



Dublin City Community Co-operative Healthy Communities Project Social Prescribing Evaluation

October 2021-December 2023



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Acknowledgments

This report evaluates the outcomes for participants in the Social Prescribing Programmes from the Dublin City Community Cooperative's (Co-op's) Healthy Communities Programme, based in Dublin North East Inner City. The research for this project was conducted by the Think-Tank for Action on Social Change (TASC).

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List of Abbreviations

Co-op	Dublin City Community Co-operative
CSO	Central Statistics Office
DOH	Department of Health
SHCP	Sláintecare Healthy Communities Project
HSE	Health Service Executive
MYCaW	Measure Yourself Concerns and Wellbeing
NEIC	North East Inner City
SP	Social Prescribing
SWEMWBS	Short Warwick- Edinburgh Mental Well-Being Scale
TASC	Think-tank for Action on Social Change
WHO	World Health Organisation
WHO-5	5-item World Health Organisation Wellbeing Index

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Executive Summary

Executive Summary

Social Prescribing (SP) is a means of enabling healthcare professionals and other professionals to refer people to a range of local, non-clinical services, primarily provided by the voluntary and community sector. The problems of social isolation, fear and loneliness and often associated inactivity have negative consequences for health and can particularly impact older age groups, those with chronic health problems, people with mental health difficulties and psychosocial needs, carers, single parents, migrant and immigrant and minority ethnic groups. Social prescribing began as a community-led movement that seeks to address these needs in a holistic way using an assets-based approach by empowering participants to improve their Health and Wellbeing.

The aims of SP are to address the individual's physical and mental health needs in conjunction with traditional medical treatments. The Dublin City Community Cooperative (Co-op) SP programme operates on a SP model where link workers collaborate within a team that includes a project coordinator, community health workers, and fellow SP link workers.

This report assesses the progress made by the SP programme at the Co-op thus far. The evaluation focused on examining the experiences of participants and their immediate outcomes, gauged through wellbeing scores and post-exit interviews. The research utilised a mixed methods approach, blending client interviews with quantitative data extracted from programme management software.

Findings indicate that through direct engagement with clients and attentive listening to their needs, SP link workers establish trusting relationships and tailor recommendations to address both client needs and referrer concerns. The personal effects of the SP programme are noteworthy, with clients experiencing a range of benefits depending on their level of involvement.

In addition, this research presents evidence of enhanced client wellbeing attributed to the SP process itself, regardless of whether the participant attended the prescribed interventions. Clients appreciated the attentive listening, personalised support, and tangible resources offered through the SP process. They expressed satisfaction with social prescriptions aligned with their interests or objectives.

Additionally, SP clients noted reduced feelings of isolation and loneliness, increased hopefulness, and improved social connectedness resulting from participation in community activities. Engaging in diverse community programmes provided structure to their daily or weekly routines, contributing to a more positive emotional outlook since beginning the programme. Throughout, the programme maintains a person-centred approach, ensuring that the pace aligns with the client's preferences and needs. Finally, the Dublin City Community Co-op's SP programme continues to adjust programme provision in alignment with the diverse needs of the population in the NEIC.



1. Introduction

1. Introduction

1.1. Report Aims

This report seeks to extend prior research and findings from 2021, 2022 and 2023 which focused on the early establishment and development of the Dublin City Community Co-operative's (Co-op's) Sláintecare Healthy Communities Project (SHCP), by focusing specifically on client outcomes. Here, the objectives are to trace client journeys through the Social Prescribing (SP) programme and to understand the factors that shape the individual trajectories of SP participants. The aims were achieved by employing a mixed methods approach, which combined client interviews with quantitative data derived from programme management software.

The following section provides some background information on the Co-op, the local area in which it functions and SP.

1.2. Background

Co-op's SHCP

The social determinants of health encompass non-medical factors that impact health outcomes, shaping individuals' conditions from birth to ageing. Good physical and mental health are essential for overall wellbeing, with various factors influencing these conditions. The World Health Organisation emphasises that the social conditions in which people live significantly affect their health chances, citing poverty, food insecurity, social exclusion, discrimination, poor housing, unfavourable early childhood conditions, and low occupational status as key determinants of diseases, deaths, and health inequalities globally (WHO, 2004).

The Healthy Ireland Strategic Action Plan 2021-2025, as outlined by the Department of Health (Department of Health [DOH], 2021), places a significant focus on promoting health within disadvantaged and harder-to-reach communities, with the North-East Inner City (NEIC) population reaching 37,704 (Central Statistics Office (CSO), 2022)¹. The NEIC hosts a diverse population which is characterised by a significant demographic mix.

¹ Calculated from data on the following electoral districts: Ballybough A, Ballybough B, Mountjoy A, Mountjoy B, North City, North Dock C and Rotunda A.

Within the NEIC, the population is slightly skewed to consist of more males (52.2%) than females (47.8%). The most dominant age group are the 18-64 year olds (77.7%), in comparison to the 0-17 year olds (16.1%) and those 65 years of ages and older (6.2%). Of the residents in the NEIC, 47.2% were born in Ireland. All electoral districts of the NEIC report a steadily increasing in recent years ([City Population](#), 2022).

Both the [Trutz Haase \(2009\)](#) and the [Mulvey \(2017\)](#) reports underscore the diverse and evolving demographics of the NEIC region, characterised by a mosaic landscape intermixing highly deprived and affluent areas. The [Mulvey \(2017\)](#) report specifically addresses the social and economic challenges in the NEIC, offering strategies for regeneration based on the 2011 Central Statistics Office (CSO) census. This report highlights the area's characteristics, including above-average population density, a relatively young population, diverse ethnic and national composition, and high levels of socioeconomic deprivation. Issues such as unemployment, educational attainment, and housing conditions are noted, emphasising the need for comprehensive intervention in the NEIC. Unfortunately, there has not been a published analysis of the 2022 census data for the NEIC. However, more general figures from the CSO indicate that Ireland has experienced increasing migration in recent years, with non-Irish citizens accounting for 17% of the population in Dublin.

Sláintecare Healthy Communities represents a cross-government initiative aimed at enhancing health inequalities in community areas throughout Ireland. This initiative adopts a collaborative approach by involving local authorities and community groups to address health inequalities in these regions. The primary goal is to empower individuals and communities, fostering healthier lifestyle choices to enhance both physical and mental health and overall wellbeing.

The overarching goal of the SHCP was to pinpoint specific areas in which health and wellbeing risk factors were notably heightened due to deprivation. The objective was to implement tailored initiatives within these communities to address these challenges effectively. The SHCP was jointly funded by the NEIC Programme Implementation Board, Healthy Ireland and the Health Service Executive (HSE). Notably, the Co-op's SHCP officially started on 1st December 2020, before the Sláintecare model for area-based initiatives was developed. In 2023 the Co-op SHCP was aligned with the initiative. One of the programmes run by the SHCP is the Social Prescribing (SP) programme.

Social Prescribing

SP represents a holistic approach to healthcare that acknowledges the impact of social factors on the health and wellbeing of individuals. It entails healthcare professionals, including GPs or nurses, or social care workers recommending non-medical interventions to tackle patients' social needs and enhance overall health outcomes. This recommendation is called a "social prescription".

The Co-op SP programme runs based on a model in which link workers function within a team consisting of a project coordinator, community health workers and link workers. This team runs the SHCP. In the SHCP, the SP link worker is the individual responsible for providing the social prescription for the client. This social prescription is a recommendation for the client to attend one or more community programmes, courses or activities which are of interest to the participant. These recommendations may encompass various activities such as community-based exercise programmes, art classes, gardening clubs, or support groups. The primary objective is to improve patients' quality of life by connecting them with local resources and services that address the underlying causes of health issues, fostering a more encompassing and person-centred healthcare strategy. SP is in alignment with the broader objective of encouraging community engagement, diminishing social isolation, and empowering individuals to actively engage in their health and wellness.

In depth details on the functioning of the SHCP are available in the [SHCP evaluation \(2023\)](#) report.

TASC Research

TASC has completed a series of reports assessing the SHCP by monitoring and evaluating the associated programmes it offers. The latest report, titled "Healthy Communities Project: Impact Evaluation Report," was launched in December 2023, focused on evaluating various programmes offered by the SHCP and how the SHCP is integrated into the local community. The SHCP evaluation covered the initial years of the programme and looked at outcomes for the first cohort of SP participants by looking at general trends in wellbeing scores and qualitative interviews. The report particularly emphasises the benefits provided by each facet of the programme. Noteworthy among these benefits are the favourable responses regarding the SP programme shared within the community and the reported enhancements in participants' feelings of wellbeing and improved mental health. In addition, some SP participants undergo non-linear journeys, with an average completion time of approximately 6 to 8 months, with some individuals remaining engaged with the programme for a year or more.

The report also provided a set of suggestions addressing different aspects of the SHCP's operations. These recommendations were focused on bolstering service delivery to accommodate the expanding population and evolving demographics of the NEIC. Of particular relevance to the ongoing evaluation are recommendations regarding evaluation of factors contributing to programme completion by participants to gain a deeper understanding of the impact of social prescribing on individual outcomes and conducting follow-up research to assess programme outcomes for participants who have completed the programme. Therefore, a comprehensive evaluation is warranted now that additional quantitative and qualitative data are available.



2. Methodology

2. Methodology

2.1. Data Collection and Methods

To gain a thorough comprehension of the Co-op SHCP's SP programme, a mixed-methods approach was employed. Both quantitative and qualitative data were gathered and examined to explore diverse facets of the programme as perceived by clients in order to better understand client journeys.

Elemental Database

General Overview

Quantitative data were obtained from Elemental, the client relationship management system utilised by the SHCP in order to streamline and oversee the implementation of the SP programme. Elemental consolidates information from various sources, with staff inputting participant details at various stages of their programme journey. These individual cases are then synthesised into reports for review. Moreover, certain client data is presented in a tabular format, facilitating statistical analyses.

For this assessment, data from 259 participants entered into Elemental between the 1st of October 2021, and the 31st of December 2023, (N=260) were utilised. After removing duplicate entries and disaggregating data using registration information, the final sample size was 248 and included demographic details encompassing ethnicity, disability, health status, carer presence, caring responsibilities, living arrangement, employment status, substance use, relationship status, and gender; a summary of referral quantities; the nature of referrals; participant status; interactions with SHCP personnel; and participant well-being. Importantly, disaggregated demographic data for each participant could not be accessed, limiting possible analyses and prohibiting the removal of duplicate entries from this data².

² Although personal demographic data may be entered in Elemental for individuals, Elemental does not allow certain "sensitive" categories to be accessed. This is because Elemental was created and is maintained in compliance with [UK General Data Protection 2018 Article 9\(1\) section 51](#), which pertains to the processing of special categories of personal data. These data include demographic categories, such as nationality and ethnicity. Such data are aggregated/grouped and it is not possible to look at the individual level data but rather at the group level. For example, the data show that there is one Irish Traveller who participated in the programme, but it is not possible to link this information with date of registration, interventions or wellbeing scores. This same issue arose in the analysis of the WHO-5 data, which were only available as aggregated averages across all SP participants.

Also, the demographic breakdowns and WHO-5 data offered by Elemental for equality monitoring provide information which does not allow for assessment of potential duplicate entries in the dataset (e.g. in the case where individuals may have been referred twice into the programme at two different timepoints). Therefore results are conflated.

In addition, the recording of complete demographic data (inclusive of ethnicity, disability, employment status, civil status, caring responsibilities, and other equality monitoring variables) began approximately in late January 2023. As such, this information (in aggregated format) is only available for 100 participants. For participants registered prior to this change, only age and binary gender (i.e. male or female) are available.

Wellbeing Assessments

General

As a component of the wellbeing evaluation within the SP programme, participants were provided with the following questionnaires to fill out at the programme's commencement and upon completion:

- The Measure Yourself Concerns and Wellbeing (MYCaW)
- The Short Warwick-Edinburgh Mental Wellbeing Scale (SWEMWBS)
- The 5-item World Health Organization Wellbeing Index (WHO-5).

Scores were inputted into the programme software and subsequently examined as part of this assessment. The score changes between pre- and post- SP participation were calculated for each participant and the average changes in scores compared across wellbeing tests. However, it is important to note that not all participants responded to every question in the three wellbeing assessments, resulting in variations in the number of participant responses for each question. Additional details on data processing and analysis in Elemental, analysis of the wellbeing questionnaires and qualitative analysis are available in the [Healthy Communities Project Impact Evaluation Report](#). An overview of Elemental data utilised are available in Table 1.



Table 1. Overview of Elemental data sources

Reports	Data Utilised
Monitoring Tools	Date of Birth, Referral Date, Social Prescriptions/Interventions, Wellbeing pre & post scores ((i.e. SWEMWBS [(Shah et al., 2021)], MYCaW® [(Paterson et al., 2007)]), GP Attendance, A+E visits, Hospital admissions
Report List Referrals	Referrals
List Cases	Overview: averages for tools used (i.e. SWEMWBS [(Shah et al., 2021)], MYCaW® [(Paterson et al., 2007)], WHO-5 [Topp et al., 2015])
Referrals Case Activity Report	Reasons for referral
Case ManagementContacts	Number of contacts (e.g. phone, text, in person appointment, etc.), contact type, visit time spent

Source: TASC, 2024.

Established psychometric properties of wellbeing assessments

SWEMWBS, MYCaW and WHO-5 are wellbeing assessments which come as a part of the Elemental software package. These questionnaires are often asked as part of a client's journey when they enter and when they exit social prescribing programmes as a way of measuring client outcomes. This report does not test the validity or the reliability of these assessments. However, a brief background from the published literature is available below.

A number of evaluations of the psychometric properties of the SWEMWBS exist, generally demonstrating high reliability and validity. In particular, the SWEMWBS has shown high internal consistency and convergent and discriminant validity across a number of populations, including among secondary school students in Scotland and Northern Ireland ([McKay & Andretta, 2017](#)), the general population of the UK ([Ng Fat et al., 2017](#)), and adult populations in Sweden and Norway ([Haver et al., 2015](#)). 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' psychometric properties are in existence. Jolliffe et al. (2015) demonstrated the scale's high sensitivity to change as well as good convergent validity. However, it is important to note that these evaluations were conducted on a sample of cancer patients and thus may not be generalisable to a wider population. In addition, the validity of the scale was assessed in relation to an assessment of quality of life in 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.

The WHO-5 demonstrates sufficient validity for detecting depression and evaluating results in clinical trials and has been employed across a wide range of study fields. Research employing item response theory among both younger and older individuals suggests that the scale effectively measures well-being as a single dimension in these demographic groups (OMANI-SAMANI et al., 2019; Topp et al., 2015).

Statistical Analyses

A master dataset was extracted from Elemental, detailing all SP participants who registered on the programme between April 2021 and December 2023 inclusive. Prior to any analyses, this dataset was tidied to consolidate and/or remove duplicate entries. A total of 11 duplicate entries were identified, three of which could not be consolidated and remained in the dataset.

To aid later analyses, a number of further variables were added to the dataset on the basis of the existing data. Firstly, participants' ages were calculated from their date of birth. In addition, participants were categorised into one of four age groups: 18-34, 35-44, 45-64, and 65+. Secondly, for each participant, a list of social prescriptions that they had been signposted to was provided in the original dataset; these were tallied to provide totals for each participant. Thirdly, the length of time between the date of referral and date of registration was calculated for each participant. Finally, the status of all registered participants was tallied to gauge how many individuals were currently engaging with or awaiting the programme and how many had completed it or been discharged.

To evaluate the quality of the wellbeing measures used to assess participants' wellbeing, a search of existing data on their psychometric properties was conducted. In particular, data was sought concerning their validity and reliability (Bannigan & Watson, 2009; Bhattacharjee, 2012). In the context of psychometric scales, the concept of validity refers to the extent to which a scale truly measures what it purports to measure. For example, convergent and discriminant validity capture the extent to which participants' scores on a scale correlate with other similar or opposite constructs respectively, for example, scores on other measures of wellbeing.

The concept of reliability broadly refers to the consistency of the scale. For example, tests of internal consistency reliability assess whether different items (questions) on the scale all measure the same concept. Inter-rater reliability captures the consistency of participants' scores on a scale when the scale is administered by different individuals (Bannigan & Watson, 2009; Bhattacharjee, 2012).

Established psychometric properties of wellbeing assessments

Participants' scores on wellbeing measures pre- and post-SP were used to examine the quantitative impact of the SP programme on their wellbeing. Pre- and post-SP scores were compared to calculate the change in scores across each of the following scales for each participant who had completed the measure both pre- and post-SP: SWEMWBS (N=40), MYCaW overall (N=38), MYCaW Concern 1 (N=38) and 2 (N=24), and MYCaW Wellbeing (N=38). Changes in scores were assessed in terms of their meaning, rather than strictly 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-SP 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.

The post-SP scores for all participants who had experienced an improvement, a disimprovement, or no change on each of the scales were summed and expressed as a percentage of the total post-SP scores for all participants. The results of this calculation were compared across each scale. Scores on the WHO-5 were not included in this specific analysis as disaggregated pre- and post-SP scores for each participant were not available. In addition, average pre- and post-SP scores as well as the average changes in scores from pre- to post-SP were calculated for each measure.

In order to investigate the underlying phenomena regarding wellbeing score differences statistical tests for significance were conducted. T-tests³ and Wilcoxon signed rank tests⁴ were used to assess the statistical significance of changes in wellbeing scores from pre- to post-SP. The tests were conducted in the R programme (R Core Team, 2020). Wilcoxon signed rank tests were performed on the MYCaW Concern 1 and 2 scores as these data did not meet the assumption of normality. Paired samples t-tests were performed on the SWEMWBS, MYCaW general questions, and MYCaW wellbeing questions.

³ A T-test is a statistical test used to determine if there is a significant difference between the means of two independent groups or the mean of a sample compared to a known value, assuming normal distribution and homogeneity of variances.

⁴ A Wilcoxon signed-rank test is a non-parametric statistical test used to determine whether the medians of two paired samples are significantly different. This is used when the data distribution is not normal.

Age-based differences

Pre-SP scores, post-SP scores, and changes in scores from pre- to post-SP were compared across the aforementioned four age groups, to investigate differences in the effect of the programme on participants of different ages. Where the data were shown to have a normal distribution, an analysis of variance was performed. Otherwise, Kruskal-Wallis tests were conducted on six of the datasets due to the data being non-parametric (i.e. not having a normal distribution): SWEMWBS pre-SP scores, MYCaW general post-SP scores, and MYCaW Concern 1 and 2 pre- and post-SP scores.

Interventions and change in scores

Simple linear regressions were conducted to assess the relationship between the number of interventions that a participant was prescribed and the change in their scores on wellbeing measures from pre- to post-SP assessments. These analyses were limited to the participants for whom both pre- and post-SP scores as well as a list of prescribed interventions were available⁵. In addition, simple linear regressions were performed on participants for whom a list of interventions and pre-SP scores were available⁶, to assess whether there exists a relationship between a participant's pre-SP scores and the number of interventions that they are prescribed.⁷

Qualitative wellbeing data

Alongside quantitative answers, the MYCaW Concern 1 and 2 subscales ask participants to name up to two concerns that they are hoping to receive support for through the programme. These concerns were coded so as to categorise them into broader groupings. A count of the resulting categories was subsequently performed. A total of 126 participants' concerns were coded.

⁵ N=27 for SWEMWBS; N=25 for MYCaW general questions, MYCaW Concern 1 and MYCaW Wellbeing; N=15 for MYCaW Concern 2.

⁶ N=67 for SWEMWBS, MYCaW general questions, MYCaW Concern 1, and MYCaW Wellbeing; N=49 for MYCaW Concern 2.

⁷ Not all SP participants who complete the programme have both pre- and post- SP scores. This type of drop-off is to be expected as not all SP participants choose to engage in the wellbeing assessment, or may not attend the last meeting. In addition, not all clients had a secondary concern. therefore the numbers naturally would decrease in comparison to the MYCaW Concern 1.

Qualitative Interviews

Qualitative interviews with SP programme participants were undertaken to gain insights into their personal journeys. Interviews took place during the discharge/exit meeting with the SHCP link worker, either in person or over the phone, or shortly thereafter. Interviews were conducted from June–November 2023. Approximately 15% of completed programme participants were interviewed.

Approximate time spent on the programme was calculated based on subtracting the interview data by the date of referral. In addition, SWEMWBS pre, post and change scores for the interview group are described.

2.2. Sample and selection process

SHCP link workers spoke with clients completing the SP programme and interview participants indicated a willingness to engage in an interview with TASC staff. TASC staff were subsequently furnished with the participants' contact information. The interview questions centred on individual experiences, the motivations behind referrals, community involvement, interactions with social prescribing staff, participation in courses, and future aspirations. An illustrative interview topic guide can be found in Appendix 1. Eleven client interviews were conducted as part of this research.

2.3. Limitations

Balancing depth and breadth: The interview's research questions were crafted to bridge informational gaps and provide greater clarity to the data present in the Elemental database. Since participants were invited to interviews upon completion of the SP programme, it was impractical to preselect participants in advance to obtain a representative sample. In addition, analyses of Elemental data were limited by the aggregation of demographic variables for participants.

Bias and interpretation challenges: The research team acknowledged and recorded their inherent biases and assumptions to mitigate their impact. Furthermore, instances of biases observed in the available data were explicitly mentioned in the report.

Time and resources: TASC researchers led this research project in partnership with the Co-op's SHCP. This collaborative effort aimed to optimise the combined expertise of both teams in pursuit of the research objectives.

Observational research: This is an observational research project, and is therefore limited by the parameters set by the SHCP SP programme. Therefore it is not possible to test the outcome of not participating in the SP programme or to determine cause and effect.

2.4. Ethical Considerations

Informed consent: Before participating in the interview, participants received a transparent explanation of the study's objectives, their role in the research, the utilisation of their contributions, and the handling of their data. Additionally, any necessary support that an individual might require to engage in the research was taken into consideration and accommodated whenever feasible.

Data protection and anonymity: Only essential information was collected during interviews.

Prevention of harm: Participants were provided with a comprehensive explanation of the research's purpose, enabling them to prepare for the forthcoming discussions. During interviews, the researcher vigilantly observed individuals for signs of distress and promptly called for a pause or break if deemed necessary.

Position of the research: Clearly outlining the research objectives and the researcher's role is crucial for carrying out an external evaluation. While this study is conducted collaboratively with the Co-op SHCP team, maintaining the researcher's independence is paramount to ensuring the evaluation remains as impartial as possible. This approach facilitates participants in expressing their views and sharing their experiences openly and without reservations.



3. Overview of Client Data

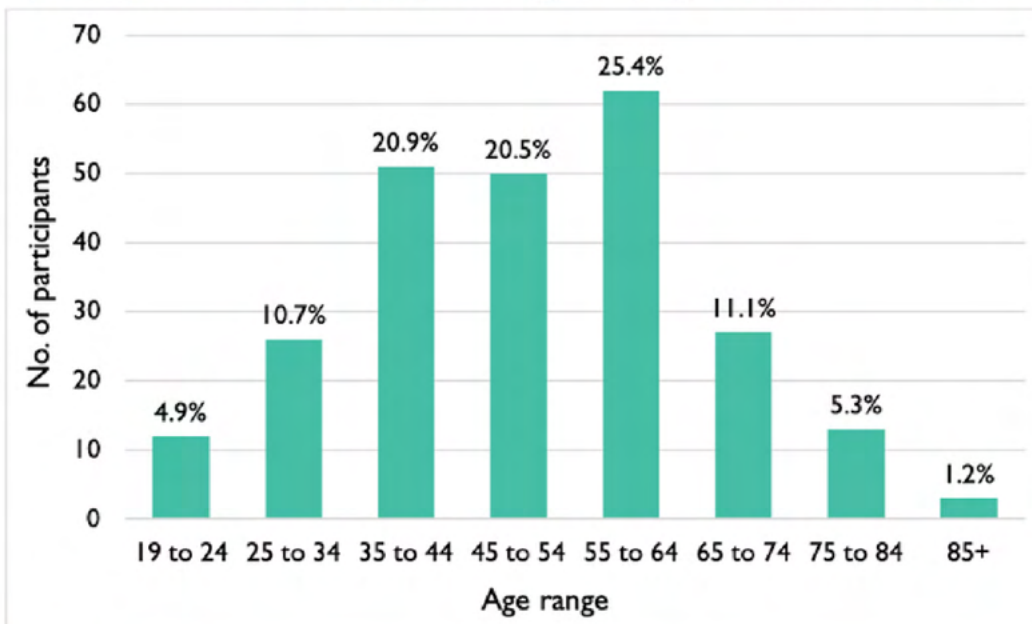
3. Overview of Client Data

3.1. Demographic Breakdown

In total, 121 women (46.7%) and 138 men (53.3%) registered on the programme, inclusive of 11 duplicate entries which resulted from individuals being re-referred to the programme (sometimes by multiple sources). Notably, partway through the programme, in approximately late January 2023, the recording of gender identity was amended to create a second gender variable with the entry "transgender" as an option. Since then, one transgender person was recorded. This individual is also included in the male-female breakdown. However, as disaggregated demographic data are not available for participants, the specific gender of this person (e.g. male, female, non-binary) in addition to the fact that they are transgender cannot be determined.

The age of five participants (including one duplicate) is unknown. Among the remainder, the greatest proportion of participants fell in the 55-64 age range (25.4%). Over two-thirds of participants were 35-64 years old. The complete age breakdown is depicted in Figure 1 below.

Figure 1. Age breakdown of SP participants (N=244, with 10 duplicates removed, 5 unknown)



Source: TASC, 2024.

A more detailed breakdown of this research population, including gender, nationality, and health status, is available in the [SHCP evaluation \(2023\)](#).

3.2. Client Journeys

Wait times

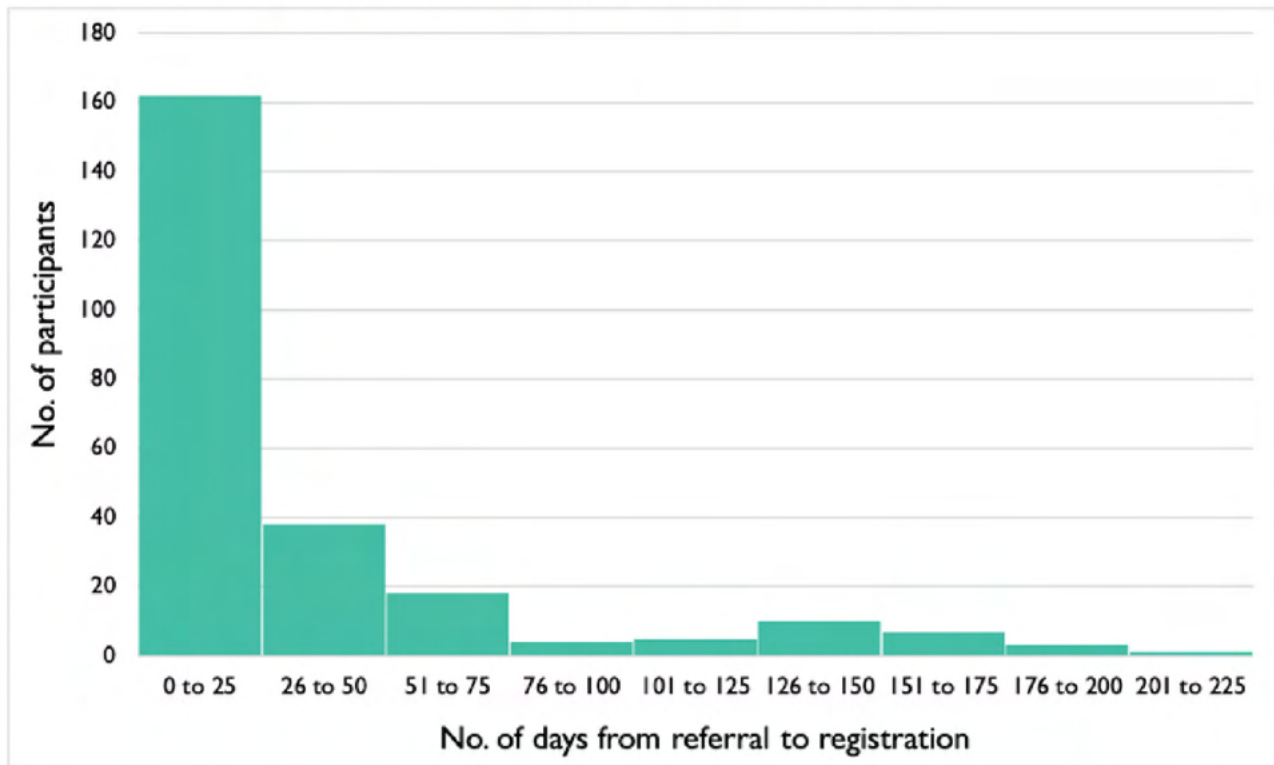
Clients' wait times were defined as the time passed between the person's referral and their registration, that is, the number of days from the date of referral to the date of registration. This ranged from 0 to 201 days, with an average of 30.94 days (SD=45.11). The majority of participants waited less than three weeks. Figure 2, below, shows the distribution of participants' wait times, in 25-day intervals. However, this does not take into account the call or calls which were made to the client prior to registration. Link workers contact potential SP participants upon receipt of the referral, and it may take multiple attempts to reach the potential client. The investment that link workers make in following up on referrals is not recorded in Elemental.

All longer wait times (e.g. maximum 201 days) were associated with individuals in some of the most challenging situations. For some individuals, the appropriateness of some referrals was borderline due to their housing or addiction status. For other individuals their health status was not stable due to changes in their physical or mental health. Once it was realised that the referral was inappropriate or that individuals' health would not allow them to participate for some time, then the link worker discharged them from the programme with the knowledge that they could always be referred again once they are more stable and able to participate in activities.

This research is observational, therefore it is not possible to determine what factors are resulting in longer waiting times for some SP participants. However, various factors related to the participant (e.g. having their own phone ([SHCP evaluation, 2023](#)), health status, housing situation, etc.) may be delaying registration and increasing waiting times. These are issues and challenges faced by the SP client end which may affect the speed at which they may be registered by the link worker. These hurdles for the client may also impact the duration of time that individuals spend in each stage of the programme (see below).

⁸Link worker's time investment in clients prior to registration is discussed thoroughly in the [SHCP evaluation \(2023\)](#).

Figure 2. Distribution of participants' wait times (N=248, with 11 duplicates removed)



Source: TASC, 2024.

Case status

The status of all registered SP participants as of December 2023 is summarised in Table 2 below. In total, 80% of all participants who had registered on the SP programme were no longer engaged in the programme as of December 2023, either due to being discharged or having completed the programme. Thirteen participants were awaiting further engagement with the programme, three of whom had an appointment scheduled and four of whom were on hold. As of the 31st of December 2023, the remaining six participants had been waiting between 23 and 111 days since the date of their referral to the programme, with an average wait time of 76 days. As stated in the previous section, long wait times were linked to changing health status, borderline inappropriate referral and challenges contacting clients. These can all cause delays in SP link workers being able to contact individuals, as well as delay SP programme participation.

As discussed above, some SP participants had excessively long waiting times. In this report, we discuss potential causes for this based on data which are available from the client's perspective. These factors plus the additional factor of demand for services exceeding staff capacity are discussed in the [SHCP evaluation \(2023\)](#).

Table 2. Social Prescribing participant programme status (as of 31 December 2023)

Case Status Group	Case Status	N	%
Active	Awaiting appointment	1	0.4%
	Contact made	10	4.0%
	Engaging in service	26	10.4%
Active total		37	14.7%
Complete	In meaningful activity	15	6.0%
	Needs met	30	12.0%
	Not specified	10	4.0%
	Referred on	19	7.6%
Complete total		74	29.5%
Discharged / Closed	Client deceased	1	0.4%
	Did not attend appointment	5	2.0%
	Disengaged	28	11.2%
	Inappropriate referral	8	3.2%
	No longer requires service	36	14.3%
	Not specified	9	3.6%
	Out of area	2	0.8%
	Re-referral	1	0.4%
	Referral declined	2	0.8%
	Unable to contact	35	13.9%
Discharged / Closed total		127	50.6%
Waiting	Appointment booked	3	1.2%
	Awaiting service	1	0.4%
	New	5	2.0%
	On hold	4	1.6%
Waiting total		13	5.2%
GRAND TOTAL		251	100%

Source: Elemental data, 2021-2023; contains duplicates (N=3).

Interventions/Social prescriptions

In total, 233 interventions (also known as social prescriptions) were listed for the 77 participants who completed the SP programme, with no interventions recorded for 174 individuals. On average, SP participants received prescriptions for 3.03 interventions. A list of interventions is available in Appendix 2. Likely the number of interventions presented here is an underestimate, due to gaps in the recording of these data.

There are gaps in the data collection from the initial phase of the project when Elemental was being set up, the SHCP team were just learning how to record client data and not all organisations which were being referred to were available as options for entry in Elemental. In addition, for at least a few of the missing client data intervention information was recorded among the text written in the client notes. Unfortunately, the case notes contain sensitive information for participants and thus this information was not available for this study. This seems to have occurred mainly in the early stage of the SHCP when multiple staff were responsible for entering client data. Systematic data collection (e.g. use of the intervention field) improved when a full time link worker was employed by the project. Lastly, some gaps in the data may have been caused by some clients who disengaged from the project prior to being given a social prescription (i.e. clients who registered but left the programme prior to completion). This may have also contributed to missing intervention data. However, it is not possible to quantify which of the different reasons may be attributed to a specific client case due to the way in which data are recorded in Elemental and presented by the programme.⁹

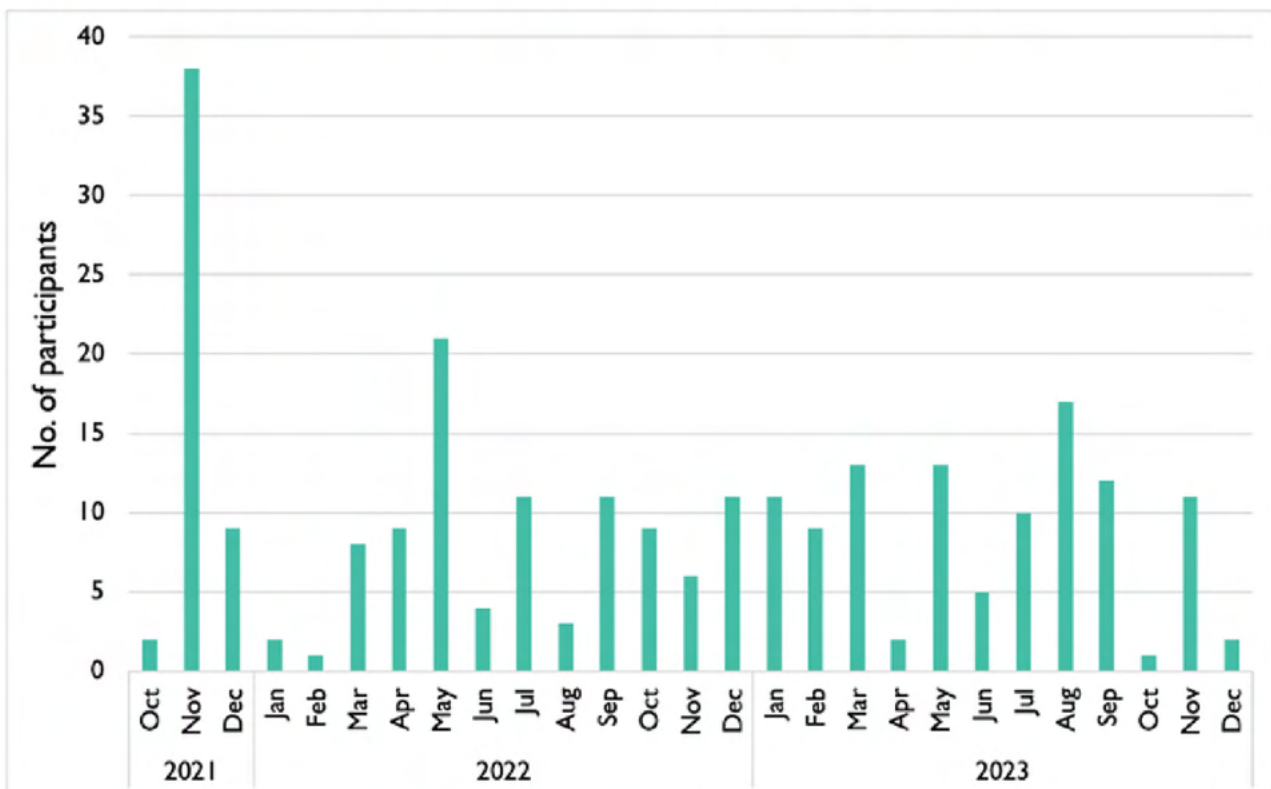
Simple linear regressions revealed no relationship between the number of prescribed interventions (/social prescriptions) and changes in scores from pre- to post-SP, across any of the wellbeing measures. The number of prescribed interventions does not appear to predict change in scores on wellbeing measures. Further simple linear regressions also found that participants' pre-SP scores did not predict the number of social prescriptions they would receive. These analyses should be rerun with a larger and more complete dataset to adequately test the relationship between wellbeing scores and interventions.

⁹Case notes are not available for research in order to protect client privacy.

Interventions/Social prescriptions

Figure 3, below, depicts the temporal distribution of participants' registration in Elemental. Comparing annual figures, 19.5% of participants were registered in the last three months of 2021, 38.2% were registered in 2022, and 42.2% were registered in 2023. This averages to approximately 16.3 new participants per month in 2021, 8 in 2022, and 8.8 in 2023.

Figure 3. Temporal distribution of participants in Elemental (N=251, contains 3 duplicates)



Source: Elemental data, 2021-2023; contains duplicates (N=3).

Unfortunately, calculating the number of exits per month is not possible as Elemental does not keep track of the date that someone has exited the SP programme.

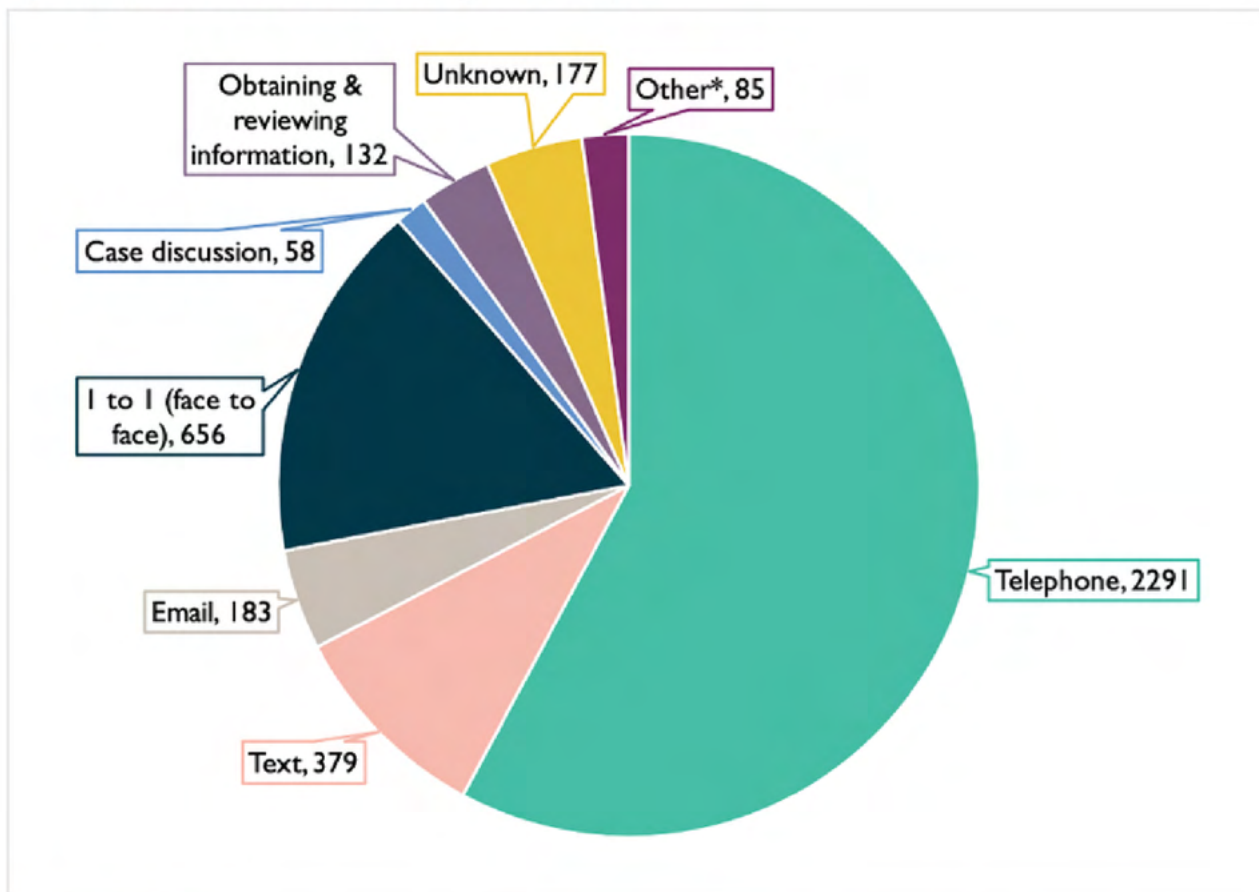
Journey Length

As above, calculating the exact length of time SP participants spent on the project is not possible as these data are not systematically collected by Elemental. However, during interviews clients mentioned being enrolled in the SP programme for a few months up until one year. This is within the range of the estimate obtained in the [SHCP evaluation \(2023\)](#).

Contact with participants

In total, SP staff had made 3,961 contacts with participants by the end of 2023. A breakdown of the contact types is provided in Figure 4, below. Over half of all contacts made were by telephone. The second most common contact type was 1-1, face-to-face appointments, at 16.6%.

Figure 4. Types of contact made with SP participants by staff



Source: TASC, 2024.

*Other consists of: office visit (N=2), drop in (N=3), school visit (N=3), reminder (N=4), internal communication (N=11), group session (N=11), scheduled appointment (N=11), letter (N=18), video call (N=19), and other (unspecified: N=3).

3.3. Client Outcomes

Health Impact

At the time of registration 119 SP Clients provided information on their contact with healthcare workers in the last three months. On average, SP clients attended GP services 3.1 times (range=0 to 24), attended accident and emergency (A&E) 0.5 times (range=0 to 10) and were admitted to hospital 0.2 times (range=0 to 5).

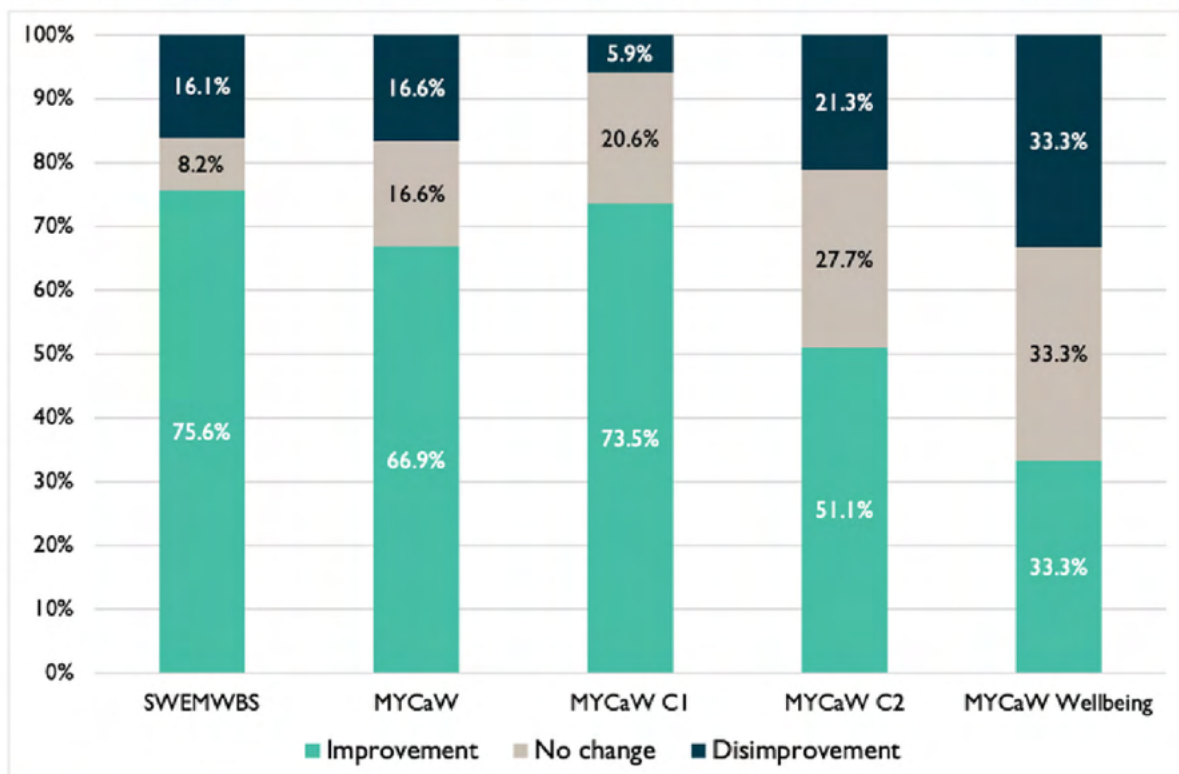
Quantitative data on contacts with GP services, A&E attendance and hospital admissions are not included at discharge. However, clients stated during interviews that participating in the SP programme improved their physical and mental health; see section 3.3 Client outcomes, for details regarding qualitative interview data.

Wellbeing Scores

Change in wellbeing scores

Figure 5, below, depicts the total scores of participants on each of the wellbeing measures post-SP: SWEMWBS, MYCaW overall, 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-SP score. The numbers within each coloured bar show the percent for each subcategory. Improvement and disimprovement are defined in terms of wellbeing, that is, the meaning of the scores.

Figure 5. Participants' wellbeing measures categorised by improvement, disimprovement, and no change



Source: TASC, 2024.

Note: Some percentages sum to 99.9% or 100.1% due to rounding.

The greatest improvement in wellbeing was recorded in terms of scores on the SWEMWBS, with over three-quarters of participants' post-SP scores on this measure constituting an improvement from their pre-SP score. Interestingly, participants' outcomes varied across the subparts of the MYCaW; that is the outcome portion (improvement/no change/disprovement) for MYCaW, MYCaW C1, MYCaW C2 and MYCaW Wellbeing varied. For example, almost three-quarters of participants' total post-SP scores on the MYCaW Concern 1 constituted an improvement, while the MYCaW Wellbeing scores consisted of equal parts improved, disimproved, and the same scores as pre-SP. Appendix 3 outlines the average pre- and post-SP scores as well as change in participants' scores across all of the wellbeing measures. For the WHO-5, only mean change is available due to lack of disaggregated data.

Notably, some participants' changes in scores from pre- to post-SP were inconsistent, showing improvement, no change, and even disimprovement across different scales. For example, one participant's SWEMWBS score decreased from 19.98 to 15.84, indicating worsening of their wellbeing. However, their general MYCaW score also decreased from 11 to 9, indicating an improvement, while their scores on the MYCaW Concern 1 and Wellbeing subscales did not change. Another participant showed disimproved wellbeing on all scales except the MYCaW Wellbeing scale, where their score decreased from 4 to 0 (on a scale of 0 to 6), indicating that they described their wellbeing as "as good as it could be". These variations (and potential disagreements) in score directionality across the different wellbeing tests may be due to what is actually being measured and the context in which these tests were developed.

The nature of the SP intervention is complex and, as such, is composed of a variety of elements which are not independent of the variations in a client's situation. The process of engaging in the social prescribing process is a form of intervention, varying between the participants, the participants experiences and the way that participants interact with the link workers. In addition, these data were collected over a period of time during which any number of experiences could serve to influence an individual's wellbeing, not only the SP programme. The data here show that the majority of participants showed an improvement in wellbeing scores when comparisons were made between individual's pre and post scores. However, as this research is observational in nature no causal relationship can be established between the SP participation and the change in wellbeing scores. That is, it can not be said that SP is responsible for the improvement or disimprovement of any individual's wellbeing based on the quantitative data which are presented here. Qualitative evidence coming directly from participants supporting improved wellbeing scores can be found in Section 4.1.

Age-based differences

Comparisons of participants' pre-SP scores, post-SP scores, and changes in scores across the four age groups (18-34, 35-44, 45-64, 65+) revealed no significant age-related difference. Therefore indicating that age group was not a predictor of any of the wellbeing scores or the change in wellbeing.

SWEMWBS

Thirty participants (75%) experienced an increase in their SWEMWBS score over the course of the SP programme, symbolising an improvement in their wellbeing. Three participants (7.5%) experienced no change. The difference between pre- and post-SP scores on the SWEMWBS was statistically significant (see Appendix 3 for further detail).

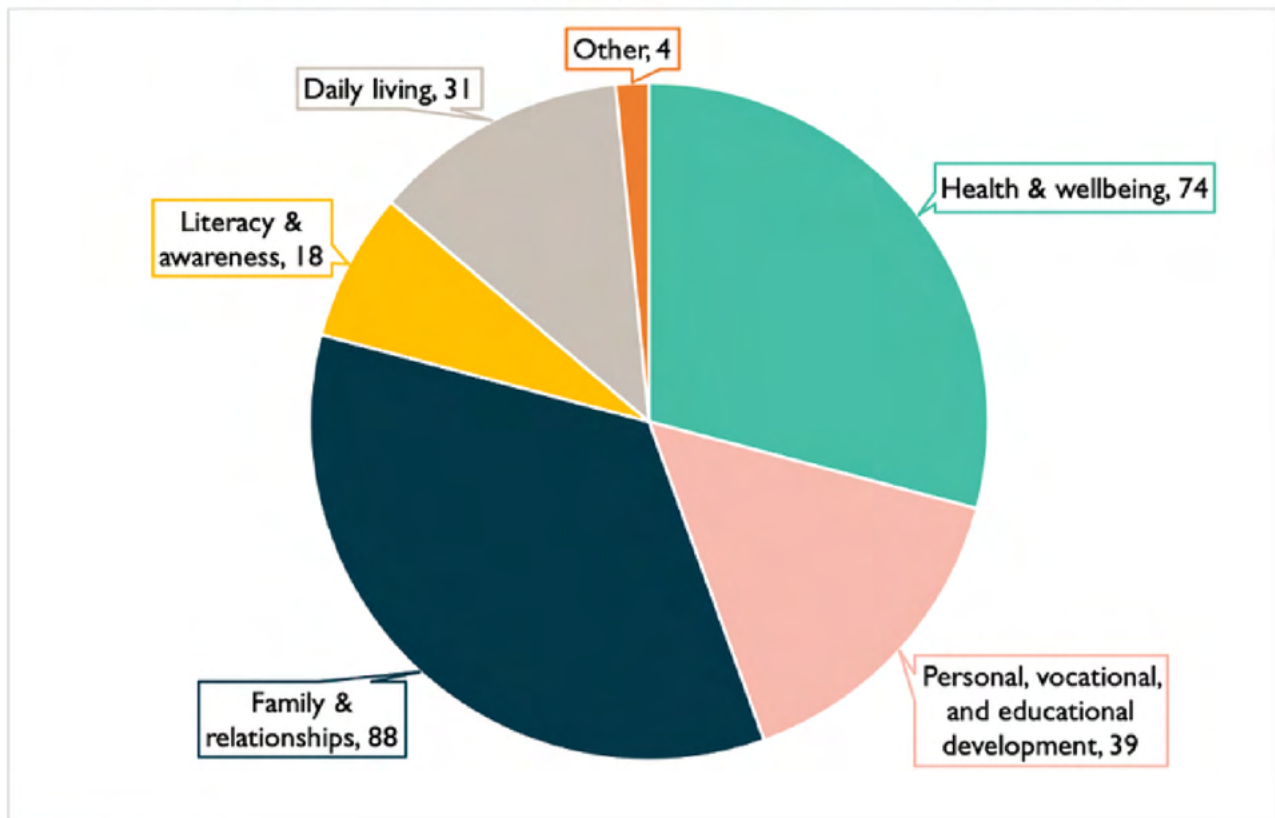
MYCaW

The MYCaW scale consists of four sections: general questions, Concern 1, Concern 2, and wellbeing questions. Across all subscales, lower scores indicate more positive wellbeing. On the general questions, 84.2% of participants for whom pre- and post-SP scores are available experienced a decrease in their scores. Three people experienced no change. On the Concern 1 subscale, 86.8% of participants saw a decrease in their scores pre- to post-SP, while four saw no change. On the Concern 2 subscale, exactly three-quarters experienced a decrease in scores and the scores of 4 participants remained the same. Finally, on the wellbeing questions, the scores of 52.6% of participants decreased from pre- to post-SP while the scores of ten participants did not change. The differences between pre- and post-SP scores were statistically significant on all subscales of the MYCaW (Appendix 3).

MYCaW concerns

Figure 6 below shows the broad categories of concerns raised by participants (N=126) in the MYCaW Concern 1 and 2 subscales. Each major category included 4-6 subcategories, outlined in detail in Appendix 4. The most common concerns included social and community engagement (N=61; 48.4%), mental health supports and mood (N=27; 21.4%), physical health, chronic illness, and mobility (N=25; 19.8%), and housing (N=19; 15.1%).

Figure 6. Major categories of concerns raised by participants (N=126) in the MYCaW Concern subscales.



Source: TASC, 2024.

WHO-5

On average, SP participants had a 20.54 increase in wellbeing according to WHO-5 scores. However, the lack of disaggregated data for this wellbeing measure makes it impossible to assess these changes on an individual level (as shown in Appendix 3).

Qualitative Interviews

Interviews were conducted with SP participants in order to ask them about their experiences participating in the SP programme. During these interviews, participants provided basic demographic information.

Background of Participants

Of the 11 interviews which were conducted, six were with female SP participants and five were with male SP participants. Two participants were born outside of Ireland (i.e. France and China) and one participated in the interview with the support of a skilled interpreter. On average, participants were 53.3 years of age, with the youngest being 33 and the eldest being 69. All participants had lived in the area for at least 2 years, with some residing in the NEIC for their entire lives.

Self-reporting revealed that interview participants spent approximately 5 to 18 months (mean=10.9 months) engaging with the SP programme. Looking at their quantitative wellbeing scores, on average participants SWEMWBS pre score was 21.78 (N=9) and their post score was 23.78 (N=8), with an average increased wellbeing of 1.60 (N=8). Although the group average shows an overall increase in wellbeing at the individual level three individuals show decreased SWEMWBS scores of -2.45, -0.9 and -1.16.

Although the reduction in wellbeing scores for some individuals in this population indicate quantitative evidence of disimprovement, the comments that these same individuals made during their interview highlight key areas of positive change which have resulted from participating in the SP programme. It is not clear why this discrepancy in the two datasets occurs. The following section covers the results from the qualitative interviews conducted as a part of the SP evaluation.

Referred because of isolation and loneliness

Ten of the eleven participants expressed having feelings of anxiety, depression, loneliness or isolation prior to their engagement with the SP service. They were referred by counsellors, social workers, GPs and dieticians who had heard about the SP programme and recognised the potential benefits to their clients/patients.

One SP client who was interviewed had a history of depression which he had struggled with for years. When asked about why he was referred to the SP programme, he said "because I needed a bit of motivation ... [At that time] I would just sit at home and watch TV all day". Another participant highlighted that "the people that would most benefit off the top of my head will be people [who are solitary] or just isolated, normally closed off."

"Basically, it was loneliness and isolation. I live on my own. And I've lived more or less like, navigate on my own. But, like, worked up till May 2020. Then I retired, and then COVID is also around at that time ... because I was working from home for a while. [I] also isolated at the same time so basically, to kind of phrase that has gone up the walls basically, basically, work has been delivered to my house once a week and it was in my front room. You know, a lot of paperwork and stuff like that, and I just couldn't deal with it. So after a few months of that, I just contacted him and said, I want to go over. I had done 42 years anyway... But then, like with the COVID and all that and then you know having all that time on my hands. Yeah, it was probably like retired and then also retired during COVID lockdown. Yeah, it was a bit much, you know what I mean but you know, you couldn't even meet people for a long time."

He felt that "those two" problems, of loneliness and isolation were "crushing" him.

For another participant, depression, mental instability, hospitalisation and subsequent homelessness were cited as reasons for referral:

"Because I became homeless at the beginning of COVID. Just before COVID there was, I was in hospital for four months. Because in December... I took two months supply of my medicine. When I wasn't in the right frame of mind, and I wasn't getting any ups. I was unwell. So that made me homeless."

Illness and homelessness were mentioned again as reasons for referral. One female participant living in temporary accommodation spoke about her long-term health status "See, I wasn't well for a long, long time. I didn't know what was [expletive] wrong with me. Diabetes. Me [expletive] sugar levels [inaudible] sky high." She went on to express dissatisfaction and concern at being placed in a hostel with active drug users. She stated that "the hostel. ... only give you six months, I don't take drugs I don't take anything like that. What am I in [expletive] here for?" The combination of her health status and challenging living conditions resulted in her becoming increasingly stressed.

In addition to inadequate housing conditions, participants expressed dissatisfaction due to the lack of safety in their neighbourhoods, including safe places to walk and spend their time outdoors. For one female participant this was a particular concern as her neighbours were regularly engaged in antisocial behaviour. Through her interpreter, she stated that "I don't have any personal dispute with my neighbours. I'm [a] single lady and we have a lot of men in the community. I don't have much contact with them." She later mentioned that she was fearful whenever she left the house as there were often fights and she did not feel that the Gardai were able to manage the situation with her neighbours' antisocial behaviour.

As such, she rarely left the house unless it was for a specific purpose (e.g. work or shopping) and did not feel comfortable inviting friends over. She also faced challenges around accessing a skilled interpreter, which may have exacerbated her situation of feeling isolated and socially distanced. She felt that "five years [ago] due to some errors in the translation [and] interpretation" she had been assigned to the accommodation in that area. In addition to a stressful living environment, she was facing high levels of stress at work and began facing challenges with her mental health.

Individual level variables: Personality and Lifestyle

The question of personality preferences and types were raised by two interviewees. They both raised the individual preferences and personality types as variables which can influence a person's ability to deal with loneliness.

"Because like, some people are okay, living a solitary life. But I'm a social animal. You know? I think I'm at my best when I'm with people, meeting people, you know, so a simple interaction, like, say, in the coffee shop or something like that... but like, I suppose being idle is the worst thing in the world for you know, especially if you're living on your own."

Differences in personality and changes in life circumstances can influence individual levels of engagement in the social prescribing programme. The story of one female participant in her mid-thirties is described in Box 1.

Box 1: Social Prescribing Programme participant case study (May-November 2023)

When asked about reasons for referral she stated:

"I was in counselling for issues. And I have at the moment, one of the main issues I'm, I'm living in a one bedroom apartment with [multiple] children, myself and my husband. So I'm really struggling with so when I was in therapy, he, me counsellor, referred me on to social prescribing to see could they help me with medication I was in forms and things like that, just to help me and kind of put me into different whatever might be going on around the area that might help me with these situations, you know?"

She then went on to talk a bit about her experience with the SP programme:

"[The link worker] wanted to help me find somewhere if I wanted to keep me occupied in the mornings to be able to interact with other parents so that I don't feel so secluded. ... To be honest with you, I'm I'm a very secluded person, I haven't taken up on going to these places. But [the link worker] made me feel comfortable enough to be able to kind of come back to it and say like if I need to come back to you, is it okay to go to these places and to say that was fine. Right now I'm kind of I'm very secluded in myself so I'm not really a mixer at the moment."

Her life had been quite busy and she has had caring responsibilities for multiple family members which has not allowed her to have any personal time for herself. Although she was in contact with the social prescribing link worker throughout her five month enrolment in the SP programme she was unable to avail of any of the opportunities presented to her. For example, although she was aware of the SP coffee mornings, she was not able to attend.

However, she now is aware of supports which might be helpful in the future and knows where to find someone to aid her in accessing community supports through her contact with the SHCP. She mentioned this knowledge as a positive outcome from her experience with the programme.

"Yeah well to know it's, it's a very comforting thing to know that I have somewhere to go with I am in any which ways, you know, feeling lost. And they feel like I need help. Because I am. Most of the time I do kind of keep to myself, and I don't like asking for help, you know. So to know that I can kind of go to [the link worker] or anybody else that might be in this in the centre or wherever it may be. That's out there to reach out, you know what i mean ?. So I for myself I'm because I'm so secluded any help she has kind of offered to me. I've been like, yeah, yeah, I'll do that. And then I've not done it myself. But for other people that might not be as secluded as me, I say, it'd be very, very helpful. You know, people that are looking to go and interact, what other people or, you know, get out into the community. It's a very great service.

Although she did not engage with any of the suggested social prescriptions, her wellbeing scores show an improvement in wellbeing (e.g. increased SWEMWBS score by 1.1).

All interviewees stressed that SP link workers who were supporting them were able to assess their personalities, needs and abilities, factoring them in when making social prescriptions. Staff were also described as being persistent in trying to find opportunities which fit best with the client's wishes and staff were also portrayed as having a willingness to pursue additional opportunities when hurdles presented themselves (e.g. if a group was not suitable to the client or if the location where an activity was being held was discovered to be not accessible).

SP Experiences

The experience of engaging with SP was transformational. This experience began to change people's lives from the first contact:

"So anyway, then [the link worker] got to work as on the team, social prescribing team, and things started happening, and he was giving me ideas, things I could do and ways to find solutions to those two problems."

However, finding the time between responsibilities can be challenging for some participants and those challenges may be insurmountable (e.g. Box 1). For other participants, they are able to set aside a bit of time to engage with some of the suggestions made by SP link workers:

"So like my life, kind of included commitments that are outside of their social prescribing program. So it was a case of factoring things in do you know what I mean? Yes. Like, because I have other responsibilities"

One interviewee spoke about how the link worker who supported him kept him motivated and engaged with the programme and about the resulting effect:

"[the link worker] kept me motivated they kept me in there but didn't let the pressure [get to me]. [I] could have got depressed and given up all together again something came my way and [it] gave me the hope".

Another link worker was also praised by her client, who had been struggling with physical as well as mental health issues:

"And everything she's after doing for me and as I said you just have to take me from a dark place. You know I'm more happy now in myself and love life and all that but before when my nurse went I was really down do you know what I mean? and didn't care about life or care about anything."

Link workers also ensure that all SP participants, regardless of their background and language needs, are adequately supported to communicate with staff. During the one exit interview which occurred with the support of an interpreter, the SP participant spoke about her challenges in finding a good interpreter that she felt comfortable with and the support provided by the SP link worker in helping her to find a good interpreter.

"[?If you could have come a bit earlier then I would have too much trouble because I sometimes, I really don't, I don't want to meet some interpreters?] Afterwards I would like to be with [the link worker] ... because she knows me so well and she's so kind. The patience with me. We need just such a person with, full of, full of positivity. It's the effectual thing."

Positive Outcomes

SP participants mentioned a variety of positive outcomes which improved their physical health, mental health, diet, future outlook and gave structure to their week. All participants stated that they had positive experiences with the SP programme, with some making general statements about "feeling better" or that their "health has improved". Others stated that their diabetes, mobility or physical health had improved from attending the social prescriptions recommended by the link worker.

In addition, the structure provided by attending the social prescriptions was recognised as a benefit that participants repeatedly brought up. Participants enjoyed engaging with a variety of programmes that aligned with their interests, for example Healthy Food Made Easy, Wellbeing and Stress Management and Chair Yoga. The SP coffee mornings "were nice because every week could be a different person coming in doing a speech about whatever, like healthy food or mindfulness. It was different every week to go to who knows [the] introduction for me to try [to] resocialize myself." Another participant also really enjoyed the informality of the coffee mornings and saw them as a good way to engage with other community members: "I just prefer like a coffee morning when you get to meet people. Like I said, you get older and even make all new friends you know".

One person stated that "it's nice there's somewhere for people to go when we don't really have somewhere to go". He went on to highlight the activities to which he had been referred. These programmes included Wellbeing and Stress Management and SP Coffee mornings.

"Well, I mean, they were, they were actually, I found them good. I found them actually great. Because like you were getting out, you were, you were socialising, and you were meeting new people, you know, so- and you were talking to like, about similar things, basically, in common with others. What they're going through and, you know, that sorta thing, like."

For some participants it might take a few attempts to find a group which was appropriate. For one elderly gentleman, this was the case. The link worker that supported him in finding a social group which was suitable for his age and his interests. In the first group he felt that he "wouldn't have found friends" and that he "wasn't happy in that, that kind of club, elderly club". However the SP link worker tried again to find a group which would meet the participants' needs. When describing the second group he tried the participant said that

"the moment you walk in yourself to welcome yourself totally vibrant in atmosphere and everything and it's and it's brilliant. And I wouldn't miss it. I go there four days a week and I wouldn't miss it. It kind of makes a big difference in my life and to my mental state."

He even engages with individuals who he met in the programme outside of the scheduled group meeting times, including on weekends.

"Sometimes at the weekends people might still be able to get my number. And I've got their number on two occasions, we've also someone's given me a call, feeling a bit under the weather, depressed, and so on. But if you can't get like, Let's go out for coffee cup, we'll meet up a cup of coffee and it kind of cheers them up getting up as we sit in our rooms were elderly, and we're lonely. Some people because their other half has passed away, or they're, they're feeling a bit of having an opposition. And you just want to have some company and just talk to someone and have a stellar couple of hours and reach out and so on. And that happens quite a lot."

This shows an extended change in the person's life in which they have been able to expand their social network in a meaningful way as a direct result of the social prescription made through the Co-op SHCP SP programme. This participant went on to clarify that although he was in counselling, that he wouldn't have been able to change his life without the support of the SP link worker.

Another male participant found the SP programme useful as it helped him to improve his mood while moving towards his goal of re-entering back into employment. He said:

"I found it very useful because at the time my mood was quite low because I found myself unemployed after being after a long period of being employed in full employment like so. It was good to talk to somebody"

The following section summarises the personal impact demonstrated by the participants.



4. Personal Impact

4. Personal Impact

4.1. Improved wellbeing across a variety of clients

SP participants come from a variety of backgrounds, some of which can be challenging to reach. The individuals who are difficult to access represent a diverse group encountering numerous barriers, including social exclusion and socioeconomic disparities, which can detrimentally affect their health.

Overall, evidence from both quantitative wellbeing scores and qualitative interviews show improved short term wellbeing outcomes for SP participants who have exited the programme. Few participants showed decreased wellbeing scores. However, interviews indicate that several participants attribute their positive outcomes as a direct result of engaging with the SP programme. Not all were able to pinpoint exactly what it was about the programme that they found beneficial. However, a portion of participants indicated that improved wellbeing was a direct result of interacting with SHCP staff (in particular the SP link workers). Link workers were consistently portrayed in a favourable manner and many of the programme benefits were attributed to their efforts. Similar findings were found in the interviews and focus groups that were conducted in the [SHCP evaluation \(2023\)](#).

Additionally, there were a number of other personal impacts, which are outlined below.

4.2. Decreased feelings of isolation

Participants from various backgrounds felt that their feelings of isolation and loneliness had been lessened. This was the case for participants who were newer to the area, as well as those who had been lifelong residents.

4.3 Social network expansion and re-connection

Social network expansion through meeting other members of the community and reconnecting with past acquaintances, were benefits which participants mentioned during interviews.

Expanding social networks facilitate broader connections and opportunities for individuals to engage with diverse perspectives and experiences. Furthermore, reconnection within these networks can foster a sense of belonging and support, promoting mental well-being and community cohesion.

4.4. Engaging in old interests and discovering new ones

SP link workers ensured that participants found activities that were of interest to them by getting to know what the participants were interested in, as well as understanding what courses/programmes might benefit the participants overall health.

Participants learned through a variety of programmes in the community. Learning through community programmes offers a wealth of benefits, fostering collaboration and social interaction among participants. These programmes often provide access to diverse perspectives and experiences, enriching the learning environment. Specific programmes hosted by the HCP are described in the [2023_HCP_programme_evaluation](#).

Engaging in old interests revitalises nostalgia and reinforces personal connections to past experiences, fostering a sense of continuity and identity. Discovering new interests stimulates growth, creativity, and adaptability, enriching life with fresh perspectives and opportunities for personal development.

4.5. At the client's pace

SP link workers engage with the client at the client's own pace. Repeated contacts with clients and referrers show that link workers are using multiple avenues of communication to understand the situations that clients are facing. This allows for informed social prescriptions to be made.

In addition, link workers follow the pace set by the client. At the time of exiting the programme, clients expressed that the knowledge that they gained from the link worker was beneficial, regardless of whether they participated with the prescribed activity. If the client is not ready to engage at the time of contact then the link worker will provide them with information on programmes available in the community and let them know that they can always come back to them through the self referral process.

4.6. Hopefulness, trust and a more positive outlook

SP link workers took the time to understand participants' daily lives and their needs. This allowed them to make social prescriptions which were interesting and appropriate. As evidenced by the interviewee whose schedule was too busy and she exited the SP programme without engaging with a single course, there are benefits and a change in outlook which can come from engaging with SP staff and knowing what possibilities are available.

General improvements to a person's circumstances, through support from the link worker in accessing external support services needed by SP participants in their daily lives, led to participants having a positive experience. These supports included access to a reliable and competent interpreter and assistance with finding housing supports (in this study) and access to mobility supports (in the [SHCP evaluation \(2023\)](#)). Support offered by SHCP link workers outside of their main responsibilities of providing social prescriptions (e.g. arranging appointments with GPs, supporting housing applications, locating key workers, finding skilled interpreters, etc.) helped to reinforce a relationship of trust and respect between the link worker and the programme participant.

5. Areas for Learning, Improvement or Expansion

5. Areas for Learning, Improvement or Expansion

5.1. Extending the wellbeing assessment

This research included short-term assessments of participant wellbeing. However, both the post SP wellbeing questions and the qualitative interviews were conducted on the day of, or shortly after the client had exited the programme. Therefore it is not possible to determine the long-term impact of the SP process on participants.

- Recommendation 1: Include a follow up of SP participants to determine long-term progress/impact after completion of the programme: quantitative scores (e.g. SWEMWBS) and qualitative interviews.

5.2. Highlighting the importance of documenting interventions

The documentation of the interventions recommended to each participant were not consistently available in Elemental. Some of these data are recorded in the notes, which were not accessible for this research. It is therefore not clear if no social prescription was made for some participants or if the data were not entered into Elemental. This is a historic issue as more recent clients have interventions recorded.

- Recommendation 2: Continue to record all interventions/social prescriptions in Elemental for each participant's record.

5.3. Attendance of interventions

For the majority of interventions it is also not clear which were ever attended by the participants. Attendance is already being recorded in Elemental for the SHCP Coffee mornings. However, for the other interventions which are recorded for participants there were no values entered. Thus, it is not possible to determine from the database if participants ever attended any of the other interventions which were recommended.¹⁰

¹⁰ These data may be recorded in the notes in Elemental, but these data are not available for research. This is discussed in the [SHCP evaluation \(2023\)](#)

- Recommendation 3: Systematic documentation of which interventions were attended by the programme participant would be useful to assessing the efficacy of the programming available. This could be done by recording attendance for all SHCP run courses (e.g. Healthy Food Made Easy). For courses not run by the SHCP, questions could be asked during the regular meetings and the exit interview between the SP participant and the link worker.

5.4. Increasing availability of information on participants

The current version of Elemental aggregates much of the demographic data on SP participants. Other individual level variables, such as “reasons for referral” and “cohort” are also automatically aggregated in Elemental.

As discussed in the SHCP evaluation (2023), the lack of access to such information, through the data being aggregated, makes it impossible to investigate journeys and assess outcomes based on vulnerable group status (e.g. disability status or ethnic background). In addition, investigating the role of intersectionality is not possible without these quantitative variables included.

- Recommendation 4: Individual level data on programme participants should be made available in a disaggregated format. This issue needs to be raised again with Access Group, the software company which distributes the Elemental software.

5.5. Promoting and increasing accessibility to outdoor activities/programmes

Access to safe outdoor places to exercise and socialise are limited in the NEIC. Multiple participants in interviews and focus groups for this study and the SHCP evaluation (2023) have requested that safe outdoor “green” spaces in the NEIC are made available to members of the community. These spaces need to be inviting and include benches and resting places so that people are able to sit and relax. A lack of outdoor seating and safe pathways would exclude many members of the community from utilising the space as it would not be accessible to community members who may be elderly, ill or have a mobility challenge.

- Recommendation 5: Work towards increasing safe access to parks and safe recreational areas in the NEIC.
- Recommendation 6: Seek out and promote additional community supports which are able to fill this need.

5.6. Encouraging the uptake of a national CRM

The Department of Health and the HSE have put considerable investment into the SHCPs, nationally, and there is evidence that these initiatives are having a positive outcome on local communities. However, the administrative burden of monitoring and managing services is placed on the projects themselves. SP programmes use an array of purpose built and bespoke tools for managing their client data.

There are a number of benefits to using an established CRM designed for social prescribing, like Elemental. However, there are considerable limitations when it is not possible to make adjustments and additions easily to the standard package. In addition, a standard CRM which is used nationally for all of the SHCPs and one which would allow the HSE to access the necessary data for KPIs would allow for an efficient use of staff time and to minimise paperwork as HSE staff would be able to access the data they need for KPI reports directly.

- Recommendation 7: Push for a national CRM to be developed for the management of client data, which should be set to national standards yet be informed by the experience and needs of the local areas.

6. Conclusion

6. Conclusion

In conclusion, this report evaluates the work to date conducted by the social prescribing programme at the Co-op. This evaluation investigated the journeys of participants and their short-term outcomes as determined by wellbeing scores and post-exit interviews.

By speaking with clients and listening to their needs, SP link workers develop a trusting relationship with clients and work towards recommendations which meet the needs of the clients as well as the concerns of the referrers. The personal impacts of the SP programme are significant, with clients showing a variety of benefits at different levels of engagement with the programme.

Data from the database (i.e. increased wellbeing scores post intervention) as well as client interviews (i.e. declared improved wellbeing at time of exit interview) show improved client wellbeing, with clients feeling improvements from the nature of the intervention itself. That is, clients benefited from the SP process itself: someone listening to them, listening to their needs and finding tangible supports to access. SP clients stated that they benefited from engaging with particular social prescriptions which were aligned with their interests or goals.

Furthermore, SP clients reported a reduction in feelings of isolation and loneliness, increased feelings of hopefulness, along with enhanced social connectedness through participation in community programmes, leading to increased interactions with fellow community members. Engaging in a diversity of community activities has provided them with a sense of daily or weekly structure, contributing to an improved emotional outlook since they commenced the programme. The whole process follows a person-centred approach, ensuring that the programme moves at the client's pace.

The importance of these findings expands on those found in an earlier report ([SHCP evaluation \(2023\)](#)) which included an evaluation of all programmes run by the SHCP. We know from the [SHCP evaluation \(2023\)](#) that the SP programme is integrated within the SHCP. Where needed, link workers provide feedback and raise concerns with other members of the team. In addition, SHCP staff (i.e. community health workers and programme management) provide support for additional programming specifically for SP participants. The SP coffee mornings is a programme of particular benefit to clients which allows them to engage socially with each other and experience taster sessions of a variety of programmes offered in the community on a casual basis.

The SP coffee mornings are designed to cater to the more general needs of SP clients and brings a more group-based element to the SP participants' SP journeys.

Having an understanding of the long-term impacts of SP is of key importance. As of yet, there is no indication of how long the effects of the intervention (i.e. SP) endure and to what extent the benefits observed here in this research are exhibited later on in life. Future research should be designed to better understand the demographic trends in the SP client population which were not possible in this small scale, short term study, with limited access to the demographic data. It would be important to pay particular attention to how intersectionality may influence the ways in which individuals engage with the SP programme (e.g. gender or ethnicity).



References

References

Bannigan, K., & Watson, R. (2009). Reliability and validity in a nutshell. *Journal of Clinical Nursing*, 18(23), 3237-3243. <https://doi.org/10.1111/j.1365-2702.2009.02939.x>

Bhattacharjee, A. (2012). Scale Reliability and Validity. In *Social Science Research: Principles, Methods, and Practices* (pp. 55–64). CreateSpace Independent Publishing Platform.

Haver, A., Akerjordet, K., Caputi, P., Furunes, T., & Magee, C. (2015). Measuring mental well-being: A validation of the Short Warwick-Edinburgh Mental Well-Being Scale in Norwegian and Swedish. *Scandinavian Journal of Public Health*, 43(7), 721–727. <https://doi.org/10.1177/1403494815588862>

Jolliffe, R., Seers, H., Jackson, S., Caro, E., Weeks, L., & Polley, M. J. (2015). The responsiveness, content validity, and convergent validity of the Measure Yourself Concerns and Wellbeing (MYCaW) patient-reported outcome measure. *Integrative Cancer Therapies*, 14(1), 26-34. <https://doi.org/10.1177/1534735414555809>

McKay, M. T., & Andretta, J. R. (2017). Evidence for the psychometric validity, internal consistency and measurement invariance of Warwick Edinburgh Mental Well-being Scale scores in Scottish and Irish Adolescents. *Psychiatry Research*, 255, 382–386. <https://doi.org/10.1016/j.psychres.2017.06.071>

Ng Fat, L., Scholes, S., Boniface, S., Mindell, J., & Stewart-Brown, S. (2017). Evaluating and establishing national norms for mental wellbeing using the short Warwick-Edinburgh Mental Well-being Scale (SWEMWBS): findings from the Health Survey for England. *Quality of Life Research*, 26(5), 1129–1144. <https://doi.org/10.1007/s11136-016-1454-8>

Paterson, C., Thomas, K., Manasse, A., Cooke, H., & Peace, G. (2007). Measure Yourself Concerns and Wellbeing (MYCaW): an individualised questionnaire for evaluating outcome in cancer support care that includes complementary therapies. *Complementary Therapies in Medicine*, 15(1), 38-45. <https://doi.org/10.1016/j.ctim.2006.03.006>

R Core Team (2020). R: A language and environment for statistical computing. R Foundation for Statistical Computing, Vienna, Austria. URL <https://www.R-project.org/>.

Appendices

Appendices

Appendix 1 - Interview topic guide¹¹

Introduction

- Interview length
- Overview of topics
 - Confidentiality of data
 - Consent/recording

Demographic profile of social prescribing programme participants

- Could you tell me a bit about yourself?
- What is your age, gender?
- What is your nationality?
- When did you arrive in the NEIC? When did you move into your current residence?

Social prescribing programme

- Why were you referred to the social prescribing programme?
- What was your initial conversation about?
- What activities were you referred to?
- What has being engaged in those activities done for you?
- What has your relationship been like with the CHWs?
- What other activities/courses did you partake in?
- Would you recommend the social prescribing programme?

¹¹ Note: questions will vary with interview participant background and experience.

Appendix 2 - List of Interventions

- [Acquired Brain Injury Ireland](#)
- [Age Action](#)
- [AWARE Online Programmes](#)
- [Beaumont Hospital Mindfulness and Relaxation Centre](#)
- [Care After Prison Family Support](#)
- [Chrysalis](#)
- [City of Dublin Education Training Board](#)
- [Croi Physical Activity & Exercise](#)
- [Crosscare Community Cafe](#)
- [Crosscare Food Poverty Support](#)
- [Crosscare Migrant Support](#)
- [DALC \(Dublin Adult Learning Centre\)](#)
- [Daughters of Charity Community Services](#)
- [Dublin City Community Co-op](#)
- [Dublin City Community Co-operative Healthy Communities Project](#)
- [Dublin City Council Social Work Section](#)
- [Dublin Counselling & Therapy Centre](#)
- [Dublin Northwest Partnership Employment Services](#)
- [Early Learning Initiative National College of Ireland \(Restorative Practice Support Group\)](#)
- [European Health Insurance Card](#)
- [Exwell Medical](#)
- [Finglas Training Centre](#)
- [Foundations Project Dublin](#)
- [Free Legal Aid](#)
- [Friends of The Elderly](#)
- [Frontline Alcohol Hub](#)
- [Headway Brain Injury Service and Support](#)
- [Healthy Food Made Easy](#)
- [Hill Street Family Resource Centre Family Support](#)
- [Housing Welfare Section, South Dublin County Council](#)
- [Inner City Organisations Network](#)
- [Intreo Office Parnell Street](#)
- [Irish National Organisation of the Unemployed](#)
- [Irish Refugee Council](#)
- [Living Well Programme](#)
- [Lourdes Day Care Centre](#)
- [Lourdes Youth and Community Services](#)
- [MABS Money Advice and Budgeting Service](#)
- [Maynooth University Return to Learning Certificate](#)
- [Meitheal Family Support](#)
- [Mens Shed Swords](#)
- [Mind Yourself! Men's Health & Wellbeing program](#)
- [New Communities Partnership](#)
- [Oasis Counselling Service](#)
- [Ozanam House Men's Group](#)
- [Ozanam House Retirement Group](#)
- [Parenting While Separated](#)
- [Parnell CDETB](#)
- [Primary Care Centre Occupational Therapy](#)
- [Primary Care Team Central Referrals Office](#)
- [Primary Care Team Social Work](#)
- [Safety Net](#)
- [Seafield Strollers Walking Club](#)
- [Snug Counselling](#)
- [Social Prescribing Information Coffee Mornings](#)
- [St Lawrence O Toole Gym](#)
- [Strength Through Diversity Project](#)
- [Sunflower Recycling](#)
- [SUSI Grant Information](#)

- [Swan Youth Service SUSI Application Workshop](#)
- [Swan Youth Services Yoga Classes](#)
- [Tai Chi Class](#)
- [The Irish Heart Foundation Stroke Connect Service](#)
- [The Larkin Centre](#)
- [The Spellman Centre RDRD](#)
- [UCD Access Course](#)
- [We Can Quit Smoking Cessation Programme](#)
- [Wellbeing and Stress Management](#)
- [Wellness Stress Management Class](#)

Appendix 3 - Scores and change on wellbeing measures

Figure 6. Major categories of concerns raised by participants (N=126) in the MYCaW Concern subscales.

Assessment	Item	N	Pre-SP scores		Post-SP scores		Change		Test statistics		
			Mean	Variance	Mean	Variance	Mean	Variance	t ¹²	Z ¹³	p
Measure Yourself Concerns and Wellbeing (MYCaW)	General	38	10.74	14.31	4.76	18.13	-5.97	23.92	7.53	-	<.001
	Concern 1	38	4.87	2.60	1.79	3.31	-3.08	4.89	-	575.5	<.001
	Concern 2	24	4.71	2.82	1.96	4.48	-2.75	7.76	-	104	<.001
	Wellbeing	38	2.74	2.85	1.74	2.42	-1	3.73	3.19	-	0.003
Short Warwick-Edinburgh Mental Wellbeing Scale (SWEMWBS)		40	21.37	20.39	24.45	18.43	+3.09	17.83	-4.62	-	<.001
World Health Organisation Wellbeing Index (WHO-5)		37	-	-	-	-	+20.54	-	-	-	-

Source: Elemental data, 2021-2023.

¹² Paired samples t-test.

¹³ Wilcoxon signed rank test, performed on MYCaW Concern 1 and 2 data as these data do not satisfy the assumption of normality.

Appendix 4 - MYCaW Concerns

Table A2. Participants' (N=126) coded responses to the MYCaW Concern subscales

Category	N	%¹⁴
Health & wellbeing	74	58.7
Exercise	2	1.6
Healthy eating	11	8.7
Mental health supports & mood	27	21.4
Physical health, chronic illness, & mobility	25	19.8
Self-care	3	2.4
Alcohol, drug use, & smoking	6	4.8
Exercise	2	1.6
Personal, vocational, and educational development	39	31.0
Volunteering	4	3.2
Education	9	7.1
Employment	6	4.8
Hobbies & skills	16	12.7
Language & communication	4	3.2
Family & relationships	88	69.8
Social & community engagement	61	48.4
Social isolation	10	7.9
Supporting others	2	1.6
Parenting & childcare	5	4.0

¹³ Percentage values sum to more than 100% as some participants listed multiple concerns.

Family support	10	7.9
Literacy & awareness	31	24.6
General literacy	1	0.8
Digital literacy	6	4.8
Completing forms	2	1.6
Information needs	9	7.1
Daily living	31	24.6
Cleaning	1	0.8
Financial support	2	1.6
Housing	19	15.1
Routine/structure	7	5.6
Transport	2	1.6
Other		
Advocacy	1	0.8%
Migration	1	0.8%
Legal aid	1	0.8%
Spirituality & religion	1	0.8%

Source: Elemental data, 2021-2023.





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