration with the HSE, local authorities, and community agencies, launched the Sláintecare Healthy Communities (SHC) Programme to enhance health and wellbeing services in 19 communities across Ireland. Using an evidence-based approach, areas with concentrated health and wellbeing risks were identified to deliver targeted initiatives like Healthy Food Made Easy, Programmes for Parents, We Can Quit (smoking cessation peer programme), a Community Food and Nutrition Worker and the Social Prescribing service. Clondalkin as well as Tallaght were two areas in South Dublin designated as a SHC areas. All of the above programmes are delivered by SDCP as a local delivery partner under SHC, providing a connected suite of wrap around programmes that are easily accessed by a single pathway within SDCP.

Clondalkin Sláintecare Healthy Communities

Sláintecare Healthy Communities (SHC) represents a collaborative government initiative aimed at enhancing health and wellbeing in community areas throughout Ireland. SHC adopts a partnership approach, urging local authorities and community groups to collaborate in reducing health inequalities by empowering individuals and communities to make healthier lifestyle choices. This approach leads to improvements in overall physical and mental health and wellbeing.

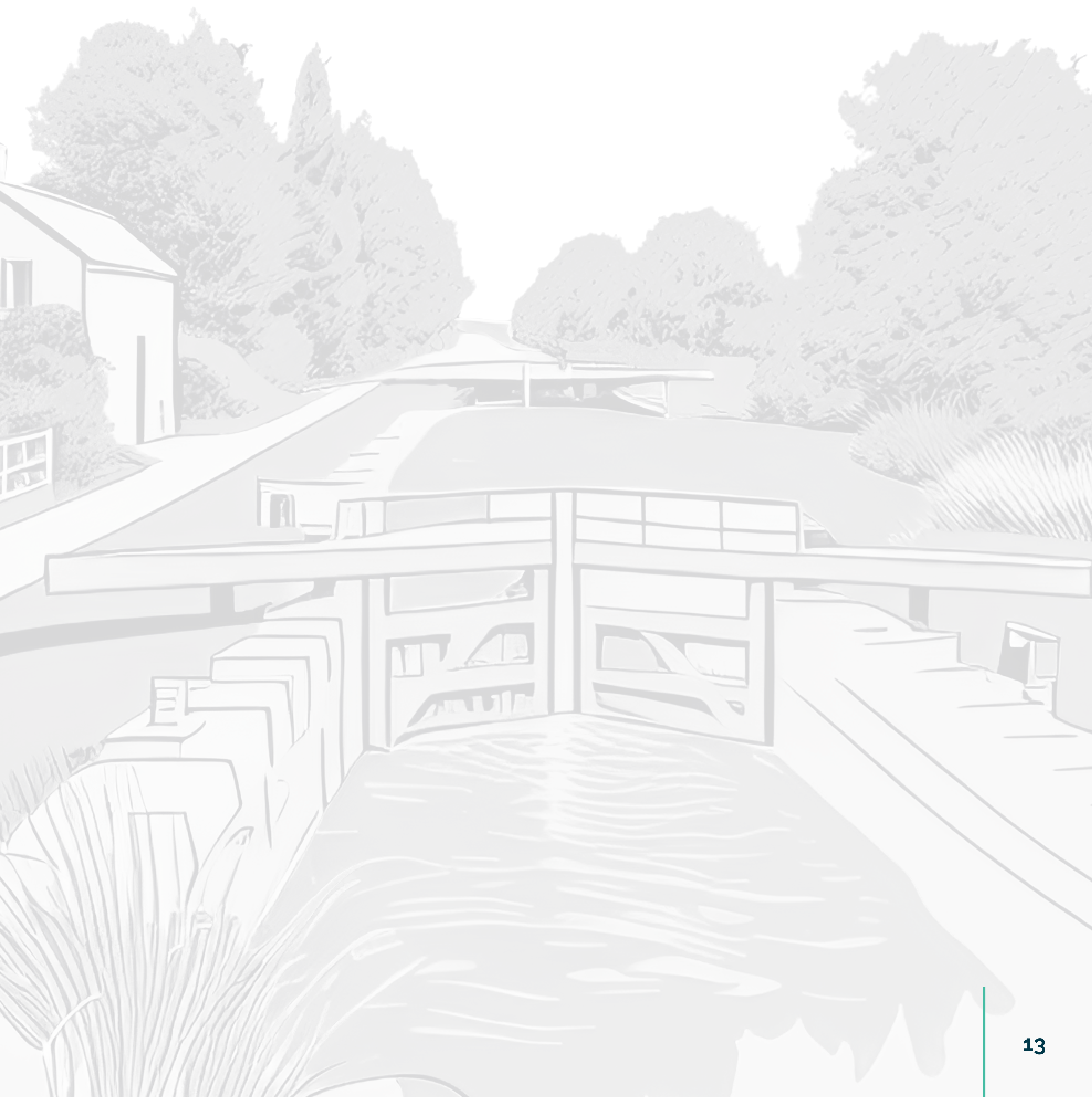
The SHC program targets areas characterised by high deprivation and significant risk factors affecting the health and wellbeing of the population. To address health disparities in these areas, SHC implements specific initiatives to address challenges faced by individuals and communities. Among the supported programmes is SP, a targeted strategy endorsed by SHC to alleviate isolation and loneliness while enhancing the mental and physical health of participants. Clondalkin is one such area benefiting from these efforts.

Figure 1. Map of Clondalkin Sláintecare Healthy Communities Project Site



Social Prescribing

SP embodies a holistic healthcare approach that recognizes the influence of social factors on individuals' health and wellbeing. SP comes in various forms. In Clondalkin, it involves social prescribing link workers (SPLWs) suggesting non-medical interventions to address patients' social needs and enhance overall health outcomes. These recommendations may include diverse activities like community-based exercise programs, art classes, gardening clubs, or support groups. The primary goal is to enhance patients' quality of life by connecting them with local resources and services that target the root causes of health issues, promoting a more inclusive and person-centred healthcare strategy. SP aligns with the broader objective of promoting community engagement, reducing social isolation, and empowering individuals to actively participate in their health and wellbeing. Social prescribing was first formally recognised in Irish government policy through the Stronger Together Mental Health Promotion Plan 2017 - 2022, calling for the integration of social prescribing across the HSE, community and voluntary sectors and highlighting this as a priority.



2. Methodology

2. Methodology

2.1. Data Collection and Methods

A mixed methods approach was used; a combination of quantitative and qualitative data were collected and analysed in order to understand various aspects of the programme from the perspective of the clients, SPLWs, and management.

Service Documentation Review

Conducting a review of service documentation entailed examining both internal and external written materials, manuals, guidelines, reports, and other pertinent documents linked to the service, providing insights into the program's structure, processes and operations. Documents for review were provided by staff at the Clondalkin SP Service.

Service Documentation Review

Quantitative data were obtained from the bespoke CRM set up by SDCP on Salesforce. These data covered the first year of the SP Service: September 2022 to September 2023. Salesforce data standardisation, type, and quality were investigated. Where possible, interventions and social prescriptions were tracked, as well as client outcomes, in order to understand client journeys (see Appendix 1 for a description of the Salesforce Database).

Data from 115 participants entered into Salesforce between September 2022 and September 2023 were used. Participant referral data were automatically populated into Salesforce through an online referral form. Information in Salesforce was cleaned in order to identify individuals who had been referred multiple times.[2] No duplicates were identified. Demographic details encompassed age and gender. Participant status, interactions with health care workers, and participant wellbeing were also included.

As part of the wellbeing assessment in the SP service, participants completed the following questionnaires at the start and conclusion of the program:

- The Measure Yourself Concerns and Wellbeing (MYCaW): a person-centred measure which empowers service users to recognise and address the two paramount factors influencing their health and wellbeing during consultation.
- The Short Warwick-Edinburgh Mental Wellbeing Scale (SWEMWBS): a concise and standardised measure designed to assess an individual's mental wellbeing by capturing various aspects of positive mental health in a brief questionnaire format.

Wellbeing scores were inputted into Salesforce and subsequently examined as part of this assessment. The difference in scores before and after participation in the SP service was computed for each participant, and the average changes in scores were compared across wellbeing tests. However, it is important to note that not all participants participated in the wellbeing assessment at their exit interview and not all respondents completed every question in the two wellbeing assessments, resulting in variations in the number of participant responses for each question.

Interviews and Focus Groups

Qualitative interviews and focus groups were conducted to obtain a more nuanced understanding of the perspective of the staff and clients. Only clients who had completed the programme were invited to interview. Seven clients who had completed the SP programme were interviewed. Interviews with the programme director and the database manager, and one focus group with three SPLWs were conducted.

Survey

An online survey was sent to referring organisations to gain insight into their perspectives on the SDCP SP service. Invitations were sent to twenty-one service providers based on the number of referrals from these organisations to the SDCP SP service and their disciplines. The survey was initially open for two weeks, with a one-week extension. Seven referrers completed the survey.

2.2. Sample and Selection Process

Participants for interviews were selected based on their roles in the service. Staff selected for interviews were three SPLWs, one database manager, and one project manager.

Client participants were selected for interviews to try and obtain a representative sample from those who had already completed the SP programme (e.g. in terms of background, gender, ethnicity, and support needs). SP client interviews were conducted with seven participants, three male and four female.

2.3. Data Analysis

Changes in Wellbeing Measures

Participants' scores on wellbeing measures pre- and post-intervention were used to examine the impact of the SP service on their wellbeing. Pre- and post-intervention scores were compared to calculate the change in scores across each of the following scales: SWEMWBS (N=35), MYCaW Concern 1 (N=35) and 2 (N=30), and MYCaW Wellbeing (N=34). Changes in scores were assessed in terms of their meaning, rather than numerical change. This is due to the fact that on the SWEMWBS, higher scores indicate better wellbeing, while on the MYCaW subscales, higher scores indicate poorer wellbeing. As such, on the SWEMWBS, increases in scores from pre- to post-intervention were defined as improvement in wellbeing, while decreases were characterised as disimprovement. Conversely, increases and decreases on the MYCaW were characterised as disimprovement and improvement respectively.

Changes in wellbeing scores may be due to causal factors or due to random chance. A variety of statistical tests were therefore conducted to look at the likelihood of causal variables influencing the scores or score change. These tests include t-tests, Wilcoxon signed rank tests, and Pearson's correlations. T-tests[1] and Wilcoxon signed rank[2] tests were conducted in R to assess the statistical significance of changes in wellbeing scores from pre- to post-intervention. A paired samples t-test was performed on the SWEMWBS scores while Wilcoxon signed rank tests were performed on the MYCaW Concern 1 and 2 and MYCaW Wellbeing scores, as these violated the assumption of normality. Pearson's correlation coefficients were computed to investigate the relationship between changes in scores on wellbeing measures and the number of outcomes reported per participant.

[1] The majority of referrals from the Tallaght catchment area are referred to the Tallaght service and hence not included in this evaluation.

[2] A Wilcoxon signed-rank test is a non-parametric statistical test used to determine whether the medians of two paired samples are significantly different.

Age- and Gender-based Differences

As mentioned above, causal or random factors may influence scores. CSO data indicate that there may be age- and gender-based differences in the percentage of the population that feels lonely. Two-way analyses of variance (ANOVAs)[3] and Kruskal-Wallis[4] tests were performed to investigate age- and gender-based differences across pre-intervention and post-intervention scores on wellbeing measures as well as changes in scores from pre- to post-intervention. Kruskal-Wallis tests were carried out on SWEMWBS post-intervention scores, MYCAW Concern 1 pre-intervention scores, and changes on MYCAW wellbeing scores, as these did not meet the assumptions of a two-way ANOVA. Two-way ANOVAs were conducted on all other pre-intervention scores, post-intervention scores, and changes in scores.

2.4. Limitations

Balancing Depth and Breadth: Research questions in the interviews and focus groups were designed to fill gaps in and add clarity to the information available in the Salesforce database. Participants were selected to provide a representative sample across demographic categories and to represent the breadth and depth of journeys supported by the SDCP SPLWs.

Bias and Interpretation Challenges: The research team documented their own biases and assumptions in order to minimise their effect. In addition, where the data available showed biases, these were noted in the report. Selection bias for interviews was minimised as much as possible by selecting participants to invite to interviews and focus groups based on information in the database.

Time and Resources: This research project was conducted by TASC researchers, in collaboration with the SDCP. This collaboration served to maximise the expertise available on each of the two teams to achieve research objectives.

Observational Research: As an observational research project, it is constrained by the parameters established by the SDCP SP programme. Consequently, assessing the outcomes of non-participation in the SP programme or establishing causation is not feasible.

[3] An ANOVA is a statistical method used to analyse the influence of two categorical independent variables on a continuous dependent variable.

[4] The Kruskal-Wallis test is a non-parametric statistical method used to determine whether there are statistically significant differences between three or more independent groups, based on their ranks.

2.5. Ethical Considerations

Informed Consent: Participants were provided with a clear explanation of the study's purpose, their role in the research, how their contributions would be used, and how their data will be handled prior to the interview or focus group. Any supports which an individual might need to participate in the research were considered and catered for, where possible.

Data Protection and Anonymity: Only essential information was collected during interviews and focus groups.

Prevention of Harm: The purpose of the research was explained to participants, allowing them to prepare themselves in advance for what would be discussed. The need for anonymity of individuals' personal stories was expressed in the focus group and participants who preferred to have a one-to-one interview were able to do so, the researcher monitored the individual or group for signs of distress and would call for a halt or a break if necessary.

Position of the Research: Explanation of the goals of the research and the position of the researcher was important to conducting an external evaluation. Although this research was performed in collaboration with the SDCP, the researcher remained independent so that the evaluation would be as unbiased as possible. This allowed participants to feel comfortable in expressing their views and talking about their experiences without concern.

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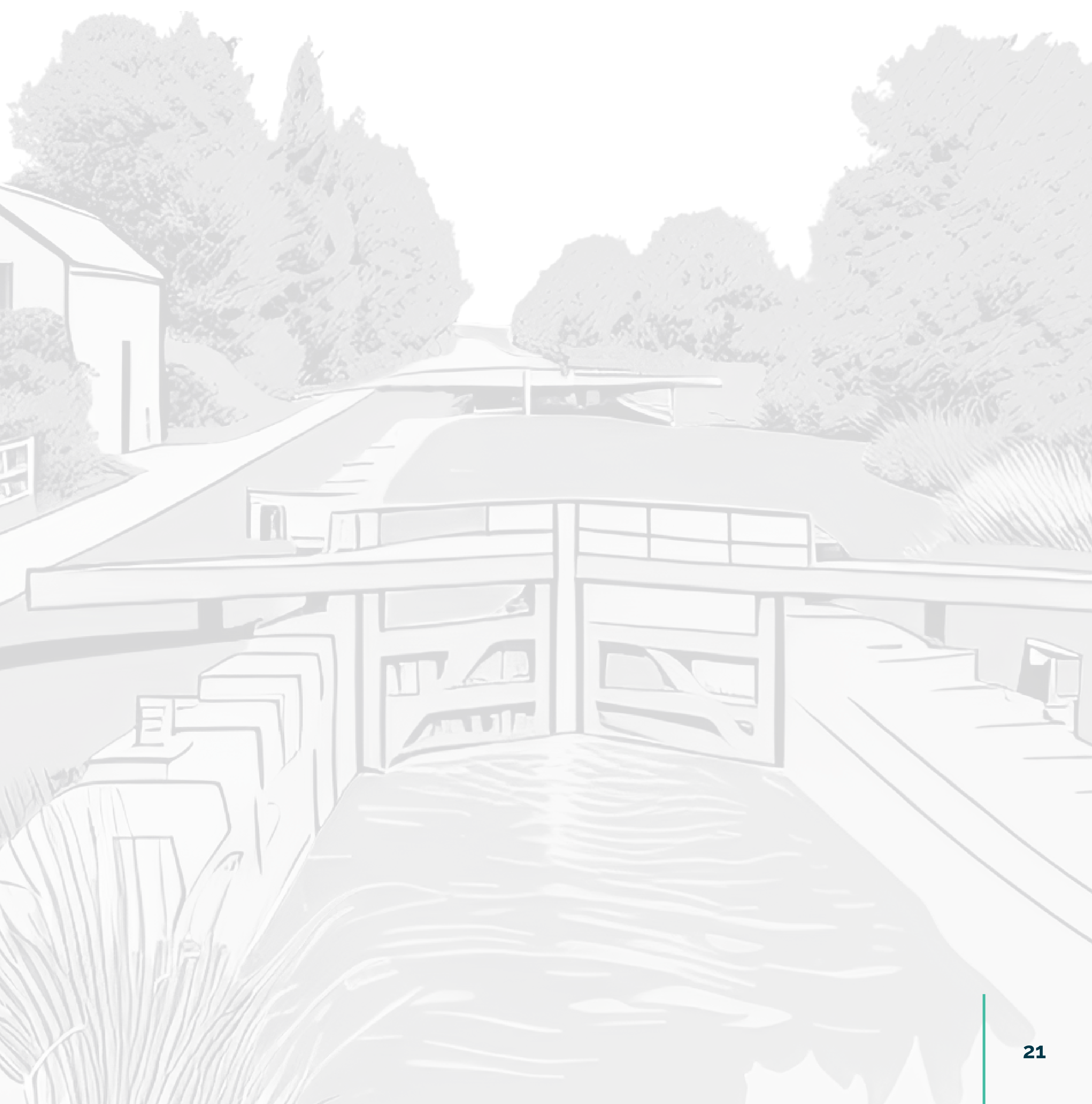


3. Overview of Programmes and Services

3. Overview of Programmes and Services

3.1. Clondalkin Social Prescribing Service

Background

The SDCP SP Service was launched in 2018, prior to the launch of Sláintecare and the HSE SP Framework. The SDCP Service was among the first SP Services in Ireland, with initial pilot projects launching in Mayo and Donegal, in 2012 and 2013 respectively (Whyte & O'Kelly, 2022). The service was initially launched in Tallaght, expanding to Clondalkin in 2022 under SHC.

Role of the Service

SP fulfils a wide range of functions for its clients. The purpose of SP intrinsically varies from client to client, as SP is designed to be person-centred, adapted to the needs of each individual. Interviews with both clients and staff provided insight into some of the roles fulfilled by the service and SPLWs.

Both clients and SPLWs positioned SP as one element of a broader support network for some. For example, a client may be availing of specific mental health supports, with SP complementing this by indirectly supporting their mental health, for example, through facilitating social connections. This was reflected in the situation of one interviewed client, who simultaneous to his engagement with SP also engaged with counselling, keyworking, and availed of specific, regular medical care. Relatedly, SP may fill a gap while a client awaits other, more specific supports. For example, clients may be on a waitlist and in the interim avail of SP to ensure that they are not left unsupported and do not deteriorate while awaiting more intensive or suitable care.

One SPLW also referred to SP as a "conduit" to other services, particularly in situations where a client needs support with an issue that SP cannot address. The SPLW may not have the capacity to directly support a client in resolving the issue, but they can link the person in with services which are better equipped to do so. During the focus group, they provided the example that the SPLW may link a client with an "all consuming" housing concern to a social worker or occupational therapist. This too was reflected in the accounts of some interviewed clients, who spoke of the various supports and services which they had been linked in with by their SPLW. Some examples include organisations supporting specific populations, designated supports for mothers and their babies, and community mental health programmes.

Adapting the Service

Interviews with staff indicated a range of changes that had been made to the service over its course, including changes in database systems, implementation of new protocols and procedures, and streamlining of processes. Internal targets are reviewed regularly in accordance with what is achievable and realistic, for example, the number of contacts per client that appear to be needed or the number of clients that each SPLW has the capacity to support. In addition, the director spoke of regular review meetings held with the team to ensure that the service continues to meet the needs of both clients and staff. This commitment of the service to continuous improvement and learning was emphasised in staff interviews. One example of this is the hiring of a migrant SPLW to specifically work with new communities. As reported by the director, the specifics of this role will be reviewed and adapted as it develops, in line with the SPLW's experiences and their clients' needs.

The director went on to express the hope that their work can inform not only the Clondalkin service, but SP services across the HSE. ''The more we learn about how to share best practice, and the more we learn from what we're doing as well, is really important."

3.2. Clondalkin Social Prescribing Programme Documentation and Structures

Service Documentation

Regulatory documents from SDCP provide some insight into standard procedures and practices. These documents included a Client Registration Form, a Data Protection and Retention Policy, and a DNA/Cancellations/No-Show Procedure.

Internal Policies and Procedures

Internal procedures involve regular meetings with team members regarding specific cases, caseload, and programme management. These opportunities allow staff to voice experiences and share knowledge, as well as maintain a unified approach. When needed IT staff may also attend meetings concerning necessary changes to Salesforce.

Reporting

The SDCP SP programme reports key performance indicators (KPIs) to the HSE on a quarterly basis. KPIs changed various times during 2022 and 2023, during which new data were requested. In response to these reporting changes, the SP team modified Salesforce as necessary. A Salesforce Guide describes the factors which are recorded for each participant, and have been set up by SDCP IT staff to efficiently

calculate and provide the required data upon request, allowing for easy data extraction for reporting purposes.

Supports for Social Prescribing Link Workers

The SDCP makes a number of supports available for SPLWs to ensure that their own wellbeing is maintained and they are offered a confidential space to debrief if needed. These include access to a counsellor, case management meetings, one another, and clinical supervision. A minimum number of engagements with supervision is required (i.e. twice per year), though staff are free to avail of it more frequently. In line with the commitment to continuous service improvement, these supports were implemented in response to the experiences shared by SPLWs with the service director. "I do really think [clinical supervision] is a crucial part of the support that a social prescriber needs. Because they do have some very, very tough conversations with people."

During the first year of the programme the HSE supported the Clondalkin Social Prescribing service with the following:

- A local Social Prescribing Peer Network
- 2 day Essential Skills training specifically for Social Prescribing
- A dedicated local Health Promotion & Improvement Officer for the Clondalkin SHC area to provide linkages and supports within HSE networks
- Support through Clondalkin SHC Local Implementation Group to promote service and network with key stakeholders

3.3. Clondalkin Social Prescribing Service Promotion

Staff's Awareness-Raising Work

During interviews, staff emphasised the need to raise community awareness of their service and the time this requires. Some noted that the SP rollout is relatively new in targeted SHC areas. Promoting the service and establishing connections with other community services is ongoing, which hinders SPLWs from meeting HSE casework targets. Regular awareness-raising is also necessary due to staff turnover among healthcare workers. Promotional work takes various forms to accommodate different referral pathways. Staff engage with healthcare workers, social care, and other services by reaching out to potential and past referrers, often arranging meetings to introduce the service and its referral process. These engagements usually lead to increased referrals from healthcare workers. Additionally, staff engage directly with the community to promote self-referral through information stands, local events, leaflets, and advertising in newsletters. As the service grows, staff have observed a snowball effect, with word-of-mouth referrals from those who previously used the service.

Promotional Materials

The SDCP SP programme maintains a website and generates materials to promote the SP programme among potential referrers and to provide information to referrers, including an introduction to SP, contacts for the team, and referral criteria.

3.4. Client Record Management: Reduced Administration Time

Database management and the evolution of the databases used by the service was discussed with staff members during interviews. Staff agreed that the previous system used by the service, Elemental, was not suited to the needs of the programme. Staff felt that the system was time-consuming and labour-intensive, potentially necessitating the hire of a full-time administrator to manage the system. Options to customise the database were also limited. A "benefit analysis" was conducted to compare the suitability and efficiency of Elemental and Salesforce, following which SDCP SP ceased using Elemental and transferred to Salesforce.

3.5. Wellbeing Assessments

As discussed, the SP service uses two quantitative measurement tools to assess the wellbeing of clients pre- and post-intervention: the SWEMWBS and the MYCaW. The quality and utility of these tools was assessed as part of the present evaluation.

Psychometric Properties of Wellbeing Measures

A search of existing data on the psychometric properties of the wellbeing measures used by the service was conducted, including data concerning their validity and reliability (Bannigan & Watson, 2009; Bhattacherjee, 2012). When evaluating questionnaires designed to track changes in wellbeing, it is important to consider the balance between test-retest reliability and sensitivity to change; scores should change on repeated administration if there has been a meaningful change in the participants' wellbeing between the two measurement points.

A number of assessments of the psychometric properties of the SWEMWBS were found, demonstrating high reliability and validity. The SWEMWBS has shown high internal consistency, and convergent and discriminant validity across a number of populations (McKay & Andretta, 2017). Evaluations of the test-retest reliability of the SWEMWBS are limited, but suggest that it is moderate to good (Sun et al., 2019). Further detail is available from the UK Child Outcomes Research Consortium.

The MYCaW has not been evaluated to the same degree, though some assessments of the scales' validity and reliability exist. Jolliffe et al. (2014) demonstrated MYCaW's high sensitivity to change as well as good convergent validity. However, these evaluations were conducted on specific populations, such as patients with chronic illness, rather than a general measure of wellbeing in any population. Paterson et al. (2007) provided further evidence for the MYCaW's sensitivity to change, again only among cancer patients. Evidence to support the robustness of the MYCaW is therefore limited, and that which does exist may not be generalisable to SP services and clients.

Quality and Utility: The Staff Perspective

Questions regarding the value of the questionnaires were posed to staff during interviews, in order to gain insight into their perspective and experiences. In general, SPLWs felt that the MYCaW is more useful than the SWEMWBS, but both come with some limitations. They also discussed the efforts that had been made to address the shortcomings of the questionnaires.

When asked about the contributions of the questionnaires, SPLWs felt that they help the client to open up and develop trust in the staff member. They promote self-reflection by prompting the client to think about various aspects of their wellbeing, including elements which they may not have thought about previously. Through this, the SPLW may gain valuable information about the client and their situation, which the client may not have disclosed otherwise. The MYCaW, which is based around the identification of specific concerns, was highlighted as a useful tool in identifying realistic goals, as the SPLW and the client can then work together to address those concerns. Finally, changes in scores from pre- to post-intervention as well as reflecting on the identified concerns post-intervention allow the client to see their progress, which is in itself a helpful and encouraging exercise for the client. Additionally, this can assist staff in both making the decision to discharge a client and enacting this decision. SPLWs can use the client's score to assess whether the goals of the programme have been achieved. If a client feels that they are not ready to be discharged, their scores can be helpful in demonstrating the progress and positive changes they have made since engaging with the service.

At the same time, a number of challenges with the use of the questionnaires were noted. While the pre- to post-intervention comparison is helpful for clients whose scores have improved, some clients' scores indicate a deterioration in their wellbeing over the course of the programme, which can be discouraging and difficult to navigate for both the client and SPLW. Relatedly, the questionnaires do not capture the nuances of the client's situation; they reflect their wellbeing at the point at which they are administered, and not the context around this score.

A third, mid-way assessment point which could add nuance to these results and quantify the client's wellbeing while engaging with the service is not currently in place. In addition, some clients may find the questionnaires difficult to complete, as they require that the client disclose very personal information to the SPLW. Some SPLWs felt that, in the case of the SWEMWBS in particular, "if you ask the same questions, the next day, you might get a completely different answer. … [It] depends on how the person is feelingin that moment". Given these limitations, SPLWs introduced the recording of client outcomes to complement the wellbeing measures (see Section 4.3). These outcomes qualitatively describe accomplishments and changes made by clients over the course of the programme, such as engagement with specific supports, physical activity, learning new skills and volunteering. These outcomes are indicative representations that provide a more complete picture of the impact of the programme on the client, when used alongside the wellbeing measure. They can also assist in supporting clients whose wellbeing scores may have deteriorated, as the SPLW can highlight positive changes in the clients' life even if, quantitatively, their wellbeing appears to not have improved. In addition, SPLWs can explore the potential reasons for this deterioration with the client, as it may be tied to recent events in the person's life.

3.6. Compliance with HSE Standards

During staff interviews, some interviewees felt that the standards and targets prescribed by the HSE are disconnected from the reality of their work. For example, targets surrounding annual caseload (e.g. 120 clients for an established SPLW) may not be achievable due to variations in clients' needs as well as the volume of work associated with the running of the service outside of casework (e.g. promotional efforts; see Section 3.4). As such, an objective of the present evaluation was to compare the experiences of staff members, clients, and the service as a whole to the HSE SP Framework and standards, so as to assess if these standards are reflective of the reality of SP.

3.7. Referrers

Seven referrers completed the survey, representing organisations which work across healthcare, housing, social care, and local area non-governmental organisations. Similarly, respondents were employed in a range of roles, including healthcare workers, health promotion, therapy, and support. They had been in the South Dublin area from two to 16 years and had experience in their role from 1.5 to 23 years.

Referrers reported that the most common reason for referring patients and clients to the service was social isolation (N=6), followed by life issues (N=4), loneliness (N=4), physical health (N=4), and mental health (N=3).

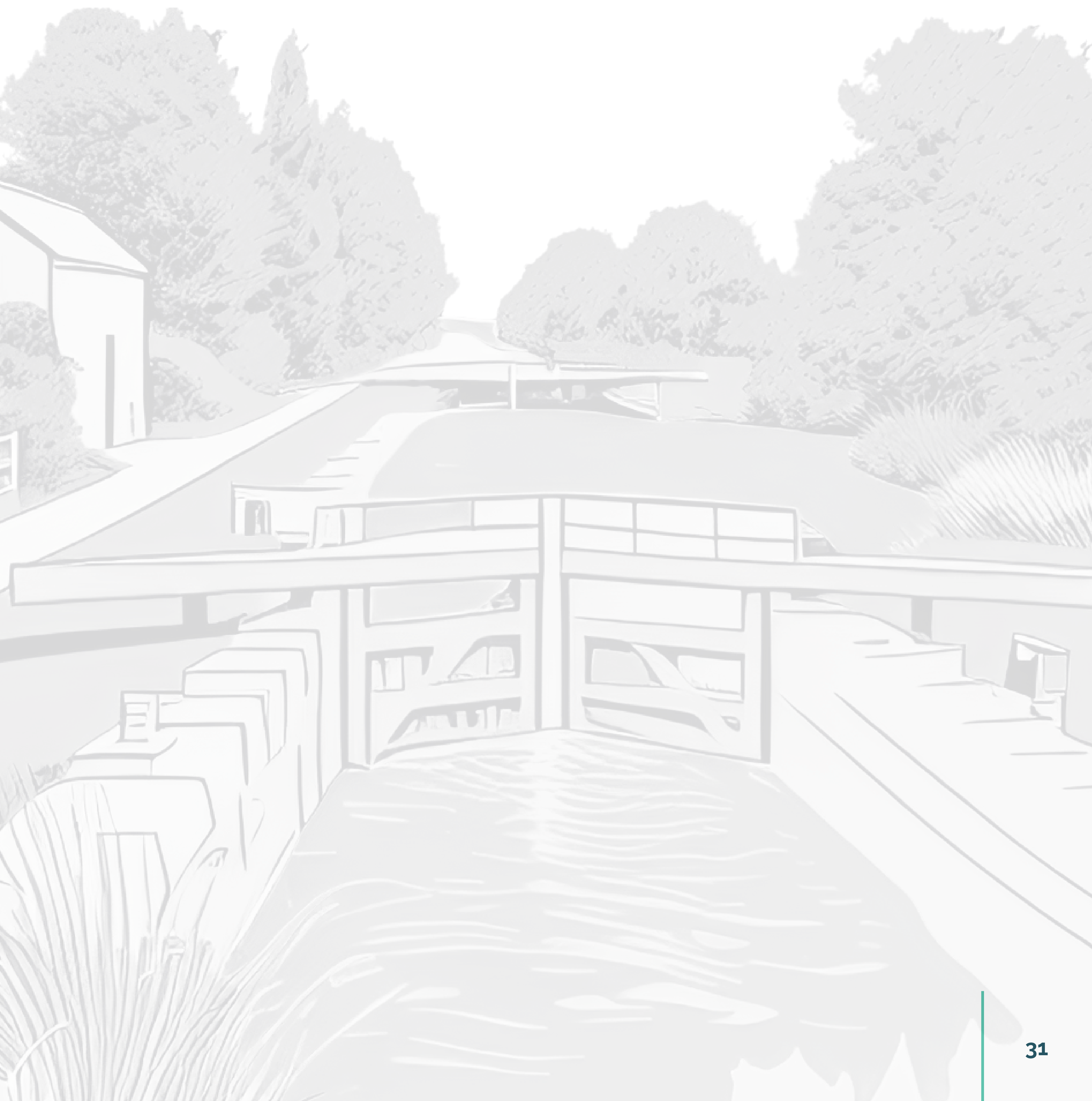
It is important to highlight that for six of the seven referrers surveyed, the majority of referrals to the SDCP SP programme occur in tandem with clinical intervention, with the exception of the physiotherapist who stated that the majority of referrals occur after attempting clinical intervention. The physiotherapist was also an outlier in that they were the only profession which stated that they do not see their patients/clients again after they have been referred to SP. The remaining six respondents stated that they had seen their patients/clients since the referral was made and that all had engaged with the SP Service.

When asked about the outcomes from participating in the Clondalkin SP Service, six respondents expressed that the outcomes were only positive. The service was described as "attentive and person-centred", with staff being approachable and generous with their time and information.

One survey respondent stated the benefits for the local community:

> **"SP is an extremely valuable programme in Clondalkin based on the referrals I have made and outcomes experienced by individuals. Service users that engaged have reported reduced social isolation and increased wellbeing. Service users have also reported an increase in awareness of community activities and services after engaging with the SP service. Service users I have referred into the SP programme have had their needs assessed and been referred into appropriate services."**

Some responses indicated that referrers had experiences with multiple SP programmes (e.g. Tallaght and Ballyfermot) and felt that SP had a strong place in community care. They highlighted that there was a need for SP programmes to be integrated into hospital and community healthcare settings.



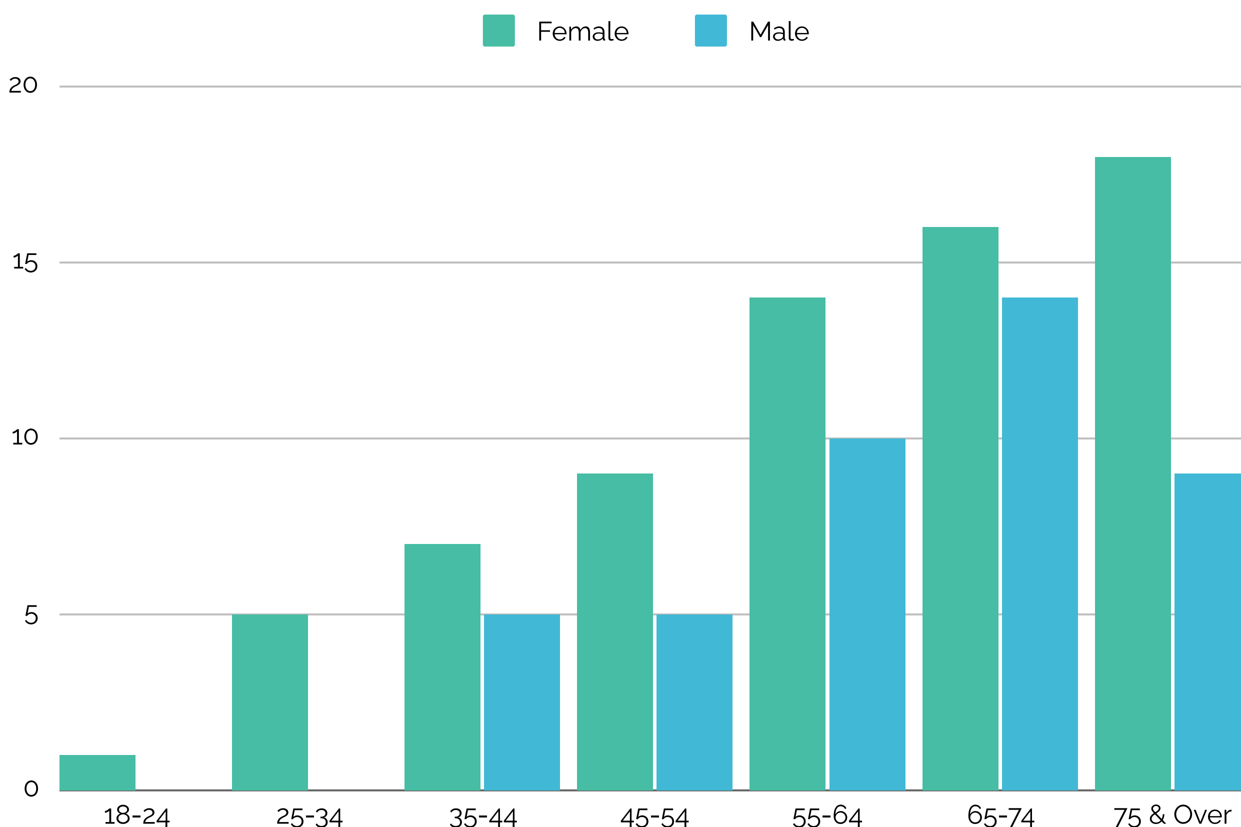
4. Client Details, Journey, and Outcomes

4. Client Details, Journey, and Outcomes

4.1 Participant Demographic Information

A total of 44 men (38.3%) and 71 (61.7%) women participated in the programme between September 2022 and September 2023. The overall figure of 115 individuals over a 12 month period meets the HSE SP Framework target of 100 referrals in a SPLW's first year. Almost half of the participants (N=54) were between the ages of 55 and 74 inclusive at the point of registration. Almost a quarter (N=27) were 75 or older. **Figure 2** below provides the gender breakdown of participants by age group.

Figure 2. Participants' gender breakdown by age group (N=115)

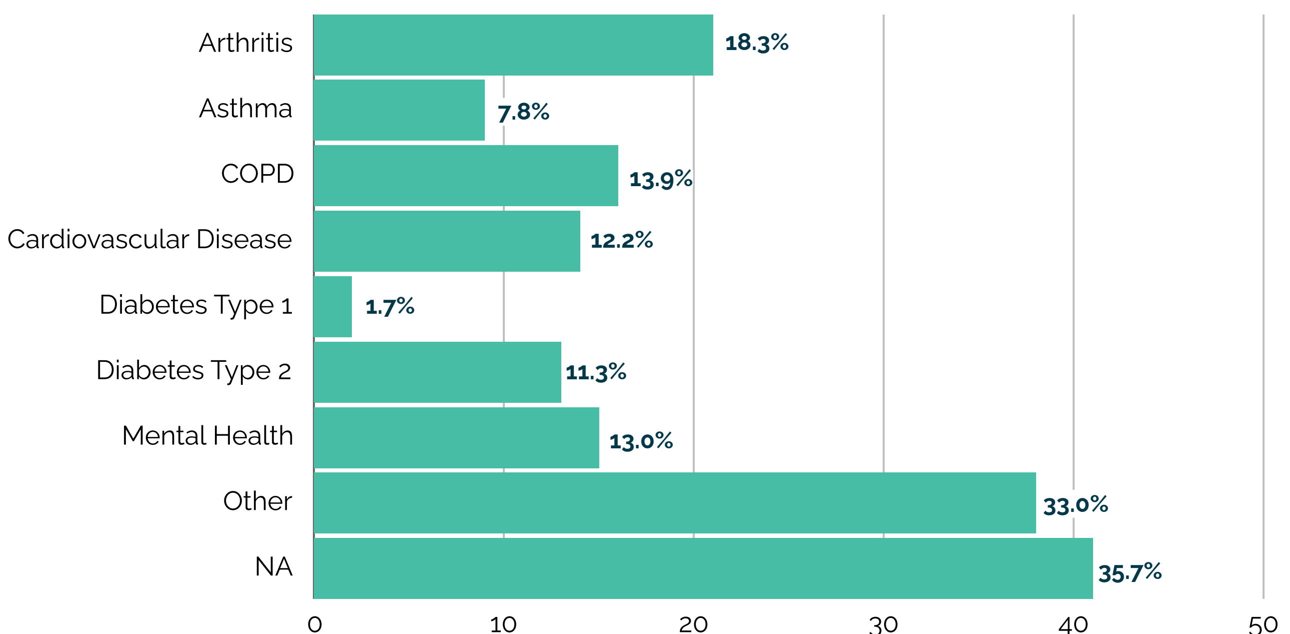


Source: TASC, 2024.
Note: The ages of two participants (one male, one female) are unknown and thus not included in this figure.

Approximately two-thirds of participants (N=75) were living in the SHC catchment area, while 40 (34.8%) were not.

One-third of participants (N=38) stated that they had access needs. These included, in order of frequency, needs to do with mobility (N=27), unspecified "Other" needs (N=7), needs to do with sight (N=3) or hearing (N=2), interpreters (N=1), and literacy needs (N=1). Almost two-thirds of participants (N=75) reported having at least one chronic condition. Details of these conditions are presented in **Figure 3.** After "Other", the most common conditions were arthritis (N=21), chronic obstructive pulmonary disease (N=16), and mental health conditions and difficulties (N=15).

Figure 3. Participants' chronic conditions categorised by type



Note: A total of 75 participants declared having a chronic condition, with a total of 90 specified chronic conditions and 38 "Other" entries. Each "Other" write-in entry listed between one and three additional conditions. Data labels (percentage values) refer to the proportion of participants who have each type of chronic condition. The sum of these exceeds 100% as some participants had multiple chronic conditions. COPD stands for chronic obstructive pulmonary disease.

On average, participants visited GPs twice in the last three months, with one individual having had 12 visits. On average, participants visited the A&E 0.4 times in the last three months, with some individuals visiting A&E four times. As individuals with high medical need may need to attend their GP or A&E more frequently, the potential relationship between GP and A&E visits was investigated. Although there was a positive correlation between these variables, the relationship was not found to be significant. However, it must be noted that the participant with 12 GP visits had also had three A&E visits in the last three months. Other data indicated that they experience chronic mental health issues, with frequent GP visits, social isolation, and mental health conditions listed as referral reasons.

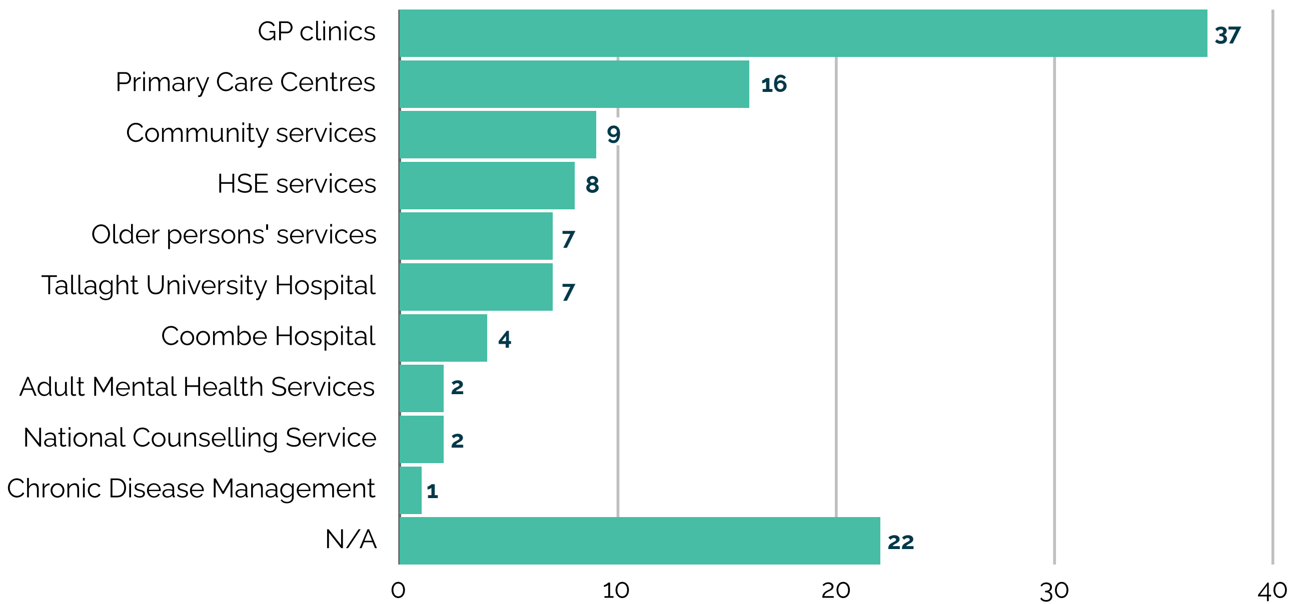
Three types of additional risks and considerations were recorded: housebound (N=1), lives alone (N=45), and other (N=4).

4.2. Participant Journey

Referral

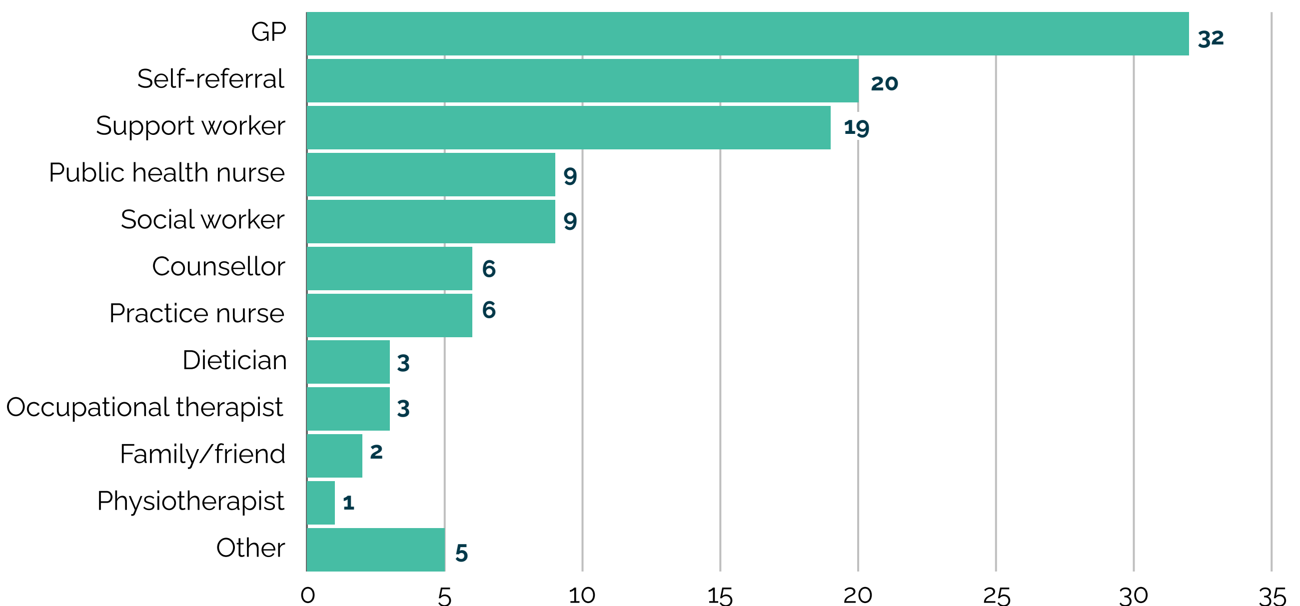
A total of 10 types of clinicians across 25 different organisation settings referred participants, in addition to self- and family/friend referrals. **Figures 4a** and **4b** show a breakdown of referrals into the programme by the organisation and role of the referrer.

Figure 4a. Referrals into the programme broken down by referral organisation type



Source: TASC, 2024.
Note: Data for four primary centres are aggregated. Data for four GP clinics are aggregated. Data for five community services are aggregated.

Figure 4b. Referrals into the programme broken down by referrer role



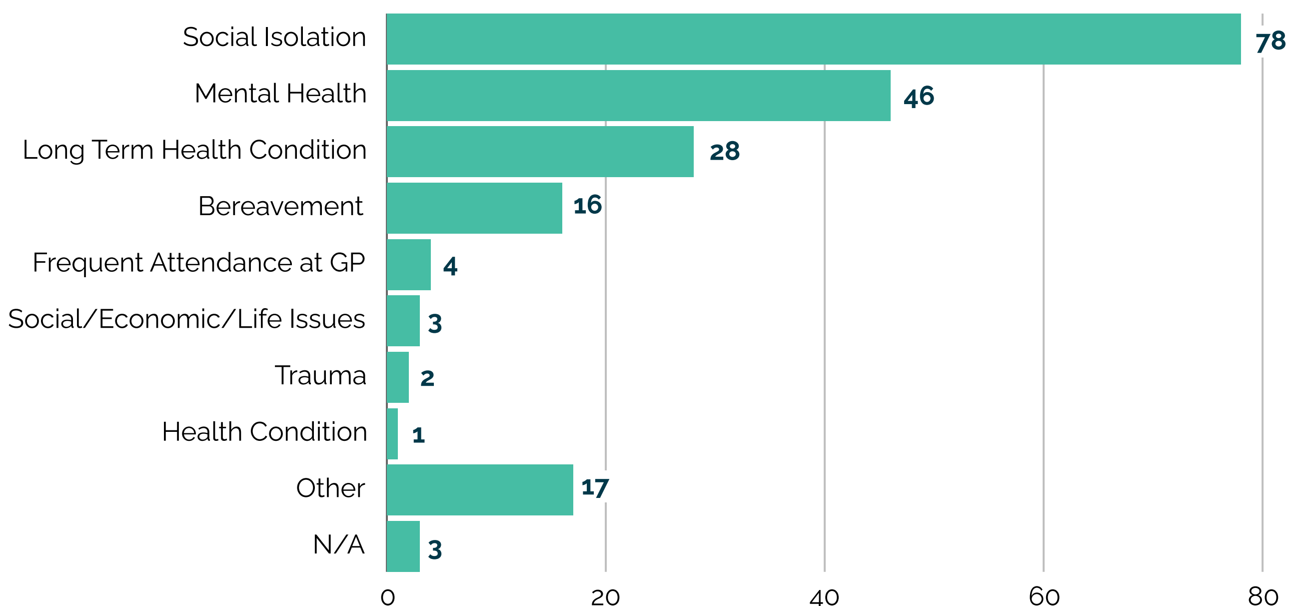
Source: TASC, 2024

The topic of referrers and referral sources was discussed during interviews. Interviewed clients' referrals were issued by a range of health and social care professionals, with one client stating that they self-referred. In accordance with these accounts and Salesforce data, one interviewed staff member reported that the primary referral pathways involve local GPs, Primary Care Centres, and hospitals. While a self-referral option is available, they noted the importance of a clients' relationship with their healthcare worker in facilitating their referral to and engagement with the service, as well as the difficulties that self-referral may pose to potential SP clients:

"[T]he cohort that social prescribing targets, a lot of the time there's trust for that person with their healthcare professional. ... The pathway from healthcare into social prescribing within the community is really, really strong, because that trust with, say, the GP, counsellor, or social worker, is already there. ... And a lot of the time people who might be interested in engaging with social prescribing might not necessarily make that call themselves."

Referral reasons were also recorded in Salesforce. These are depicted in **Figure 5**. The most common referral reason concerned social isolation, affecting over two-thirds of participants (N=78). Mental health was the second most common referral reason (N=46), followed by long-term health conditions (N=28). A regression analysis was carried out to investigate whether referral reason predicts the total number of referral reasons (e.g. whether participants who were referred due to bereavement are more likely to have multiple other reasons behind their referral), but the result was not significant.

Figure 5. Participants' (N=115) referral reasons



Note: Data labels (percentage values) refer to the proportion of participants under each referral reason.
The sum of these exceeds 100% as some participants had multiple referral reasons.

Interview data provided further insight into the reasons behind and context surrounding clients' referrals. When asked about the reason why they were referred to the programme, interviewed clients spoke of physical and mental health difficulties as well as bereavement, bullying, and loneliness or isolation. In addition, a lack of other available services was noted by a number of participants. Reflecting on the experiences of clients, staff members cited mental health difficulties and social isolation as common reasons for referral to their service.

Staff highlighted the important role of community support at various stages of a person's mental and physical health journey. They stated that community support should "work in tandem with other healthcare professionals". Some individuals need to be supported with whatever medical difficulties they are facing in order to be ready to engage with SP. Staff also gave examples of why clients might be referred to the SP service:

- Before a mental health decline and the use of antidepressants
- Close to discharge from a community mental health service
- Close to discharge from a perinatal mental health specialist
- Alongside the use of antidepressants and counselling
- Following engagement with a physiotherapist

Staff stated that SP clients are "linked in with us and we find a way to refer them into something in the community, which will also benefit them".

Inappropriate Referrals

Internal documentation specifies a number of referral criteria that must be met by potential clients. Clients must be 18 or older, living in the Tallaght or Clondalkin SHC catchment area, be willing to give consent and engage with the SP service, and have the capacity to leave their home and engage with the community.

As it stands, people who are currently in crisis cannot avail of the service. The nature and severity of any mental health conditions may also impact eligibility. To date, SHC SP services have been awaiting clarity regarding national HSE policies concerning mental health and exclusion criteria.

[5] The majority of referrals from the Tallaght catchment area are referred to the Tallaght service and hence not included in this evaluation.

Interviews with staff provided insight into the nature and handling of inappropriate referrals received by the service. Both SPLWs and the service director stated that referrals outside of the catchment area are among the most common, though the frequency of these has decreased with increasing awareness and understanding of the service. When such referrals are received, staff will notify the referrer and may redirect the client to a suitable SP service in their area, if one exists. Adjustments have also been made to referral forms, highlighting the referral criteria and specifying the catchment area.

However, there exists some flexibility surrounding the referral criteria. Internal service documentation states that minimum 60% of SP participants must come from the relevant SHC catchment area, thereby allowing SPLWs to accept some referrals outside of this region.

Participation in the Program

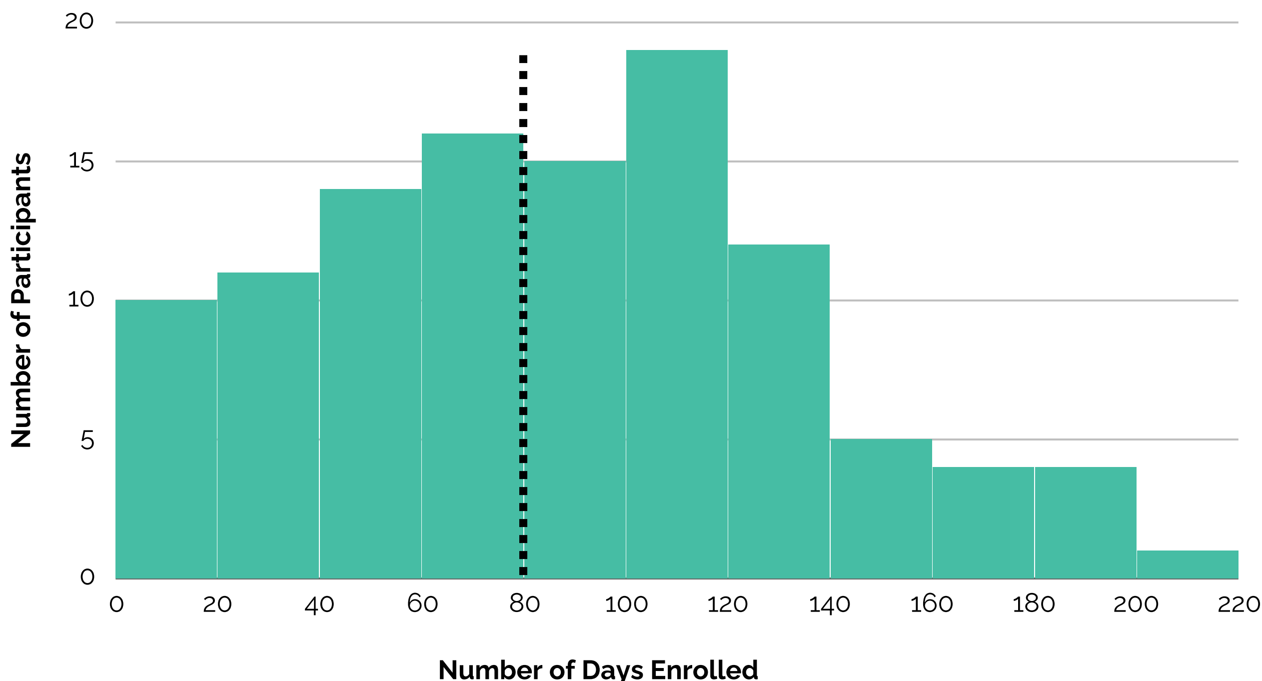
After referral, participants waited an average of 12.4 days to be contacted. During the focus group with SPLWs, staff mentioned that multiple attempts were often needed to speak with clients for the first time, which may explain some of the longer wait times observed. Some of these participants deferred their participation, as discussed below. When these participants were excluded from the analysis,[5] the wait time was reduced to 11.2 days.

Thirty participants deferred their participation in the programme. Eight deferred due to admission to hospital, 10 due to ill health, and 11 due to an unspecified “other” reason. For one person, the reason for deferral was not specified.

As of September 2023, 90 participants had completed the programme. Participants engaged with the service for 0 to 204 days, with an average of 87 days (12 weeks) (**see Figure 6**). Four of the participants included in these analyses were still engaged in the programme at the point of data processing. All of these participants had become active in the programme in September 2023.

Of those individuals who were enrolled for 0 days, three were referred on to another service and one was no longer in need of support. On average, the Clondalkin SP programme is meeting the HSE SP Framework target of having SP participants enrolled for approximately three months.

Figure 6. Distribution of the number of days participants were enrolled in the programme (N=111)



Source: TASC, 2024.
Note: The dashed line shows the average number of days, at 86.37.

Salesforce data did not allow for a deeper analysis of the reasons behind this variability in clients' journey length. As such, questions about this were posed to staff during interviews, with a focus on the reasons why some clients' journeys are substantially longer than others. Staff cited reasons related to health; many of their clients may have physical and/or mental health difficulties, and as their wellbeing fluctuates, their ability to engage with the service may also change. Some clients go through periods of illness, hospitalisation, and recovery, during which they may not have the capacity to engage with SP. These clients will therefore require more time to complete programmes and benefit from the service, as they may need to pause and restart their participation.

Interventions

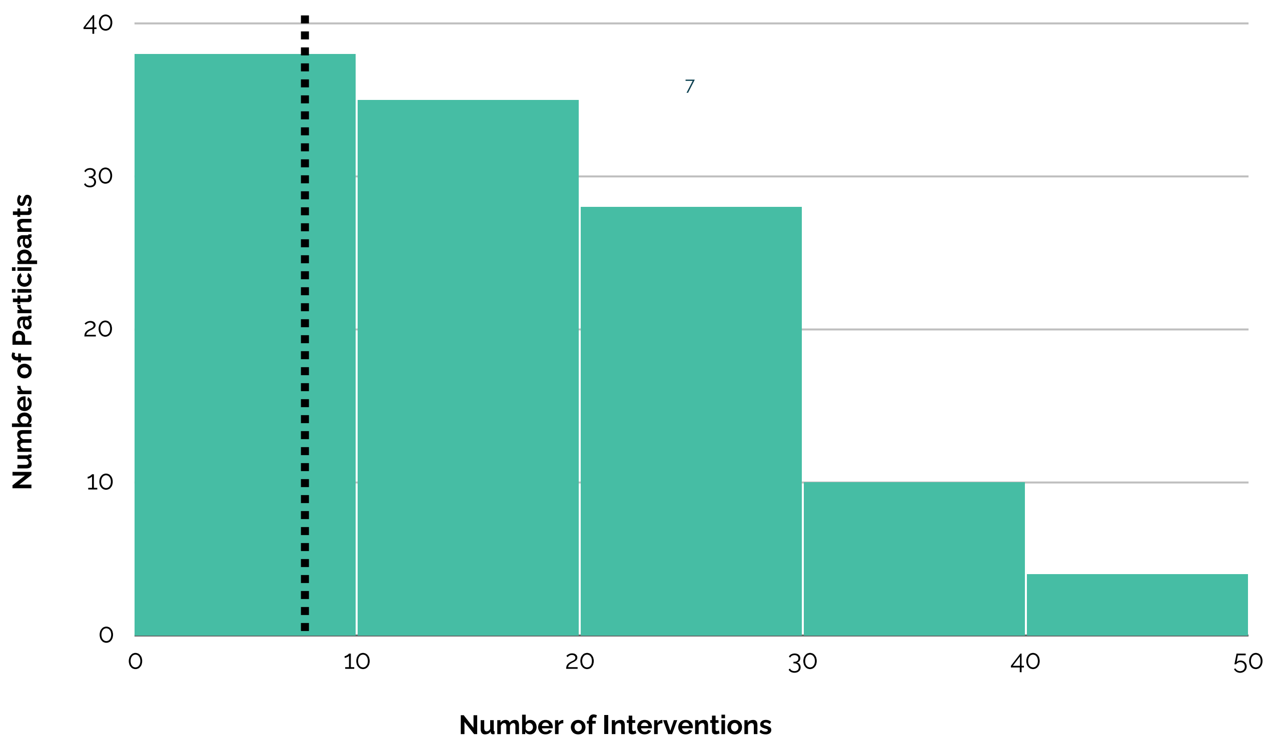
Documentation provided by SDCP defines an intervention as "any interaction with, or on behalf of, or for the purpose of supporting a client" and states that all interventions must be logged onto Salesforce.[6] A total of 1,856 interventions were recorded in Salesforce across the 115 participants. **The number of interventions per participant ranged from 1 to 47, with an average of 16.1. This is well above the expected number of eight interventions stated in the HSE SP Framework.**

[6] Interventions are also referred to as "contacts" in some of the HSE documentation.

As per the HSE SP Framework, 1,400 interventions are expected to be performed by an established SPLW over a 12-month period. This target was determined by the HSE based on the experiences of SPLWs from across the country who reported approximately 30 weekly interventions made. Therefore, it is interesting to note that SDCP data indicates that the Clondalkin SP programme has 28% more interventions than expected in its inaugural year.

The HSE SP Framework also states that each SP client should have up to eight interventions with their SPLW. The eight interventions expected by the HSE is at odds with the on-the-ground experiences of the Clondalkin SP service, where only 37 of the 115 clients (32.2%) had eight or fewer interventions, four of whom had not been discharged from the service by the end of 2023 and may still exceed this number before discharge. In fact, **less than 30% of the clients who have been discharged from the service had eight or fewer interventions.** **Figure 7** below shows the distribution of the number of interventions of each participant. Further information concerning the clients who had eight interventions or fewer (and so met the HSE recommendation) is provided in the next section (Clients with up to eight interventions).

Figure 7. Distribution of the number of interventions availed of by each participant [5]

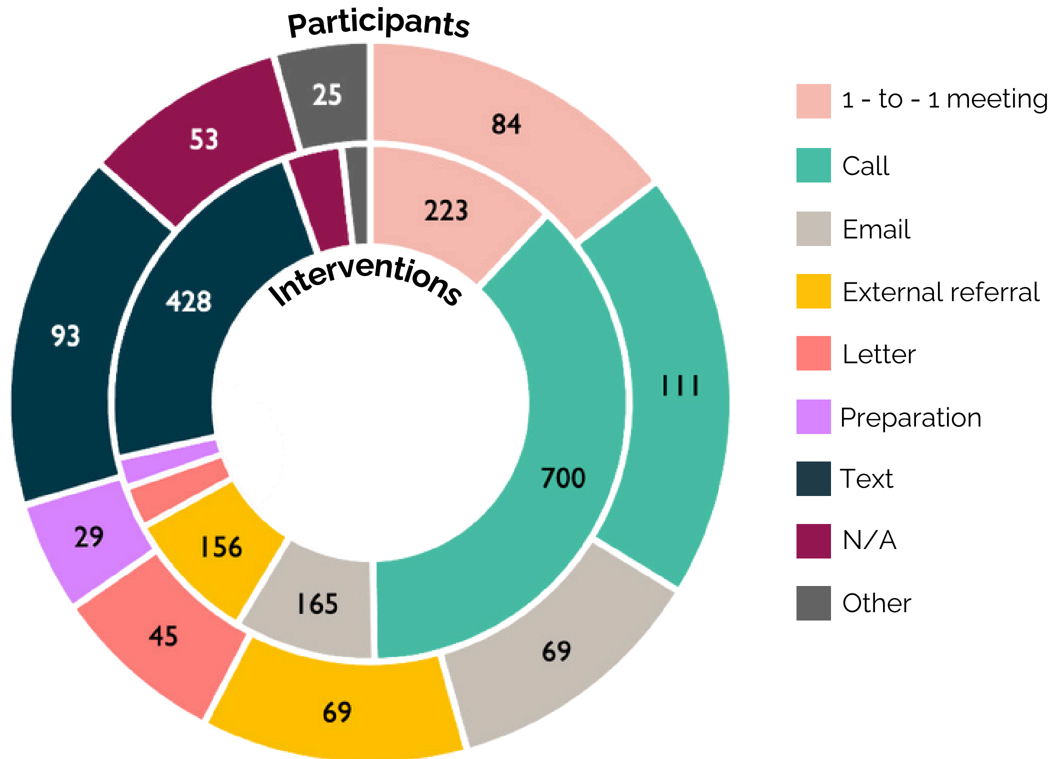


Source: TASC, 2024.
Note: The dashed line indicates the HSE target of up to eight interventions (interventions) per participant.

[7] These interventions include communications with health professionals and community groups, as well as communications and sessions with the clients.

Figure 8 displays the breakdown of each intervention type, as a proportion of the total number of interventions and the number of participants who availed of that type of intervention. Phone calls were the most common, with a total of 700 phone calls (38% of all interventions) made to 111 participants (97% of all participants).
Appendix 1 provides further detail on the types of interventions observed.

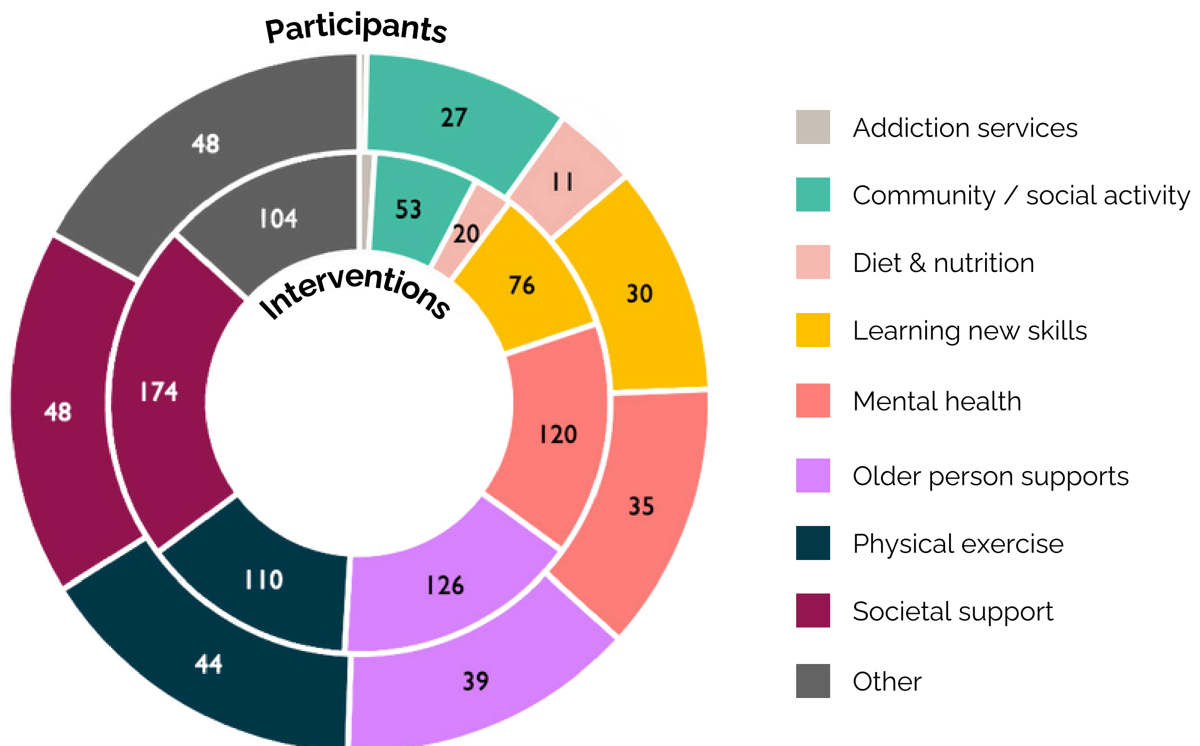
Figure 8. Breakdown of intervention type as a proportion of total number of interventions and participants



Source: TASC, 2024
Note: "NA" refers to interventions where a type was not specified. "Other" includes advocacy (19 interventions, 14 participants), facilitation (6 interventions, 4 participants), group meeting (3 interventions, 2 participants), research/analysis (2 interventions, 2 participants), video call (2 interventions, 2 participants), and site visit (1 intervention and participant).

Figure 9 displays the breakdown of each intervention by service type, again as a proportion of the total number of interventions and the number of participants who availed of that type of intervention at least once. In the case of these interventions, the services were external to SDCP, involving, for example, other services that the client was engaging with or being signposted to. For 1,065 of the interventions (57.4%), a service type was not specified. These are not included in the figure for clarity. The most common service type was societal supports, at 174 interventions, with 48 participants availing of these interventions. Further detail on the interventions observed by service type is available in Appendix 2.

Figure 9. Breakdown of intervention by service type as a proportion of total interventions and participants



Source: TASC, 2024.
Note: Service type was not specified for 1,065 of the interventions (57.4%). These are excluded from the figure for clarity.

Interventions lasted from 0 to 100 minutes, with a mean of 13.75 (see Appendix 1). On average, 1-to-1 meetings were the longest interventions, at 58.9 minutes, followed by video calls, at 25 minutes, and facilitation, at 21.3 minutes.

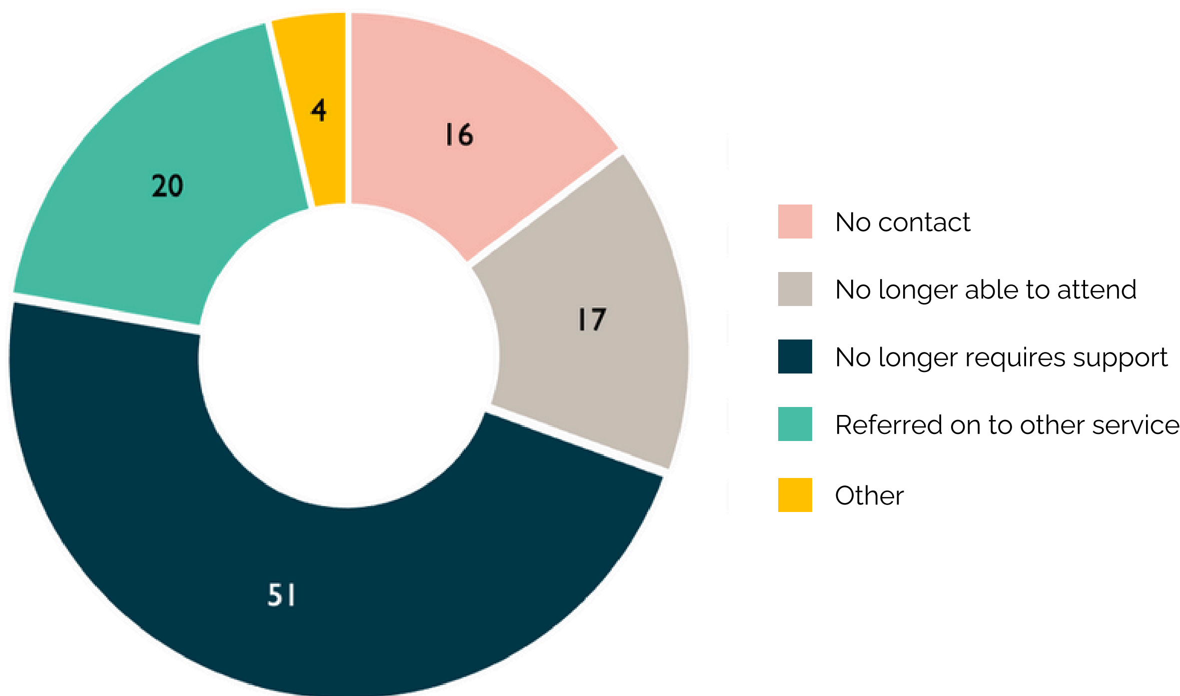
Clients with up to Eight Interventions

The Salesforce data of clients who did not exceed the HSE recommendation of eight interventions was analysed to attempt to understand the nature of the variations in the number of interventions and determine if there is a specific client profile which is best suited to this approach. These data include demographic and referral information as well as information on engagement with the programme.

With regards to demographic information, 21 women (56.8%) and 16 men (43.2%) had eight interventions or fewer, ranging in age from 33 to 89, with a mean of 66.3 and median of 67.5. Eleven (29.7%) participants reported having access needs, with mobility being the most common, affecting ten of these participants, and 22 (59.5%) had a chronic health condition. **This represents a smaller proportion of people with access needs and chronic health conditions than in the broader participant pool.**

In terms of their engagement with the programme, four of these participants were active for zero days, suggesting that their only intervention with the SPLW was an initial call.Three of these participants were referred on to another service and one was recorded as no longer needing SP. Another four participants had not been discharged from the programme by the end of 2023. The remaining participants were active in the programme for eight to 97 days. The mean number of days active for all participants who had been discharged by the end of 2023 was 42.5. **Evidence from these data indicate that the recommendation of eight or fewer interventions specified by the HSE SP Framework is best fit for clients with less complex needs. Such clients appear to be in need of fewer interventions in order to successfully engage with the short-term SP intervention. However, the majority of clients in the SDCP service have more complex needs which require more interventions than stipulated by the HSE Framework.**

Figure 10. Participants' reasons for exiting the SP service (N=108)



Source: TASC, 2024
Note: The reason for service exit was not provided for seven participants.

[8] The age of three of these participants is unknown.

Discharge

Figure 10 depicts a breakdown of participants' reasons for exiting the service. No longer requiring the service constituted the most common reason at 44.3%. The process of discharging a client was discussed with staff during interviews and the SPLW focus group. Some staff members reported that occasionally, difficulties may arise when making the decision to discharge a client. At times, the SPLW may feel that a client is ready to be discharged but the client may not feel the same. As discussed by one staff member:

> **"There's been times where ... people ... who we've given quite a lot of support to – so those people with longer journeys – we would feel ... [that] the support that we can offer is coming to an end, but that person might not feel like that. That can be quite a difficult conversation."**

Staff acknowledged that although the SP service may be fulfilled at that time for that person, the person may have other pressing issues of concern in their life. However, these would fall outside of what SP can provide support for.

In order to support staff in the process and ensure that clients are discharged at appropriate times, the service had implemented a policy surrounding discharge. In addition, staff members spoke of the importance of having "an open and honest conversation [with the client] of how [they] feel their journey has gone", as well as emphasising to the client that they can return to the service in the future if they feel they need to:

> **"[P]rior to discharge, we always send a letter or a text to say, 'we're here if you need us again, here's our details'... We always say 'this door is always open'. And that's also very important, not just for the person ... But actually for the social prescribers' peace of mind as well ... that they know that they can always come back."**

Accordingly, the service occasionally receives re-referrals from clients who previously engaged with SP. One SPLW highlighted the reasons for re-referral of clients a period after discharge:

- Decline in mental health
- Needing additional support
- Stopped engaging with prior social prescriptions
- Being ready to move on to another life stage

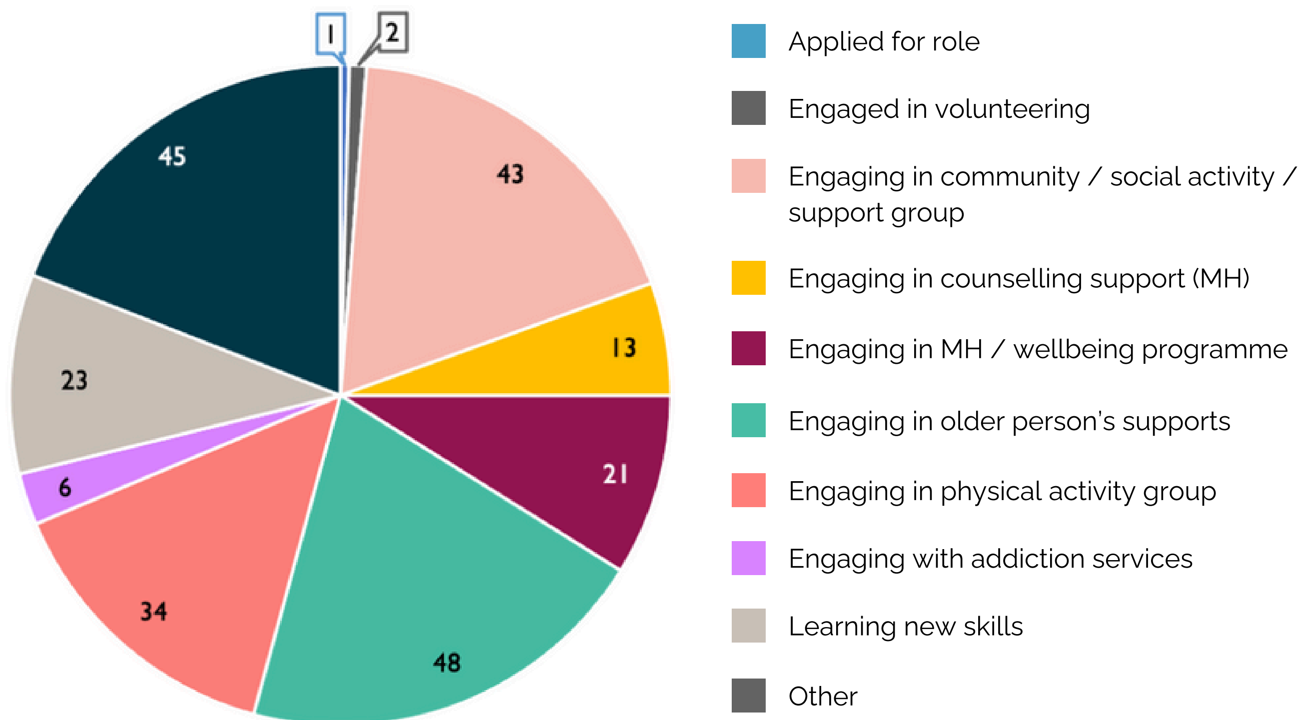
They highlighted that a client may be facing mental health issues which resulted in the loss of their job or educational opportunity. The supports put in place through the SP process have allowed such clients to re-engage with work, education or otherwise pursue their goals.

4.3 Impact of the Programme: Salesforce Data

Client Outcomes

A total of 236 outcomes were recorded in Salesforce across 67 participants, with 1 to 13 outcomes recorded per participant. During interviews, staff explained that the recording of outcomes was introduced to supplement the wellbeing questionnaires; they felt that these questionnaires do not provide enough detail and nuance, and thus began recording qualitative outcomes to provide a more complete picture of each client's journey. **Figure 11** below depicts the frequency of each outcome type.

Figure 11. Breakdown of recorded outcomes by type



Source: TASC, 2024
Note: The reason for service exit was not provided for seven participants.

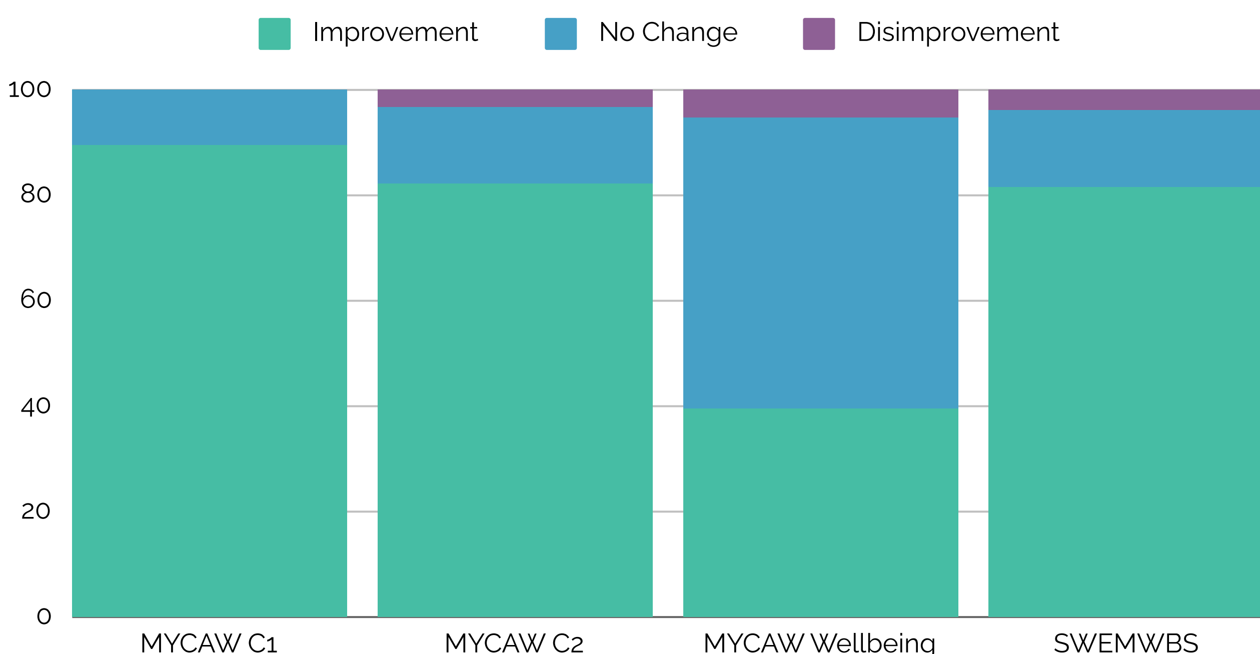
Referred because of isolation and loneliness

Figure 12 below depicts the total post-intervention scores of participants on each of the wellbeing measures: SWEMWBS, MYCaW Concern 1 and 2, and MYCaW wellbeing. Scores are colour-coded to depict the proportion of the total score which indicated an improvement, disimprovement, or no change from the participants' pre-intervention score. Improvement and disimprovement are defined in terms of wellbeing. On the SWEMWBS, higher scores indicate better wellbeing; thus, on the SWEMWBS, increases in scores from pre- to post-intervention were defined as improvement in wellbeing. Conversely, on the MYCaW subscales, higher scores indicate poorer wellbeing; thus, increases and decreases on the MYCaW were characterised as disimprovement and improvement respectively.

Changes in Wellbeing

Figure 12 depicts the total post-intervention scores of participants on each of the wellbeing measures: SWEMWBS, MYCaW Concern 1 and 2, and MYCaW wellbeing. Scores are colour-coded to depict the proportion of the total score which indicated an improvement, disimprovement, or no change from the participants' pre-intervention score. Improvement and disimprovement are defined in terms of wellbeing. On the SWEMWBS, higher scores indicate better wellbeing; thus, on the SWEMWBS, increases in scores from pre- to post-intervention were defined as improvement in wellbeing. Conversely, on the MYCaW subscales, higher scores indicate poorer wellbeing; thus, increases and decreases on the MYCaW were characterised as disimprovement and improvement respectively.

Figure 12. Participants' total post-intervention scores on wellbeing measures by improvement, disimprovement, and no change



Source: TASC, 2024

The greatest improvement in wellbeing was recorded in terms of scores on the MYCaW Concern 1, where almost **90% of participants' post-intervention scores constituted an improvement from their pre-intervention score.** The MYCaW Concern 2 showed similar outcomes, with over 80% of participants' scores indicating an improvement in wellbeing. Interestingly, this trend did not extend to the MYCaW Wellbeing measure, where over half of participants' scores did not change from pre- to post-intervention. This is mirrored in the means of participants' changes in scores across the measures. Appendix 3 outlines the average pre- and post-intervention scores as well as change in participants' scores across all of the wellbeing measures and their subscales.

Changes in scores were statistically significant across all wellbeing measures. A paired samples t-test revealed significant differences in scores on the SWEMWBS from pre- to post-intervention, $t(34) = -6.08$, $p < .001$. Wilcoxon signed rank tests revealed that post-intervention scores were significantly lower than pre-intervention scores across all subscales of the MYCaW, including Concern 1 ratings ($Z = 561$, $p < .001$), Concern 2 ratings, ($Z = 325$, $p < .001$) and Wellbeing ratings ($Z = 129.5$, $p < .001$).

No statistically significant relationship was found between the number of outcomes recorded per participant and changes in their scores across the wellbeing measures. Regression analyses were conducted to investigate whether referral reason predicts, firstly, pre-intervention scores, and secondly, changes in scores from pre- to post-intervention, but neither result was significant for any of the wellbeing measures.

4.4 The Client Perspective

Impact of the Programme: Interview Data

Interviews with SP clients provided further insight into the impact they felt the programme had on their lives, as well as the specific elements of SP that contributed to these impacts. In general, clients spoke highly of the programme and the supports they availed of through it, describing them as "really good", "great", "fantastic", and even "a wonderful thing … the best thing that ever happened". One client stated that they and the other participants "hate going home" from the activities. **More specifically, clients felt that the programmes enhanced their understanding of their own difficulties (e.g. ExWell programme), led to an improvement in their mental health and general wellbeing (e.g. Heads Up, art-based supports and services), and increased their confidence.** When speaking of the broader positive impact of SP, one client stated:

> **"It's going to help. It's going to keep people away from the doctors and hospitals and slow down the times of going into nursing homes. And I think it's going to do well. I think it should be fostered."**

In terms of the facilitators of these effects, clients highlighted a number of elements of SP and the SDCP services which they found particularly beneficial. A major facilitator was the social aspect of these activities, with some clients feeling that this is just as important, or even more important than the primary purpose of the activity (e.g. exercise).

Some clients reported keeping in touch with one another outside of, and following, the activities. One person stated that "you wouldn't meet nicer people"; while another client emphasised the instrumental role of SP in helping them to make connections which they otherwise would not have:

> **"I met people that I would never have in any other environment. You know, I never would've crossed paths within my life. Most of the people that were in [the programme], 99% of them, I loved and I loved everyone there and I have made a few friends out of it. It was just a lovely pleasant place to be and all the people working there were brilliant."**

One client stated that the low-pressure nature of the activities that they attended makes them more accessible, for example, to people with social anxiety who may struggle if they feel pressured to engage or open up. This client also appreciated the provision of some men-only and women-only supports, as they felt they would not have been able to open up as much in a mixed-gender programme.

The act of attending supports in itself benefited some clients, with one person stating that they felt a sense of pride stemming from the fact that they attended all sessions of the programme they were referred to. Some clients availed of transport supports, which alleviated some of the barriers which may have hindered their engagement otherwise.

Above all, the value of the work done by SDCP staff and the clients' relationships with staff were highlighted and emphasised as playing a major role in their engagement with SP. Every interviewed client spoke of the kindness and care offered to them by their SPLW. Clients described their SPLW as "lovely, … really good", "wonderful, charming", "very nice and very understanding". They appreciated that the SPLW "treated [them] with respect" and described them as well-suited to and good at their role. Several clients noted that their SPLW put great effort into finding suitable activities and supports for them, with one person stating that "she did anything she could do that we could think of for me to do, she either referred me or she organised it for me". Clients also emphasised the approachability of their SPLW and how comfortable they feel speaking with them:

"She listens to you. ... she was very, very understanding. ... I could sit down, I could say anything to her. ... I felt kind of comfortable with her, I don't know what it was. Because I don't usually talk to people, you know yourself, but she ... listens to you, you know what I mean? She doesn't ask any questions, she just listens to what I'm telling her."

The awareness that they can call their SPLW when they need support was emphasised as a source of comfort for clients. One client, who struggled to avail of any of the activities and supports they were referred to, felt that they nonetheless benefited from the SP service simply through their contact with their SPLW and the work of their SPLW. They stated that the SPLW "did a very big job for [them]", that there were "lots of things [that] shifted", that a lot of time was given by the SPLW, and that all of this "was a really big big help". The willingness of their SPLW to support them was, in itself, very meaningful to them:

"In my life this was the kind of first time I ever met someone who's trying to just talk with me and just to ask how I am. ... It was very, very surprising to me because [the SPLW] is very, how do you say, she's calming. ... I was really shocked because no one- it's not easy to find someone who's trying to help you."

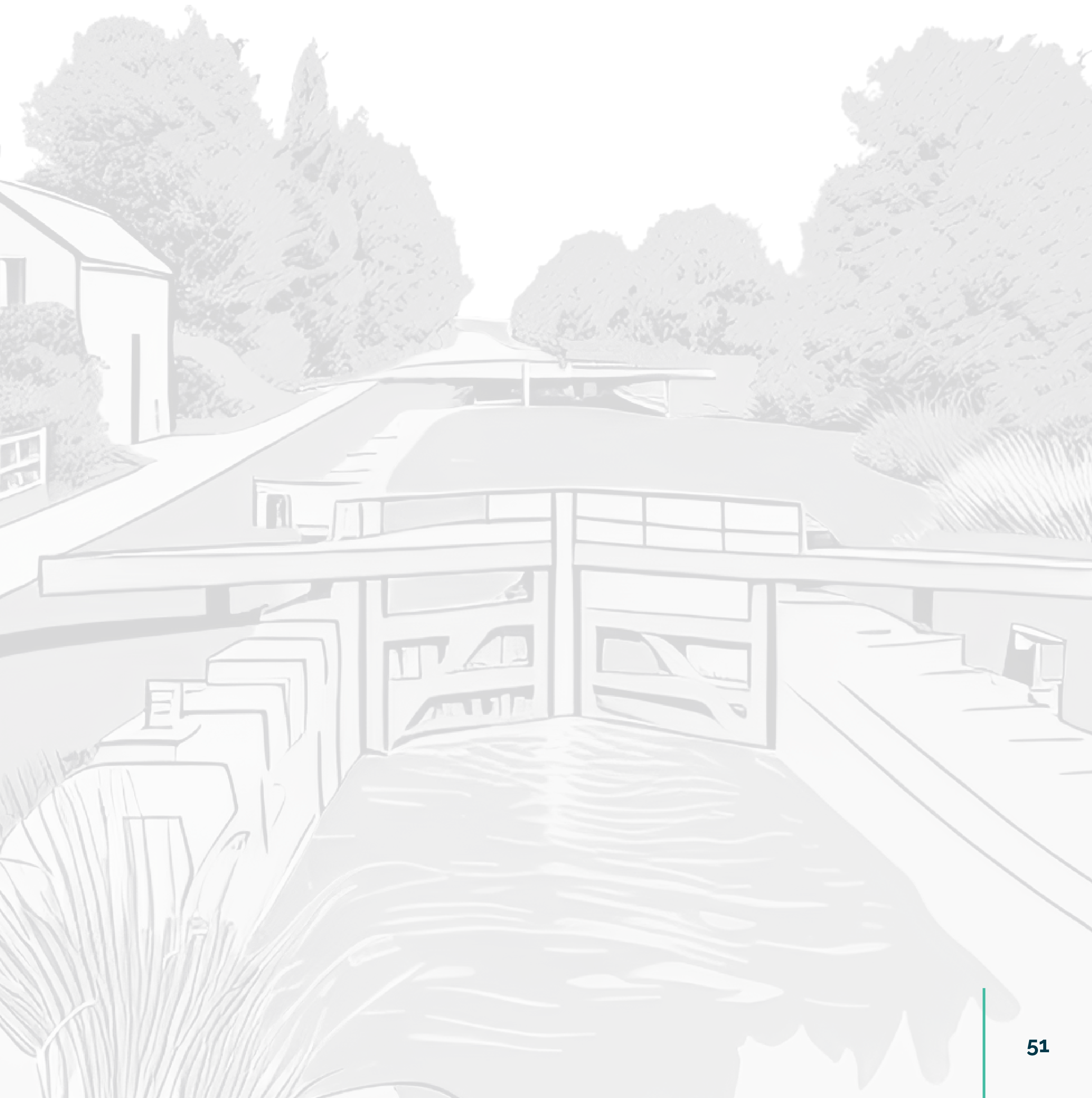
In addition to the SPLW, one client spoke of the help they've received from the HSE smoking cessation support staff. They described the person as "very good ... a nice guy" and reported finding them very helpful.

Barriers to Participation

Although interviewed clients' feedback about the SP programme was overwhelmingly positive, some barriers to and reasons for not participating in the programme and activities were raised. One such reason was the belief that certain activities or services simply will not help. Another barrier concerned the quality of the community supports available. However, some clients reported withdrawing from supports for more positive reasons, as they did not need the support anymore, for example, due to an improvement in their mental health.

Recommending the Programme to Others

All interviewed clients who were asked if they would recommend the SP programme to others responded that they would. Specific groups which these clients felt would benefit from the programme included the elderly and adults with mental health difficulties, with one person stating that they would recommend it to "anybody".



5. Overall Impact

5. Overall Impact

5.1 Social Prescribing Programme Impact

The previous sections provide extensive evidence from a variety of stakeholders on how the SP service functions and affects those who partake in it. Information gathered from stakeholder consultations and surveys provide evidence that the Clondalkin SP Service is having a positive impact on the clients accessing the service (see Sections 4.2, 4.3 and 4.4). Although client journeys appear to be longer and require more interventions than specified by HSE SP Framework, clients wellbeing scores and interviews indicate that they have experienced **improved mental health and (in some cases) physical health** as a result of participating in the SP programme, which provides a compelling argument for exceeding the targets when needed.

SP participants expressed that the SPLW was a key figure in their journey, as the SPLW listened to their needs and provided constant support and understanding. Although this study was not designed to evaluate the impact of the SPLW, it is important to highlight that the **SPLW plays a pivotal role in this process.**

Lastly, although there are no comparative data available in Salesforce, anecdotal evidence from client interviews indicates that the Clondalkin SP service is also **potentially reducing future contacts with health and social care services.** If this is indeed the case, then the long-term impact of this short-term intervention would result in decreased presentations at hospitals and GP clinics.

5.2. Social Impact

The SP programme serves to create links to services for individuals in the community. This is particularly important in a community such as Clondalkin, where some services have been discontinued and residents are not sure what services currently are available to them. By providing SP participants with social prescriptions, the SPLW makes these connections possible, allowing for additional support and skill-building to be found in the community.

5.3. Personal Impact[9]

Social prescribing has the potential to deeply affect individuals, providing them with a route to comprehensive wellbeing through tailored non-medical support, such as activities, resources, and community services. This personalised approach aims to address individual needs and preferences, fostering a sense of empowerment and enhancing overall quality of life. The HSE framework puts forward two categories of outcome measures which should be integrated into social prescribing programmes: personal wellbeing and social connectedness. As mentioned in previous sections, two different standardised measures have been used to investigate participant's wellbeing (i.e. SWEMWBS and MYCaW) and have shown that **individuals experienced improved wellbeing.** Individuals who were referred to and participated in the SP programme came from a variety of backgrounds, with different ages, relationship statuses, nationalities, ethnicities, and life experiences. When available demographic variables were considered (i.e. age and gender) no significant differences were found, indicating that those variables were not found to be predictors of wellbeing scores or changes in wellbeing.

In the following section the journeys of some SP programme participants, who completed the programme and agreed to participate in interviews, are highlighted. For narrative purposes, information from interviews is interspersed with Salesforce data. By integrating the quantitative and qualitative datasets in this way it is possible to contextualise the participants' experiences before, during, and immediately after the SP programme. Note that all of the participants' names have been changed and some details of their experiences have been modified to protect their anonymity.

As with Carol, whose story is told in Box 1, multiple health challenges combined with living alone and changes in service provision in the community can result in individuals being referred to SP. The social prescriptions which Carol received helped her to feel less isolated and allowed her to engage in physical activities.

Box 1: Case Study 1 – Carol

Carol, a woman in her seventies, was referred to the SP service by a social worker at the Tallaght Hospital A&E. The reasons for referral provided were a "long-term health condition" and "social isolation". It was also noted that Carol had additional mobility needs and was dealing with multiple chronic health conditions related to cardiovascular disease, high blood pressure, and a number of strokes.

[9] Names and personal information in this section have been changed to maintain the privacy of SP programme participants.

Carol was invited for an interview to talk about her experiences with the SP programme. When asked about her reasons for referral, Carol stated that she had "had a really bad stroke" and had also fallen into a coma. With multiple strokes, decreasing mobility, and several bereavements, Carol was living alone and increasingly feeling isolated and lonely. Prior to being referred to SP, Carol had struggled to find appropriate activities in her community on her own and during her interview she highlighted the lack of services for older people in the area. Carol mentioned that the type and quality of services and accessible transport in the area had diminished, and she attributed some of these reductions in services to her feelings of isolation and loneliness as they resulted in her losing connection with her community.

When discussing communications with the SPLW supporting her, Carol said that the SPLW was very "understanding", "kind", "lovely", and that she could sit down and tell them about anything as she felt very comfortable with them. Carol felt that the SPLW would listen to her whenever she needed it and stated that they helped Carol find activities that would work for her.

Carol enjoyed the activities which she attended, both for the exercise and the social connections that she was able to make. With the loss of her family, the social element of the activities was of great importance to Carol. She stated:

"It wasn't just the exercise, it was the people. … You wouldn't meet nicer people."

She continued to express the way the social activity had improved her quality of life:

"It's the social side as well - I like doing the exercises and the bowls and you have a cup of tea and we all talk then you have a sing song. It's grand because I'm meeting people."

Carol's pre-intervention concerns included social isolation from not leaving the house and a lack of physical activity. The SPLW connected Carol with activities in the community which allowed her to get out of the house, interact with others, and exercise. During the time that Carol was a participant in the SP programme, Carol's MYCaW scores for Concerns showed improvement (change = -4, each), as did her wellbeing score (change = -1). The overall SWEMWBS score also showed improved wellbeing with a total change of 6 points.

Carol participated in the SP programme for 101 days, during which time 23 interventions were recorded in her case file (approximately 1 intervention every 4 ½ days).

For another SP programme participant, Danny (Box 2), addiction, bereavement, familial estrangement, and other family stressors played vital roles in his declined mental health. Participation in the SP programme has resulted in him engaging with individuals in his community and widening his social circle.

Box 2: Case Study 2 – Danny

In his forties, Danny was referred by his GP to the SP service. Danny was born in Ireland and aside from a few years living abroad, he has lived in the area his whole life. The referral form stated that he was referred due to mental health. It was also noted on the form that Danny had a chronic health condition. As a part of this evaluation, Danny was invited for an interview to talk about his experiences in the SP programme. When asked about his reasons for referral Danny confirmed that had been struggling with his mental health. For multiple years he had been struggling with the loss of a parent, addiction, family illness, losing custody of his child, and bullying at home.

Danny expressed being well supported by the SPLW when they met. Their first meeting occurred at a "neutral" location and he felt comfortable immediately. He felt that he was able to discuss his current needs and past experiences freely. Of the SPLW, he stated:

"She's a lovely, loving person, really laid back. She was really nice and treated me with respect."

Danny mentioned the potential challenges faced by individuals with a history of addiction when accessing services:

"Right from the start, right from the get-go I took a risk. ... I do know, the terrible stigma attached to anyone that's been opiate-addicted, the junkies, the word they use. And I know, I'm not stupid enough or ignorant enough to think that people won't judge you. Maybe they won't say it."

The SPLW recommended supports which would bridge the gap while Danny waited for access to addiction services. One of those supports was the Heads Up programme. Danny was open about his struggles with addiction while participating in the Heads Up programme. He hoped that by "being honest" he would "be able to inspire someone else to be honest".

Although he found the Heads Up activities difficult, he said that they were well worth it and that he was proud that he did not miss a single session. When speaking about his experiences with the Heads Up programme, Danny said:

"I met people that [I] would never have in any other environment. You know, we never would've crossed paths within my life… I loved everyone there and I have made a few friends out of it… It was just a lovely pleasant place to be and all the people working there were brilliant. You know, just fantastic, I can't give it enough praise to be honest with you, it was brilliant."

There are indications that Danny's social network has expanded as some members of the group, including Danny, have made plans to meet now that the programme has finished.

These social connections would not have been made without support from the SPLW in providing Danny with the social prescription. The SP service was one feature in a broader support network that has been working towards supporting Danny's mental health challenges in various ways. In the previous year, Danny had received support from his SPLW, GP, and four different counsellors, some of whom work at the methadone clinic. He felt that this range of supports has been an important part of him being able to manage his mental health and remain drug-free over the last year. Danny only expressed having one pre-intervention MYCaW Concern, which was about minding his mental health through not becoming isolated. Unfortunately, Danny did not provide any post scores, but based on his interview it can be assumed that his wellbeing improved.

Danny participated in the SP Service for 75 days, during which time 17 interventions were recorded in his case file (approximately one intervention every 4 ½ days). **When asked about whether he would recommend the programme Danny ranked it a "10 out of 10" and said that "anybody" would benefit from participating.**

Mary, a young mother and an international protection applicant living in a direct provision centre, has been struggling with her mental health for more than a year. She received informational and instrumental supports from the SPLW and expressed that she benefited from the programme (see Box 3).

Box 3: Case Study 3 – Mary

Mary, a woman in her late twenties, was referred to the SP Service by an occupational therapist at the Coombe Hospital for reasons of "mental health" and "social isolation". Mary had no access needs and did not have any chronic health conditions.

As a part of this evaluation, Mary was invited for an interview. She explained that when she arrived in Ireland, healthcare staff were concerned about her pregnancy and sent her to a hospital.

While there, Mary was stressed and had panic attacks, at which time she was linked in with the psychiatry department. Following the birth of her child, she was referred to the SP service.

Communication with the SPLW went well. Mary's level of English was sufficient enough for her to communicate independent of an interpreter and she felt that her needs and wishes were listened to. She stated:

"In my life this was the kind of [the] first time I ever meet someone who's trying to just talk with me and just to ask how I am."

The SPLW supported Mary by recommending a baby massage group which allowed her to interact with other mothers. The SPLW also supported her in providing adequate nutrition for her baby and being a hopeful source of information.

Although she felt that she and her baby benefitted from the SP programme, she is a very private person and stated that she would feel too vulnerable to recommend the SP programme to others living in the direct provision centre because of the stigma around mental health. However, Mary has told her psychiatrist about her positive experiences with the SP service and that she "love[s] to meet … [and] talk with" the SPLW.

Mary did not complete any of the wellbeing assessments. However, evidence from her interview combined with data in Salesforce indicates that her SPLW was able to address her needs for immediate support. Mary participated in the SP programme for 86 days, during which time 12 interventions were recorded in her case file (approximately 1 intervention every 7 days).

During the interview, Mary mentioned that has been facing additional challenges since being discharged from the SP Service. She is thinking of self-referring to the SP programme for a second time in order to gain support for this new concern.

The standard wellbeing measures utilised in the SDCP SP programme appear to adequately measure changes in wellbeing, with all seven participants who were interviewed stating that their wellbeing had improved since engaging with the SP service. For those who completed the pre and post wellbeing assessments, these changes were also seen in their quantitative scores.

The HSE SP Framework references a second, valuable outcome measure: social connectedness. No standard tool was used to measure social connectedness in the Salesforce data. However, qualitative interviews with participants who had completed the SP programme indicate that improved social connection was also an important benefit from participating in the SP programme.

6. Potential Areas for Learning, Improvement or Expansion

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6.1. General Administration

HSE Guidance Documents

The HSE-issued registration forms and guidance documentation do not contain a date and version number, which makes it difficult to retroactively identify when changes were required. In addition, documentation does not indicate when changes need to be implemented. This makes it challenging to assess databases containing long-term information on clients' engagement with services. Upon receipt of new and updated documents from the HSE, this should be noted internally by the SDCP SP programme, in order to allow for accurate tracking of procedural changes.

HSE Targets

HSE-issued guidance documentation may provide conservative targets which do not account for individuals with higher needs (e.g. regarding the number of interventions specified in the HSE SP Framework). These could be updated to be more flexible and specific (e.g. regarding clients with mental health challenges).

HSE KPIs

The KPIs requested cover service volume, but do not cover metrics that would allow for the assessment of the duration of service provision. Available HSE guidance documents do not provide insight into how the KPIs will be used nationally or how the SP services should use them to manage local decision-making.

6.2. Expanding the Knowledge About Participants' Backgrounds

Expanding the demographic data recorded in Salesforce will enhance the knowledge of the backgrounds and experiences of clients in a systematic way. Variables such as ethnicity, disability, health status, living arrangement/relationship status, employment status, and substance use, would allow for a better understanding of the population utilising SDCP SP services in Clondalkin as well as the effectiveness of SP for different populations. Ideally, such an expansion of the demographic variables recorded in Salesforce would be in alignment with the Census categories.

6.3. Deepening Utilisation of Wellbeing Assessments

Each wellbeing assessment provides information on a different aspect of a client's journey and experiences. The MYCaW and SWEMWBS are standardised tools which allow for comparisons across programmes. At present, the SDCP service administers the assessments prior to and following clients' engagement with SP.

The SP Service may benefit from utilising a brief interim assessment, which would allow for more data to be collected regarding wellbeing scores. This would benefit the client by providing structure for their thoughts in a conversation with the SPLW. Meanwhile, the project would benefit by gaining insight into clients' experiences, particularly for those who have longer journeys. In addition, a third mid-way assessment point would provide valuable context for clients whose wellbeing scores may show a disimprovement from pre- to post-intervention. One or both of the wellbeing questionnaires could be reviewed with the client and/or expanded upon at a point approximately midway through the client's journey. Alternatively, it might be helpful to use the HSE SP Framework as guidance and conduct all assessments around the three-month time point, with an additional assessment to be conducted if the client were to continue with the programme for longer.

6.4. Documenting Social Connectedness

The concept of community engagement consists of involvement in one's community, their level of knowledge of community services, and their likelihood of using services. The HSE SP Framework provides some guidance on which tools could be used to measure social connectedness as an outcome variable. The Social Wellbeing Scale (Keyes, 1998) is a validated tool which consists of 33 items across five social dimensions: integration, acceptance, contribution, actualisation, and coherence. The Duke Social Support Index (DSSI) was validated as a measure of social support in adults by Waridan and colleagues (2013) and is a 10-item questionnaire.

The HSE needs to provide national requirements on which of the two measures of social connectedness should be added to the existing toolkit, and how these tools should be used by SHC SP programmes for assessing individuals' outcomes.

6.5. Referrals From Outside of the Catchment Area

Currently, participants outside of the geographic catchment area are not always able to be accepted into the SP programme. It would be helpful to keep track of these in some way as it may provide information to the HSE about growing need in a particular area.

7. Conclusion

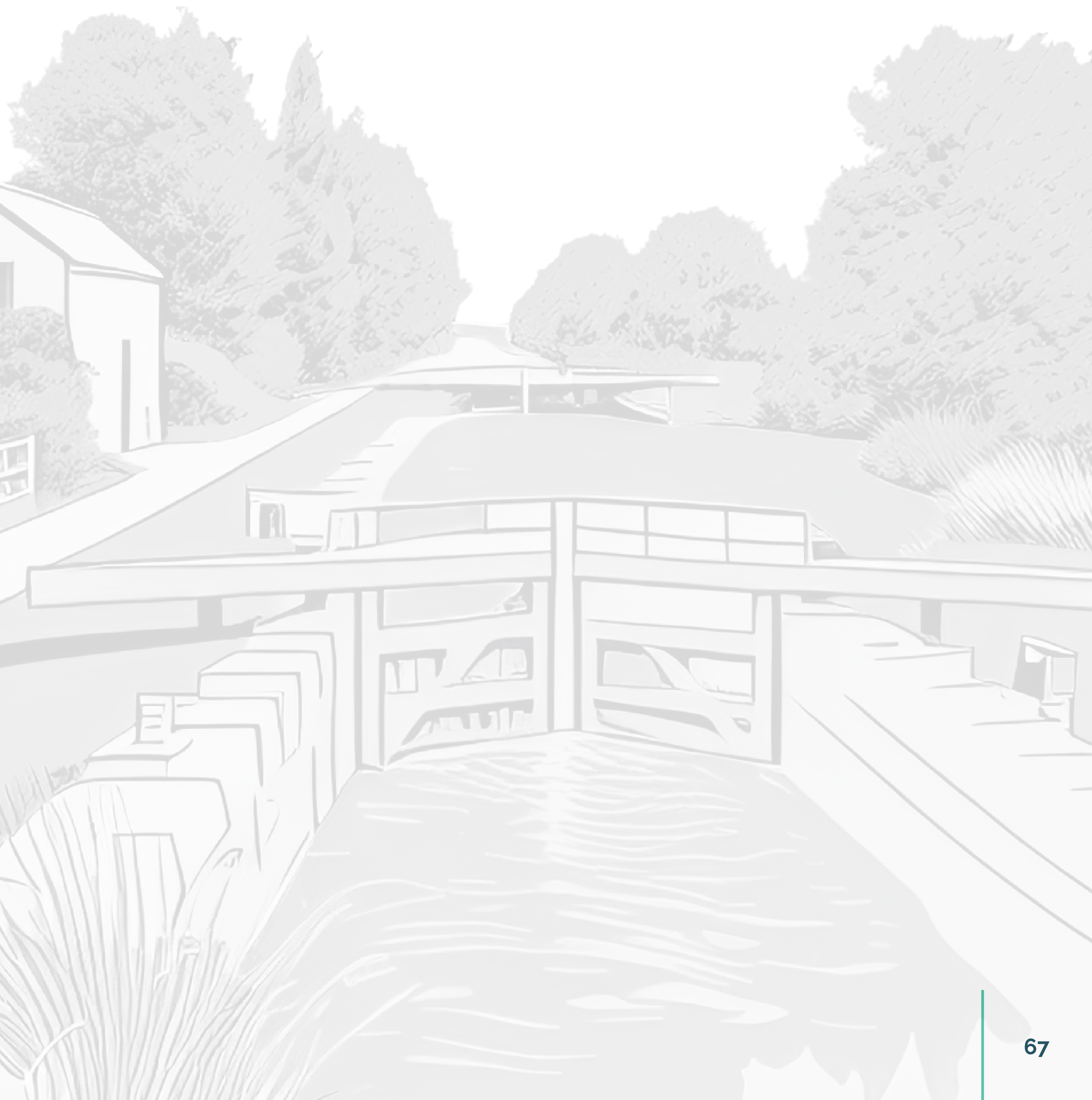
7. Conclusion

In conclusion, this report covers the evaluation of the SP programme provided by the SDCP in Clondalkin. This evaluation was conducted by TASC and allowed for the engagement of a variety of stakeholders in order to provide insights into the benefits provided by the SP programme and recommendations for the SP programme going forward.

Wellbeing scores, SP programme participants, and referrers provided positive feedback about the SP programme. Across each of the measures investigated in this evaluation, evidence suggests that the SP programme is of great benefit to the participants. The SPLW serves an important role in listening to, understanding, and supporting the clients while they are engaged in the programme. The role of the SPLW is to go at the pace of the client and to allow them to re-engage with the programme at a later date if they are not currently able to participate.

This has proven to be particularly necessary in Clondalkin, where services have been changing, residents feel disconnected, and residents may not be aware of what is available to them. As seen here, some residents in the area may be struggling with additional challenges: bereavement, mental health, physical health, or mobility challenges. The SPLW provides the link that these clients need to engage with community programmes which suit them and their needs.

The positive impact of the SDCP Clondalkin SP programme is seen across different measurements, most importantly in the feedback provided by interviewed SP programme participants. This feedback serves as a testament to the programme's effectiveness in achieving its objectives. Based on the findings of this report, recommendations have been formulated to further enhance the existing successes of the programme. These recommendations are designed to build upon the strengths identified and address any areas for improvement. Ultimately, they aim to ensure the continued growth and positive outcomes of the SDCP Clondalkin SP programme and its clients.



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Appendices

Appendices

Appendix 1 - Salesforce Data

Table A1. Overview of Salesforce data sources

Report title	Data Utilised
SocP Clients	Date of Birth; Gender ; Referred From; Date Registered/Referred to Partnership; Date Active; Date Discharged; Reason for Service Exit; Date Deferred; Deferral Reason; Living in Healthy Community Catchment; Referrer Organisation; Referral Source Role (incl. Other Referral Source); Referral Reason; Access Needs (yes/no and type of needs); Chronic Conditions (yes/no and details of condition); Number of GP Visits in the Last Three Months; Number of A&E Visits in the Last Three Months; Additional Risks and Considerations;
SocP Interventions	Activity Type; Type of Service; Duration (in minutes);
SocP Client Outcomes	Outcome
SocP Additional Info	MYCaW (i.e. Concern 1, Concern 1 Rating, Concern 2, Concern 2 Rating, Wellbeing Rating); SWEMWBS (i.e. Feeling optimistic about the future, Feeling useful, Feeling relaxed, Dealing with problems well, Thinking clearly, Feeling close to other people, Able to make up own mind)

Source: SDCP, 2023.

Appendix 2 - Intervention Type

Table A2. Intervention types by frequency, number of participants, and duration

Intervention type	Frequency		Duration (in minutes)		
	Interventions	Participants	Minimum	Maximum	Average
1-to-1 meeting	223	84	0	100	58.9
Advocacy	19	14	2	30	8.5
Call	700	111	0	60	11.2
Email	165	69	2	60	4.8
External Referral	156	69	0	60	7.1
Facilitation	6	4	3	60	21.3
Group meeting	3	2	10	45	31.7
Letter	49	45	2	60	10.5
Preparation	35	29	2	60	11.2
Research / analysis	2	2	5	5	5
Site visit	1	1	10	10	10
Text	428	93	0	60	2.9
Video Call	2	2	20	30	25
NA	67	53	0	45	2.1

Source: TASC, 2024.
Note: "Participants" refers to the total number of participants who availed of each intervention at least once.

Appendix 3 - Interventions by Service Type

Table A3. Intervention service type by frequency and number of participants

Service type	Interventions	Participants
Addiction Services	8	1
Community/Social activity	53	27
Diet & Nutrition	20	11
Learning New Skills	76	30
Mental Health	120	35
Older Person Supports	126	39
Physical Exercise	110	44
Societal Support	174	48
Other	104	48
NA	1065	111

Source : TASC, 2024.

Appendix 4 - Scores for Wellbeing Measures and their Subscales: Number, Dis/improvement and Change

Table A4. Average change and number of participants who showed an improvement, disimprovement, and no change on each wellbeing measure

Assessment	Item	N		n			Average scores		
		Pre	Post	Improved[10]	Disimproved[11]	No change	Pre	Post	Change
Measure Yourself Concerns and Wellbeing (MYCaW)	Wellbeing	73	34	15	1	18	2.26	1.71	-0.56
	Concern 1	75	35	33	0	2	4.21	1.91	-2.29
	Concern 2	52	30	25	1	4	3.63	2.07	-1.57
Short Warwick- Edinburgh Mental Wellbeing Scale (SWEMWBS)	Dealing with problems well	72	35	12	5	18	3.66	3.91	+0.26
	Feeling close to others	72	35	17	1	17	3.11	3.60	+0.49
	Feeling optimistic about future	72	35	16	3	16	3.11	3.54	+0.43
	Feeling relaxed	72	35	16	3	16	3.20	3.69	+0.49
	Feeling useful	72	35	15	2	18	3.26	3.66	+0.4
	Able to make up own mind	72	35	12	4	19	3.94	4.2	+0.26
	Thinking clearly	72	35	12	3	20	3.54	3.80	+0.26
	Overall	72	35	28	2	5	23.83	26.40	+2.57

Source : TASC, 2024.

[10] Improvement is defined as a decrease in scores on the MYCaW and an increase in scores on the SWEMWBS.

[11] Disimprovement is defined as an increase in scores on the MYCaW and a decrease in scores on the SWEMWBS.

South Dublin County Partnership
Páirtíocht Chontae Átha Cliath Theas

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