Ollscoil na Gaillimhe
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A Realist Evaluation of HSE-Funded Social Prescribing Services in Ireland

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Abbreviations

ADHD	Attention Deficit Hyperactivity Disorder
COPD	Chronic Obstructive Pulmonary Disease
CE	Community employment
CHO	Community healthcare organisations
ComOrgX	Community organisation
CMO	Context mechanism outcome
CBA	Cost benefit analysis
SUEstX	Established service user
FRC	Family Resource Centre
GP	General Practitioner
HSCP	Health and Social Care Professional
HL	Health literacy
HPIM	Health Promotion and Innovation Manager
HRQOL	Health Related Quality of Life
HSE	Health Service Executive
HostOrgX	Host Organisation Manager
LW	Link Worker
MTU	Munster Technological University
SUNewX	New service user
OT	Occupational Therapist
RCT	Randomised Control Trial
RefX	Referral Agent
SDT	Self-determination theory
SOC	Sense of Coherence
SU	Service User
SWEMWBS	Short Warwick-Edinburgh Mental Wellbeing Scale
SDOH	Social determinants of health
SP	Social Prescribing
SPCO	Social Prescribing Co-ordinator
SPLW	Social Prescribing Link Worker
TA	Thematic analysis
WRAP	Wellness Recovery Action Plan
WHO	World Health Organisation
WHO-5	World Health Organisation-Five Well-Being Index

Executive Summary

Introduction & Background

Social prescribing is a non-medical intervention that enables health and social care professionals to refer people to a range of local, non-clinical services, primarily provided by the voluntary and community sector (HSE, 2021). It has been described as a holistic, person centred, community-based approach to addressing health and wellbeing concerns. Employing an assets-based approach to empower service users to improve their health and wellbeing, social prescribing aims to increase individuals' social interactions and connections with community services, thereby decreasing levels of loneliness and isolation and improving overall well-being, both mentally and physically.

Social prescribing began in Ireland as a ground-up movement in partnership with the Health Service Executive and the community and voluntary sectors. This resulted in the establishment of the first social prescribing project in Mayo in 2012. Since then, Ireland, similar to other countries, has seen significant growth in the number of operational services and the development of a HSE Social Prescribing Framework in 2021. There are currently 44 HSE-funded social prescribing services in the Republic of Ireland, based on the funding of full-time link worker posts. Social prescribing has a significant policy mandate, with commitments to expand its reach for marginalised and vulnerable groups endorsed in key policy documents, including the 2020 Plan for Government, the national mental health policy, *Sharing the Vision* (Department of Health, 2020), the national Sláintecare Healthy Communities programme, and *Pathways to Wellbeing*, Ireland's first National Mental Health Promotion Plan, 2024-2030 (Department of Health, 2024).

There are several theories that can be used to understand the mechanisms behind social prescribing. Salutogenesis theory, developed by sociologist Aaron Antonovsky, aims to explain how people maintain their well-being and health, rather than focusing on the causes and treatment of illnesses. Other theories that can be used to understand social prescribing include solution focused theory, social cure theory and social capital theory. Salutogenesis theory is the main theory underpinning this current study, together with the concepts of health literacy and empowerment, which are also central to understanding social prescribing.

The international evidence base for social prescribing is broadly supportive, highlighting multiple benefits, including improved mental wellbeing, physical health, health behaviours,

and reduced social isolation and loneliness. However, there is a paucity of rigorous studies of effectiveness and relatively little is known about *how* social prescribing interventions can help improve the health and wellbeing of its service users. This evidence gap in social prescribing arises primarily due to small-scale evaluations studies that lack methodological rigour. Additionally, the varying aims and delivery models of these services make it difficult to synthesize, compare, or pool data and information. There is a lack of in-depth and robust evaluation studies, which are essential in order to establish the effectiveness of social prescribing and to examine how it works and for whom and under what circumstances it is most effective. Realist evaluations are increasingly being used to explore these questions. While there have been some small-scale evaluations of specific social prescribing services in Ireland, to date there has been no extensive evaluation that encompasses all the key stakeholders involved in this complex intervention.

Study Aims and Objectives

The current study aims to conduct a realist evaluation with key stakeholders nationally to address the question of what works, for whom, under what circumstances and how, in the Irish context. This approach seeks to provide a more nuanced and context-sensitive evaluation, capturing the breadth and complexity of social prescribing in Ireland, compared to more traditional programme evaluation approaches.

The specific objectives of this study are:

- To determine the active ingredients of social prescribing to inform future training and best practice in terms of social prescribing in the Irish context.
- To ascertain how social prescribing works for different population subgroups and for whom social prescribing is most effective.
- To identify facilitators and barriers to high-quality implementation of social prescribing.
- To determine the social, health, and well-being outcomes that social prescribing is most likely to impact and thereby, inform a more robust evaluation of the impact of social prescribing on immediate and long-term outcomes.

Methods

This study adopts a realist evaluation approach, which is a theory-driven form of evaluation, that recognises that not every intervention will work for each person in the same way and that wider context influences outcomes. Realist evaluations identify context (C) mechanism (M) and outcome (O)configurations as programme theories, which are then tested and refined against the study findings. Underpinned by the principle that context will trigger mechanisms to yield outcomes, a realist evaluation seeks to answer the questions: **what works for whom, under what circumstances, why, and how?** This realist evaluation was carried in two phases as follows:

Phase 1: Initial Programme Theory (IPT) and Context Mechanism Outcome (CMO) Configuration Development

Initial programme theories (IPTs) were developed through discussions with key HSE stakeholders, reviews of the current literature and evidence base, and consultations with Advisory Board members. The programme theory helps to explain how specific intervention mechanisms operate within a given context to produce certain outcomes. CMOs were developed for the three stages of the social prescribing programme: (i) referral of service user to the social prescribing services, (ii) interactions between the service user and the Social Prescribing Link Workers (SPLWs), and (iii) interaction between the service user and the community organisations.

Using an iterative process with feedback from stakeholders and refinement, the hypotheses, or initial CMO configurations with 'if/then/because' statements for the three stages of social prescribing service, were developed. Based on these CMO configurations, the final overall **Initial Programme Theory** was developed as:

'The supportive interaction between link workers and service users, and the referral to appropriate community activities are central to empowering service users in addressing the determinants of health that are relevant for them to improve their health and wellbeing'.

Phase 2: Study Design and Data Collection Tools

The CMOs and IPT were used to guide the development of the interviews with the key stakeholders. The interviews sought to capture both the strategic and operational aspects of social prescribing services in Ireland. Interview guides were developed for each of the following six groups of study participants: SPLWs, service users, referral agents, community

organisations, Health Promotion and Improvement Managers, and host organisation managers.

Sampling

The study included 22 social prescribing sites located across the country. Purposive sampling was used to recruit service users from HSE-funded social prescribing services. Link workers, host organisation managers, and Health Promotion & Improvement managers were the first stakeholder groups to be recruited, through an email sent by the programme manager of the HSE Health and Wellbeing Programme to attend an information session held by the research team via Microsoft teams. After this meeting and their expression of interest, the research team followed up with them to arrange interview dates. Every participant SPLW was asked to identify up to four service users to invite to partake in the study. The contact details of the service users were passed onto the research team once they gave permission of the SPLW. The research team then contacted the service user to set up a suitable interview date. With regard to referral agents and community organisations, half of the SPLWs recruited up to two referral agents, and half of the SPLWs recruited up to two community organisations.

Data Collection Methods

Semi-structured interviews were carried out via zoom/teams, phone calls and in person from October 2024 to March 2025. Other data collection methods included service level data and information on service user demographics collected through the host organisation managers.

Data Analysis

Thematic analysis (Braun & Clarke, 2006) of the interview data was carried out via NVivo. Coding frameworks were developed for each interview type (e.g., service user interviews, SPLW interviews, etc.), which included deductive codes from the interview guides (based on CMOCs) and inductive codes from the data. The coding and analysis was discussed amongst the research team to ensure inter-rater reliability. The analysis also involved an ongoing comparison and testing of findings against the IPT and CMO configurations.

Results: Findings from Stakeholder Interviews

A total of 135 participants from the nine HSE Community Healthcare Organisations (CHO) were recruited to take part in semi-structured interviews with a member of the research team. Participants were recruited from the following stakeholder groups:

Participant Profiles

Stakeholder Group	**Number of Participants (%)**
Service user	55 (41)
Social Prescribing Link Workers	30 (22)
Referral Agents	14 (10)
Community Organisations	16 (12)
Host Organisations Managers	11 (8)
Health Promotion & Improvement Managers	9 (7)
Total	135 (100)

Of the 55 service users who completed a semi-structured interview, 37 were female and 18 male. The mean age of service users was 52 years (SD=16), with ages ranging from 19 to 78 years. Just under half stated that they lived alone (44%), and the majority were not employed (71%). Just under a third of service users stated that they self-referred to their social prescribing service, while the remaining 69% were referred by a health or social care provider.

The majority of SPLWs (n=21) were based out of Sláintecare Healthy Community (SC) sites, while 9 were based in non-Sláintecare (non-SC) sites. In addition, the majority of SPLWs (n=17) were based in urban cities, with 12 based in rural towns, and only one based in a predominantly rural area.

Both Local Community Development Partnerships and Family Resource Centres served as the host organisation for 12 of SPLWs. The remaining 6 were based in Community Development Projects, and 5 of the SPLWs interviewed for the study were located part-time in a primary care setting.

Referral agents included individuals from a variety of health and social care professions, including general practitioners, clinical nurse specialists, occupational therapists and dieticians, as well as homelessness and domestic abuse support workers.

Local and Rural Development companies accounted for 5 of the Host Organisations that participated in this study.

Results of Thematic Analysis

The thematic analysis of the data set (across all stakeholders interviewed) identified three overarching themes, each aligning with a specific Context-Mechanism-Outcomes configuration.

1. Benefits and outcomes of social prescribing services (Outcomes)
2. The central role of the SPLW in relationship building for social prescribing services (Mechanism)
3. Funding structures and governance issues for social prescribing services (Context)

These themes and related subthemes are set out below.

Theme 1: Benefits and outcomes of social prescribing services

All participants unanimously recognised numerous benefits for service users arising from their involvement in the social prescribing service. The types of support that service user received through social prescribing varied from opportunities to engage in meaningful and enjoyable activities that enhanced their overall well-being to accessing locally available and affordable options that promoted exercise and healthy eating, as well as assistance with everyday practical challenges and access to a range of local services to support their independent living. Participants described experiencing immediate or proximal outcomes leading to more distal or long-term outcomes such as improved quality of life, enhanced mental health and emotional well-being, and, in some cases, a reduction in the use of healthcare services. The following subthemes were identified.

Social benefits

Reduced social isolation and loneliness: Service users discussed how the social prescribing service had changed their ability to cope with situations, as they no longer felt isolated or

alone with their problems. People talked about feeling like they had someone to turn to and could reach out to them.

"I would say it's kind of a link into community. Yeah, it's a stepping stone into the community. If you become isolated for whatever reason, whether it's an actual physical isolation, or whether it's like a social anxiety thing. It's a helpful stepping stone to get you to the community and to see what is out there in the wider world. Yeah, that you might not feel that you can access otherwise." (SUEst33)

Building a sense of community: Service users and SPLWs noted that building a sense of community was crucial to the experience of social prescribing. This sense of community was often derived from a feeling of shared similarity with other members of their group. Participants found comfort and reassurance in simply being around others who shared similar challenges.

"I mean, the most important benefit is social connection. Like I cannot push enough value on the camaraderie and the friendships that they build out of it and their sense of purpose……. it's connection with others, friendships, like-minded people, a sense of purpose, you know, getting out in the day. So, it's all of those benefits which are fantastic." (ComOrg17)

Forming friendships and support of peers: Many service users admitted that before engaging in social prescribing, they found it difficult to initiate social interactions. After joining, they gained confidence in talking to others and forming friendships, which according to community organisation responses, often led to them engaging in social activities outside of social prescribing service.

"*And I was never any good at making friends. I was bullied as a child… And I have like a party coming up later in the month where I'm inviting some of the friends that I've made through events that I've started going to because of inspiration I've taken from the ideas of the social prescriber." (SUEst05)*

Mental health and wellbeing

Sense of purpose and structure: Service users described how social prescribing helped people regain structure and focus in their lives. Regular activities created a sense of stability and gave their lives meaning, particularly those who felt adrift due to life changes, bereavement, or job loss.

"Well. Some other life events have happened, so I'm back. I have resumed my course at the university. I have a routine, you know, like I'm back to my normal life, so to speak, but I think social prescribing was crucial for me when I was in that time period a few months ago, where I was in that slump. I suppose, you know. It was really important that. It was the only good thing going on for me at the time." (SUEst03)

Reduced feelings of anxiety and depression: Some service users described being emotionally 'stuck' or being in a downward spiral, and how social prescribing helped them to get out of that state and maintain a more positive view. SPLWs and community organisation agents also described how service users experiencing social anxiety were able to overcome it and join groups with encouragement and support from a link worker.

"I describe myself as a deflated balloon or a flat balloon, and I need to reflate.
And that's what that does for me. It keeps my spirits up. It's maintenance, I think if
I didn't have it, I'd be going downhill, but this way I'm, you know, I'm maintaining,
and it's dreadfully important that I do because I can't afford to slump, you know" (SUEst01)

Increased confidence and empowerment: SPLWs mentioned that, over time, service users started independently attending activities, finding new opportunities, and reintegrating into their communities. Furthermore, community organisations noted that some service users started their own groups or initiatives and even started leading activities run by their community organisations.

"It gives me more confidence, I'd lot of confidence before, but then as life happens, you know, you kind of lose a bit of confidence. And then when you know you can kind of socialise again with people you know and yeah, that's nice. And that's your groups out there you can just take it out of the house too, because I do get out of the house." (SUNew01)

Physical health

Improved health behaviours: Service users engaged with physical activities as a way of meeting new people, but still experienced the benefits of a walking group, gym session, or yoga class. As a result, many described becoming more active in their daily lives. For some service users, engaging with SP helped them achieve a physical health goal.

"I've also joined classes now and I will park my car in the centre of town and walk to the class that might be half an hour away so I'm kind of gaining, you know, I'm getting an hour's walk in as well so from a physical point of view." (SUEst51)

"Another gentleman recently, he had been referred in by his GP. He was quite overweight, had no kind of daily routine. His eating was all over the place. You know we got him into the Healthy Food Made Easy and got him going to the gym and yes, he was really excited. Like in a very short space of time he'd lost kilos" (SPLW20)

The mental benefits of physical activity: Participants from several stakeholder groups described the reciprocal relationship between physical and mental health. They noted improvements in service users such as improved mood and increased confidence to take care of oneself and having a more positive outlook on life.

"…when I started working on myself and through the mindfulness it gave me and getting out there, and the courses themselves helped as well. Like, yeah, the Tai-Chi……. and then obviously getting better and feeling better has led to me thinking more positively, acting more positively, and hence thinking, yes, I can go back to work, right? I have to go back to education because I don't really have one, but like I can contribute and everything." (SUEst06)

Health service benefits

Improved health literacy: Referral agents and SPLWs highlighted how engagement with social prescribing has led to improvements in how service users understand and manage their conditions and new learning in how to navigate the health system.

"Like one guy came back and when I first saw him, he wasn't checking his blood sugars at all, but he came back. He was checking a good bit. And I was like, oh, you're checking a lot there. And he goes, oh, yeah, the lads in the group kind of encouraged me to check if I'm not

feeling well or, you know, they kind of they kind of said it so I think from an encouragement point of view as well, it's been good". (Ref12)

Reduced healthcare visits and missed appointments: Referral agents provided examples where they saw the potential of the social prescribing service for reducing numbers of repeat appointments and hospital admissions.

"So, you might get a reduction in need to come and use services here, but also people's lives, their quality of their lives would improve. .... Their mental health would improve, but they don't need to be in the service a lot of them once they, because it's loneliness, or once they're busy and enjoying things, their depression lifts. It's usually because of circumstances that their depression is the way it is. So once things change and they link in with things in the community, you know, a lot of them won't need to be here" (Ref14)

Social Prescribing as a wraparound service: Social prescribing emerged as a valued wraparound support that enhances the capacity of health and social care services, particularly in areas of greater disadvantage. Host organisations, and to a greater extent referral agents, consistently described social prescribing as an accessible "open door" into a broader ecosystem of community and psychosocial supports, offering service users a holistic alternative or complement to traditional clinical pathways.

"I think it's kind of a wraparound service for them. In my experience of it anyway, when they decide to engage with it, I think it can open up such a wealth of benefits for them provided they're engaged. ...complete psychosocial, complete physical and psychological as well. Overall, you know a positive health experience really, their general wellbeing." (Ref05)

Practical supports

Practical, everyday supports: SPLWs noted that, alongside supporting wellbeing and community connection, many service users require assistance with practical aspects of everyday life, such as form filling, accessing entitlements, and application support.

"I often find as well, again with maybe a cohort of clients we get, that sometimes if something that's stressing them out, that you can do an initial support with, I find a lot of time, it's

housing applications, or it's checking are they on the right benefits or it's… So, trying to figure out those little pieces first with them. And that can actually help build a bit of trust and you do something quite tangible straight away with someone, ……, because this at moment is what's stressing them out, and being able to recognise that as well." (SPLW08)

Route towards lifelong learning: Engagement with community organisations through social prescribing referrals frequently introduced service users to a range of educational and skill-building opportunities, including computer courses, IT literacy courses, language classes, and life skills or soft skills programmes. Over time, participation in these activities was seen to spark curiosity, self-belief, and motivation to learn, sometimes leading people to pursue further education or vocational training.

"So these are workshops, soft skills, life skills, kind of pr- development type courses. They're not accredited, but they are designed very much to support people who may be experiencing things like, you know, the digital divide might be holding them back from employment or holding them back from achieving their potential. So they may be struggling with technology so we have a workshop around everyday Internet skills." (ComOrg16)

Theme 2: The central role of the SPLW in relationship building for social prescribing services

This theme highlighted the role of the SPLW as being central to the effective implementation of social prescribing services through building and maintaining relationships with all the key actors in this complex programme. This was viewed by study participants as a key active ingredient of social prescribing services in Ireland. This focus is evident throughout all three stages of the social prescribing service (referral, interactions with Service user and interactions with community organisation). Further, this central role of the SPLW was seen as pivotal in bringing about the many positive benefits and outcomes associated with the social prescribing services. Findings indicate that it is the quality of the supportive relationship with the SPLW that is central to Service user' perceptions of the benefits they have received from engagement with the social prescribing services. The subthemes identified, encompassing each of the stages of social prescribing services, set out both the facilitators and barriers associated with the work of the SPLW:

Building relationships and engaging with referral agents

Trusting relationships: HSCPs believe that they have a positive reputation among patients, which can positively influence the likelihood that the service user will attend the initial appointments with the SPLW and their willingness to engage with SP services. The referrer having an insight into how the service works is also important to encourage service user to engage with social prescribing.

"It's all really about relationships. So, it's about my relationship with the patient and my relationship with the social prescriber as well. I think that's huge because then you know, I think if the patient trusts me that I'm going to send them to a service that's going to look after them, and I know the service, the person that's providing them social prescribing, I think that's the key piece." (Ref05)

Lack of integration across health and social care services: Study participants including HPIMs and HSCPs reported varying levels of awareness and knowledge about the availability of social prescribing services among referral agents, with 'pockets' of referral agents, who may then act as 'champions' or 'advocates' of social prescribing in a local context.

Promoting understanding and awareness of social prescribing: Host organisation managers and SPLWs emphasised that it is important to continue to contact referrers, reiterate, and constantly update them about the social prescribing service and the referral criteria.

"They don't know about it necessarily. So, I suppose they're relying on people championing it within services. So, I'm kind of going around and giving leaflets out to other staff members, but until you've put a patient through it, I think there's always a bit of nervousness about – there's a bit of unknown here, like I don't want to refer a patient to something that mightn't be very good. So, there's bit of work to be done, I think." (Ref02)

Understanding the referral process: SPLWs consistently highlighted that the timing of engagement is crucial to whether the intervention is effective. They described how a person's readiness for change determines how well they respond to social prescribing supports. Consequently, referrers must evaluate the appropriateness of referring a service user to a social prescribing service.

"I suppose the way I look at it is a lot of social prescribing is around the timing. So it depends at what stage in person's life or in their illness or in their mental health. But… you know some people the timings, right. And they're coming out of maybe a depression and they're really want to do something, and they're all kind of…motivated to take part in something. And for other people, maybe they're on a kind of a downward wave, and it's just not the right time so." (SPLW03)

Variation in operationalising the referral process: There is variation in how referral agents engage in the referral process, with some having access to online referral forms, and some not. Additionally, current referral pathways lack feedback and follow-up information on how the client fared with SP services.

Person-centered, supportive relationship with service user

*Qualities of the SPLW: Service user*s spoke very highly about their interactions with their SPLW, emphasising both the personal qualities and professionalism of the SPLW in earning their trust. Service users consistently described experiences of feeling genuinely heard, understood, and accepted.

"I found her particularly professional -- A tremendous aid and very efficient and affirming. She was a very good listener and present to me and held my hope." (SUEst30)

Promoting empowerment, agency, motivation: A key mechanism underpinning social prescribing is enabling the service users to bring about change in their lives based on what matters to them. This approach is based on promoting agency and motivation and empowering the service user to have more control over the factors that are impacting on their health.

"But being able to sit down and somebody listen to you here and just point you in the right direction, show you what's out there and just let you choose what you feel you need. It was very easy to use the service" (SUEst06)

"…You are building your relationship with an individual. It's a bespoke service. You are respondent to what they want. They're not doing what they think you want them to

do. They're actually doing stuff they want to do, because that's where the real impact is. So, the benefit is that it's on people's doorstep." (SPLW28)

Impact of assessments on SPLW/SU relationship: Findings show variation across SPLWs in how initial assessments are undertaken and when these occur. SPLWs emphasised the importance of understanding where the service user is at, which determines both the timing of using assessments and how these are implemented.

Community connection role

Knowledge resource for stakeholders: Participants described SPLWs as centralised sources of knowledge, situated within a web of community-based relationships. Service users, referral agents, and community organisation representatives regularly characterised SPLWs as individuals with a deep awareness of the range of supports and services available within their locality, and who could efficiently direct others to appropriate options.

"[SPLW] breadth of knowledge of what's available in terms of well-being supports in [Location] is just encyclopaedic, like [SPLW] is one that we would go to if we were like, have you heard of such a service that might do this? And she'll be able to rattle off, you know, places that we can refer to" (ComOrg16)

Cross-sector collaboration: Some community organisations described SPLWs as central points of contact for up-to-date local knowledge and network sharing. Their familiarity with community assets, coupled with ongoing relationships with clients and providers, enabled them to connect individuals and organisations that might otherwise operate in isolation.
"It's a whole help situation. So, instead of focusing on one thing at a time, if we can bring all these organisations together -- and sometimes being in the community but under the HSE, you have the ability to bring organisations together…". (SPLW10)

Informal service feedback process: Participants also reported that SPLWs' ongoing engagement with clients often positioned them to gather informal feedback on service users' experiences. Through regular contact, SPLWs developed an understanding of whether clients perceived services as accessible, appropriate, or beneficial. This information, when

shared with community organisations, was described as contributing to the refinement or adjustment of activities and supports.

Theme 3: Funding structures and governance issues for social prescribing services

Improving current funding and governance structures for social prescribing services emerged as an overarching theme, that was perceived to impact the capacity of SPLWs to meet the needs of the Service user, as well as the potential to expand the service and ensure its service sustainability. From a strategic perspective, both HPIMs, host organization managers, and link workers reflected on current funding and governance structures and highlighted challenges in this area. The following subthemes were identified:

Need for more robust funding structures

Lack of funding: Social prescribing is currently contracted out indirectly by the HSE, which leads to inconsistencies in the delivery model. Funding is provided to agencies that then employ staff, but these agencies are often underfunded. HPIMs reflected on other potential funding models to grow the reach of the service and therefore, make it more sustainable.

"The funding model doesn't include programme costs, and areas are very different. In some areas there will be lots of services that social prescribing participant can make use of, but in others they don't exist, and the social prescriber might need to set up a group or set up a programme, and that takes their time and maybe their budget from other programmes and even things like the bus. You know, if transport which is consistently coming up as an issue for people, if we don't have a budget for transport, it's another access barrier for them." *(HPIM07)*

Lack of clarity and integration: Data from several stakeholder groups conveyed a lack of clarity in how the social prescribing service fits into the overall funding and service delivery model of the HSE and that there were opportunities to look at alternative funding structures.
Rural challenges for social prescribing: Issues around accessibility and transport are of relevance to services located in rural and more isolated areas. The current model was also seen as not being best placed to identify and target social prescribing services for areas of most disadvantage.

"…Location is key, or transportation and access is key. If you're living in somewhere like [rural location] there's nothing for you, there's very little there." (HostOrg05)

Administrative support: Host organisations highlighted that having administrative support is crucial for the SPLW to be able to really focus on the direct work they do with service user. Funding for the provision of administration support for the work of the SPLWs was perceived as a major challenge.

Improved governance structures to support SPLW's

Referral criteria: SPLWs reported a need to enhance current referral forms to clearly communicate the referral criteria for referral agents. A national standardised referral form has been developed since this project was initiated.

"And I suppose then it's that piece of us doing something locally, but that needs to be reflected at the national, say, 'these are the structures, yes, this is the right way.' And so, I think to me that's the biggest concern, you know?..." (HPIM09)

Continuity of SPLW and SU relationship: The lack of governance around duration of cases was another factor that was seen as impacting on the service provision. For some SPLWs, in practice they do act as a longer-term support for some service user, based on need.
"There's no fit, it's just down to the individual and if a person who's been isolated for years needs that, you know security blanket to know that, look you're just there in the background, I'm giving them that". (SPLW14)

External supervision: SPLWs deal with a wide range of issues with the service user they work with. Many cases are complex and can be quite sensitive in nature, such as service user who have experienced severe trauma. Participants highlighted the importance of SPLWs having access to external supervision for debriefing on cases.

"I think some social prescribers are really out there on their own. They don't have all the support that they could have. And that's very challenging in itself because of the complexities of the people that are presented to us." (SPLW11)

Training and development of SPLWs: SPLWs consistently highlighted the ECHO network as a valued resource, appreciating the opportunity to connect with peers, share experiences, and

access continuous learning in a flexible and supportive environment. SPLWs expressed desire for additional training in specific areas related to their client's needs.

"So even the essential skills training. I thought was very good for the role, a really good kind of initial training to get you started and then the training that we have done through the ECHO network has also been really useful and helpful, very practical training which is always very welcome. And then I did the coaching workshops as well …." (SPLW18)

The role of the SPLW in service monitoring: Findings show that there is variation in understanding on the use of outcome measures for the purpose of evaluation among SPLWs. Collecting post-outcome data is also challenging due to the flexible nature of the service and the fact that there may be no specific closing session for many service users.

Contract challenges for SPLWs

Existing contract challenges: Existing employment contracts for SPLW were considered by participants as an ongoing challenge to retention and recruitment. Many SPLWs stay in the employment for an average of two to three years only.

"I think what is a strength and a weakness of the of the design of the project of the programme is that you have basically all the knowledge of what's happening in the voluntary and community sector, all the all the knowledge of where to signpost people to, and then relationships with those places in many cases are held within the social prescriber and if that person leaves, then you've lost that. So, it's kind of a central place where a lot of knowledge and understanding is held. But then that's also can be quite movable, which is a weakness as well." (HPIM03)

Expanding the number of SPLWs: The need for increased numbers of SPLWs to meet growing demand and ensure equitable access across Ireland also came up in the data. Participants highlighted that current provision is limited, often with only a single SPLW covering large catchment areas.

"….kind of we had grown quite quickly, and we made ourselves known and we were very happy with that, but then the funding didn't follow in the way that we hoped, if that makes sense. Like, we would have liked to be at a point where we have maybe two or three social prescribers already" (SPLW29)

Results: Context, Mechanism and Outcome Configurations for Social Prescribing Services - Barriers and Facilitators

The realist evaluation approach seeks to gain a better understanding of the mechanisms of action for social prescribing and provide greater clarity about who can benefit from it, and why. In realist evaluations, middle-range theories are theories that provide the framework to explain how specific mechanisms operate within a given context to produce certain outcomes. From a Health Promotion standpoint of social prescribing in Ireland, the theory of salutogenesis was chosen as a middle-range theory for this realist evaluation study.

According to salutogenesis theory, a strong sense of coherence is essential for promoting health, and therefore, social prescribing can help individuals to strengthen their sense of coherence and thus enable them to access available resources and move toward a health-promoting and salutogenic direction. Therefore, it was hypothesised that SPLWs and service users' interaction is central in ensuring people understand what social prescribing is and how it can help them to access available community resources to address their needs.

The initial CMO configurations were tested against the collected interview data and thematically analysed, resulting in their acceptance or refinement. Of the total initial 28 CMOCs, 22 were accepted, 5 were refined, no CMO configurations were refuted, and one new CMO configuration was created. For each CMO configuration, barriers and facilitators to effective implementation of the social prescribing programme were identified. A summary overview is provided in the table below.

Stage 1: Interaction between the service user and referral agent	
Barriers	**Facilitators**
Lack of awareness and understanding among referrers and service users. Lack of communication in explaining the benefits of SP to an SU and assessing their readiness to engage. Integration of SP into primary care is still in development. SP is not integrated into GP referral software.	Trusting relationships between referrers and SUs. SP ‘Champions’ promote SP and facilitate appropriate referrals. Host organisations based in community settings can provide referral agents with valuable information about local resources.

	Good communication between GPs and SPLWs, integrating SP with the online GP referral software, can facilitate more appropriate GP referrals.

Stage 2: Interaction between the service user and the social prescribing link worker	
Barriers	**Facilitators**
Lack of a sustainable mainstreamed funding model for SP, particularly in rural areas. Lack of administrative support. Absence of a cohesive governance structure leads to varied service delivery. SPLW/SU Boundaries – Service user not leaving service.	Host organisations seek additional funding from alternative sources to meet the needs of a local social prescribing service. Appropriate referral of the SU to community organisations by SPLW. Person-centred approach by SPLWs is a central mechanism of the social prescribing service. Trusting relationships between SPLWs and SU Qualities of the SPLW – active listening, non-judgemental support, networking. SPLW training and peer support network (ECHO). Flexibility of SPLWs regarding the boundaries and scope of their work, enables them to effectively meet people's needs and provide tailored support.

Stage 3: Interaction between service users and community organisations	
Barriers	**Facilitators**
Personal barriers for service users – anxiety, complex needs, mobility issues – impact their readiness to engage with SP. The SP funding models do not cover full programme costs Lack of public transport and access issues, particularly in rural areas. Inappropriate referrals of complex cases.	Involvement of SPLW to support SU first steps. Capacity of activity leaders to cultivate an inviting and supportive environment to enhance SU engagement Host organisations seek additional funding from other sources to enhance social prescribing services. SPLWs strive to accommodate SUs' needs, using available community resources, leveraging other supports and/or referring on to suitable specialist services when necessary.

Social prescribing in Ireland - what works for whom, under what circumstances, why, and how?

An analysis of the barriers and facilitators associated with each Context-Mechanism-Outcome configuration provides an understanding of how social prescribing operates within the Irish context. The key factors for success in social prescribing include; a personalised approach, availability and accessibility of local community services, and a commitment to addressing the social determinants of health, along with appropriate referrals tailored to the goals, needs, interests, and current state of mental health of service users to facilitate engagement and contribute to the achievement of positive outcomes.

Effective social prescribing mechanisms that explain what works and why it works successfully involve several key components including: person-centred and flexible support; co-production of a wellbeing plan; connect service users with suitable local community resources and support networks; and the central role of skilled SPLWs.

Discussion & Recommendations

This realist evaluation sought to identify the key outcomes, mechanisms, and contextual factors influencing social prescribing, in order to inform best practice and the future development of social prescribing in the Irish context.

Outcomes: A wide range of social, health, and well-being outcomes were identified by the study participants. Many of the outcomes identified can be seen as proximal outcomes, such as gains in feelings of confidence and enhanced social connections, that are important first steps toward longer-term, distal outcomes such as improved mental health and overall well-being.

Key benefits include; enhanced social connections, a sense of purpose, a stronger sense of community, reduced loneliness and decreased reliance on healthcare services. This highlights the importance of support in enhancing well-being, including the role of the SPLWs in cultivating individuals' motivation and readiness to engage. The increased opportunities for socialisation, along with an increased sense of community and belonging, was perceived as being crucial to service users' improved well-being. Furthermore, outcomes associated with

health literacy, including managing health issues and understanding the healthcare system, were also highlighted by participants.

While the most common reasons for referral were mental health problems, social isolation and loneliness, and long-term health conditions, the most common outcomes identified from the interviews were improvement in social connections and reduced isolation and loneliness, which emerged as a common thread underlying many service users' circumstances.

Mechanisms: in terms of the active ingredients of social prescribing, the role of the SPLW emerges as being a central and vital component of social prescribing in Ireland. The **link workers build trusting relationships with service users**, which plays a key role in achieving positive outcomes for service users. Many service users emphasised that the connection and trust with their link workers is a crucial element of their overall experience with social prescribing. The compassion, non-judgmental attitude, and motivation offered by the link worker are perceived as fundamental components of the social prescribing service in Ireland. T**he individualised person-centred approach** adopted by SPLWs emerges a central mechanism for the effective implementation of social prescribing services in Ireland. This approach is enhanced by the skills and qualities of the link worker.

Furthermore, the current evaluation showed that link workers, because of their deep knowledge of the community and local resources and their connections to health and social care sectors, play a central role as **'community connectors'** in building trusting relationships within their communities. This ultimately facilitates increased stakeholders' engagement with social prescribing and encourages collaboration in service delivery. In this capacity, they may also help mitigate the disconnectedness among health providers, community organisations, and other stakeholders, acting as intermediaries for these varied groups.

In keeping with previous studies, the present study found considerable variation in intervention approaches from referral of service users to social prescribing services, relationships of various stakeholders with SPLWs, and interactions of SUs and SPLWs with community organisations. The success of social prescribing interventions was found to depend significantly on mutual reliance and the establishment of trustful, supportive, and ongoing relationships facilitated by a link worker.

Context: Implementation barriers and facilitators to the delivery of social prescribing in Ireland were identified by the study participants. The main barriers identified included:

- lack of awareness and knowledge about social prescribing among referral agents and service users
- lack of funding for social prescribing programme costs, such as availability of transport and service users' accessibility issues, especially in rural areas
- a lack of integration between social prescribing service and health and social care services and other stakeholders
- need for improved national governance structure for service delivery, the lack of which results in variations in how services are rolled out in different areas of Ireland.

The key facilitator identified was the **social prescribing link workers' role** as central points of contact and a reliable knowledge resource for all stakeholders, enabling them to facilitate cross-sector collaboration and serve as a 'bridge' between health and social care and community services. This allows them to build the links between key stakeholders and break down the barriers that exist for SUs to connect with the community. Through regular engagement with various stakeholders, SPLWs build an extensive database of community contacts and resources, becoming valuable assets for both service users and organisations.

The need for stronger and **more mainstreamed funding structures** clearly emerges as being critical to ensuring the sustainability of the service. Several stakeholder groups conveyed a lack of clarity as to how the social prescribing service fits into the overall funding and service delivery model of the HSE and that there were opportunities to look at alternative funding structures.

In terms of governance, **having a well-defined framework is key to ensuring a consistent and effective delivery of services nationwide**. However, maintaining a level of flexibility was seen as crucial for addressing emerging local needs. By **balancing structured guidelines with the ability to pivot and respond to specific local demands, a more cohesive and responsive service model can be created** that ultimately benefits all stakeholders.

Who benefits the most from social prescribing?

The findings suggest that in Ireland, social prescribing is particularly effective under specific circumstances, such as when an individual's health is negatively impacted by social, emotional, or practical challenges. It is also relevant when there is a need to bridge the gap

between health services and non-medical support, when clinical services alone are insufficient to meet all of a person's health and wellbeing needs, and when suitable local community resources are available for referral.

In terms of what works for whom and in what circumstances, the study findings are very much in line with previous international studies examining approaches to social prescribing. **The individuals who are found to benefit the most from social prescribing in Ireland are those who experience social isolation and loneliness, need support for mild to moderate mental health difficulties, have one or more long-term health conditions, frequently use primary care services, retired and older adults, and individuals who face complex social needs that affect their health. Often, a high level of personal motivation to change from service users is an important prerequisite for success.**

In contrast, individuals with severe or acute mental health issues, active addiction, or other conditions that require specialist help benefit less, as they often struggle to engage, while SPLWs may lack training for dealing with very complex cases. In addition, younger service users, due to a lack of suitable community activities, or employed adults, due to scheduling conflicts, benefit least from the social prescribing service.

Conclusion

The study findings provide valuable insights into social prescribing that extend beyond traditional measures of effectiveness by addressing key questions about how social prescribing works in the Irish context, who benefits from it, and under what circumstances. The evaluation identifies the positive outcomes experienced by service users, the active ingredients of social prescribing, and describes the key factors that influence the successful implementation of these services in Ireland.

This realist evaluation highlights the complexity of social prescribing in Ireland, emphasising the interconnected factors that can inform future development and improvement efforts for these services. Specific recommendations, based on the study findings, are outlined below.

Recommendations

Recommendations for Social Prescribing Practice

Governance

- It is recommended that the HSE adopt a more coordinated and strategic approach to developing social prescribing models of delivery at a national level.
- At the local level, the coordination and delivery of social prescribing should be embedded within existing Health Promotion and Improvement Manager (HPIM) structures.
- More robust contracts of employment for SPLWs are needed, together with funding beyond the SPLW position to include programme costs.
- A national digital plan to facilitate referrals, track outcomes and measure the impact of social prescribing is needed to support effective service delivery and build the evidence base.

Improved awareness and understanding of social prescribing

- There is a need to strengthen awareness and understanding of social prescribing within health and social care settings.
- Additional resources must be targeted to building awareness for the public on the benefits of social prescribing.
- Improving recognition and understanding of social prescribing as a core element of wrap-around, community-based supports for mental health should be prioritised.
- Efforts to raise awareness and promote social prescribing should be balanced with the capacity of services and community organisations to respond to increased demand.
- The ongoing work of Health Promotion and Improvement Managers (HPIM) and their teams on building awareness of social prescribing services needs to be expanded across all their health and social care networks.

Access to external supervision and improved training opportunities for SPLWs

- SPLWs routinely engage with service users with complex needs, including traumatic experiences. Providing ongoing supervision and support to all SPLWs is critically important.
- Training and professional development opportunities should be provided for all social prescribing Link Workers to strengthen their skills in key areas related to their work.

- The online social prescribing learning network platform, known as ECHO, was positively regarded by SPLWs and is recommended for continued use as a platform for providing further training for SPLWs.
- Awareness and understanding of service monitoring and evaluation should be strengthened across social prescribing services. Link workers and partner organisations should have clear information on the role of evaluation in demonstrating service impact and informing best practice development.
- Training should also be provided to SPLWs on the routine collation of case study information that can be used for promotional purposes.

Referral Guidelines

- It is important to note that a national referral form has recently been released to support the social prescribing referral process.
- Integrating social prescribing services into the existing GP referral system known as Healthlink is recommended.
- Identifying who social prescribing is best suited for, and what is required for effective participation with the service, is critical in preventing inappropriate referrals.

Recommendations for Social Prescribing Policy

A clear policy and implementation plan is critical to guiding the strategic development of social prescribing at both a national and local level in Ireland.

Equitable Provision of Social Prescribing

- The equitable provision of social prescribing services across the country is an important principle underpinning its current and future development. This is especially critical in areas of disadvantage and more rural and isolated geographical areas.

Community & Voluntary sector

- Additional resources are required to continue to support the roll out of social prescribing services within the community and voluntary sector. This should include funding and resources to support local infrastructure and to build capacity to meet the needs of service users.

Sustainable Funding Model

- At a national level there is potential for a cross-sectoral joined-up approach to funding the development and implementation of social prescribing services.

Education

- Regarding the training of future health and social care professionals, the social prescribing service, and its relevance for addressing the social determinants of health, should be routinely embedded in all undergraduate training for future health and social care professionals.
- In addition, this mandate should be extended to further education and professional training avenues including Continuing Professional Development (CPD) courses and GP training.

Recommendations for Social Prescribing Research

- Increased investment in research and knowledge translation is crucial to build the evidence base to support the mainstreaming of social prescribing as part of Ireland's healthcare infrastructure.
- More comprehensive robust evaluations of social prescribing services are needed at the national level to inform best practice and policy concerning its future development. Based on the findings from this realist evaluation study, an evaluation logic model set is proposed to guide evaluation planning.
- In view of the significant variability in how social prescribing is implemented across different settings, it is recommended that evaluations complement outcome-based studies with implementation research on the process of implementation in order to capture the contextual level factors that impact on service delivery.
- Outcome evaluations should seek to capture not only the medium- and long-term health and wellbeing impacts of social prescribing, but also the proximal outcomes, such as increased service user motivation, confidence, sense of purpose, agency, and empowerment, as these often serve as key pathways to broader improvements.
- A robust evaluation framework is recommended, one that recognises and respects the complexity of social prescribing service in Ireland, such as, for example, the Consolidated Framework for Implementation Research (CFIR) (Damschroder et al., 2022).

- Understanding the economic impact of social prescribing is of particular importance. A cost-benefit analysis study is recommended to evaluate the costs of delivery and the economic and social returns on social prescribing within the Irish context.

CHAPTER 1: INTRODUCTION & BACKGROUND

1.1. Introduction

Social prescribing is identified as a means of enabling health and social care professionals to refer people to a range of local, non-clinical services, primarily provided by the voluntary and community sector (HSE, 2021). It is aimed at improving individuals' mental health and wellbeing by connecting people, often those experiencing loneliness and social isolation, with community services (Bickerdike et al., 2016). Social prescribing uses an assets-based approach to empower service users to improve their health and wellbeing. It empowers individuals by involving them in creating their own plans, through the link worker, coming up with a solution to the issue they are facing that helps improve their health and well-being (Bertotti et al., 2017).

Muhl et. al. (2023), based on a Delphi study involving 48 experts from 26 countries, has defined social prescribing as a holistic, person-centred, and community-based approach to health and wellbeing that bridges the gap between clinical and non-clinical supports and services. The growth of social prescribing at an international level can be attributed to its potential for addressing the social determinants of health and enhancing overall health and wellbeing, while building on existing resources (Morse et al 2022; Scarpetti e al. 2024). It represents a fundamental change in the provision of healthcare care towards a more integrated and person-centred care approach (Khan & Giurca, 2024).

The evidence base for social prescribing is broadly supportive, highlighting multiple benefits, including improved mental wellbeing, physical health, health behaviours, and reduced social isolation and loneliness (Woodall et al. 2018; Bhatti et al., 2021; Griffiths et al. 2022; Moffat et al. 2017; Chatterjee, Camic, & Lockyer, 2018). However, rigorous studies of effectiveness and cost effectiveness are scarce (Bickerdike et al. 2017, Polley & Pilkington, 2017; Kiely et al., 2022). As a result, there is ongoing debate on the evidence base for social prescribing. Moreover, relatively little is known about *how* social prescribing interventions work to improve the health and wellbeing of its service users. This 'evidence gap' in social prescribing schemes arises primarily due to evaluations based on small-scale pilot studies that lack methodological rigour (Bickerdike, 2017). Additionally, the varying

aims and delivery models of these services make it difficult to synthesize, compare, or pool data and information (Rempel et al. 2017).

Social prescribing services typically comprise three key components:

- A referral from a health or social care professional or self-referral into the service.
- An intervention between the service users and a social proscribing link worker (this can take up to eight sessions); and
- Supporting the service user to access local voluntary, community and social enterprise organisations or services through discussion and decision making (HSE, 2021).

Social prescribing meets the criteria of a complex intervention, as it is tailored to the specific needs of an individual as well as the local context of the service and thus can produce varied outcomes. This poses challenges for undertaking more traditional comprehensive evaluations (Craig et al., 2008; Drinkwater, Wildman, & Moffatt, 2019).

1.1.1 The Current Study

The current study, recognising the complexity of the social prescribing pathway, uses a realist evaluation approach to address "what works, for whom, under what circumstances and how?" (Wong et al. 2016), in the Irish context. This approach provides a more nuanced and context sensitive approach to programme evaluation than other approaches. Further, it is an appropriate approach to:

- capture the breadth and showcase the potential of social prescribing services in Ireland
- respect the complexity of the services
- recognise the challenges inherent in capturing that breath
- provide a nuanced approach to capture positive outcomes.

This approach is especially useful for the evaluation of complex interventions and is gaining momentum for the evaluation of social prescribing services (Bertotti et al., 2017; Wood et al., 2021; Westlake et al., 2024; Wallace et al., 2022; Gorenberg et al.,2023; Tierney et al., 2024).

The specific objectives of this study are:

- To determine the active ingredients of social prescribing to inform future training and best practice in terms of social prescribing in the Irish context.
- To ascertain how social prescribing works for different population subgroups and for whom social prescribing is most effective.
- To identify facilitators and barriers to high-quality implementation of social prescribing.
- To determine the social, health, and well-being outcomes that social prescribing is most likely to impact and thereby inform a more robust evaluation of the impact of social prescribing on immediate and long-term outcomes.

1.2 Social Prescribing: Definition, Concepts and Underpinning Theories.

1.2.1 Defining Social Prescribing

Social prescribing can be defined as a non-medical intervention that addresses the psychosocial factors that impact an individual's health and well-being (Morse et al., 2022). Social prescribing offers frontline health professionals and community workers a way of linking service users to non-clinical supports within their communities. The service aims to improve individuals' mental health and well-being by connecting people, often those experiencing loneliness and social isolation, with community services. (Bickerdike et al., 2017). It is estimated that up to 20% of patients visit their General Practitioner (GP) for a social problem, placing increasing pressure on GP services (Husk et al., 2019). Social prescribing is an important intervention for addressing the social determinants of health and alleviating the pressures on the health system (Morse et al., 2022).

Social prescribing is based on the principle of addressing 'what matters to the person' rather than 'what's the matter with them' (NHS, 2019). This approach initiates personalised care through referrals to social prescribing link workers (SPLWs), who engage in wellbeing conversations with service users to understand their priorities. A key aspect of social prescribing is the role of the SPLW (Sharman et al., 2022), which involves listening to the wants and needs of the service user, and linking the service user in with community organisations and activities that suit their specific needs (HSE, 2021). Service users are

referred to SPLWs by referral agents such as GPs, mental health nurses, social care workers and other community organisations. Typically, link workers meet with service users' multiple times to build rapport and identify the most appropriate social prescription. These wellbeing conversations form the foundation of a holistic model, characterised by active listening and collaboration with other agencies and services when necessary (Kimberlee, 2015). Alternatively, some approaches, based on the needs of service user, may simply direct individuals to community assets or involve a single conversation to facilitate a social prescription. This type of social prescribing intervention is referred to as signposting. These are known as light and medium social prescriptions, respectively (Kimberlee, 2015).

There are a myriad of aspects that can affect the delivery model chosen for a social prescribing intervention. These include the geographic area where the social prescribing service is located, the funding the service receives, what type of referral agents are referring services users to the service, and what resources and activities the SPLW is linking the service user in with (Dayson, 2017). Different delivery models can lead to varying levels of success of the intervention. A 2023 scoping review investigated the different types of delivery models seen across the globe (Oster et al., 2023). Covering 148 published sources, the majority originated from the UK (65.5%) and the USA (27.7%), and the remainder were from Canada, Australia, Germany, the Netherlands and New Zealand. This review identified primary care based social prescribing model as the most common model, with 78% of sources identifying primary care as their chosen model. Social prescribing models that entailed a mixture of the primary care model and community care model accounted for 27% of the sources in the review. Only 5.7% of sources reported a community delivery model.

In Ireland alone, research has shown that there are various different models of delivery in use. A 2020 pilot study found that some social prescribing services outline a clear 6–8-week social prescribing programme, others refer service users to activities primarily within the resource centre the social prescribing service sits, and the remainder develop new programmes based on the needs of the service users who enter their programme (Gage, 2020). However, the HSE Social Prescribing Networks stated that the majority of social prescribing service in Ireland fall into the holistic category (HSE Social Prescribing Network, 2021). The embedded delivery model is proposed as being a useful model for

social prescribing as it entails the intervention becoming such an integral part of routine, that it is embedded into the service user's lifestyle (Bos et al., 2024). A realist review by Bos et al., 2024 found that short-term social prescribing models were the most common type of social prescribing. This includes a SPLW having short-term interactions with the service user and linking them into community activities. The review reported that some articles included a longer-term social prescribing model, whereby the service user engages with the SPLW over multiple sessions as well as being linked in with community activities. Lastly, the review reported that some articles focused on a hybrid delivery model, featuring a combination of short-term and long-term models (Bos et al., 2024). A technique known as *tailoring* is referred to by Tierney et al. (2022) as moulding an intervention, including how the intervention is carried out, to meet the wants and needs of the service user. Study findings show that tailoring is central to social prescribing, and efforts should be made to adapt social prescribing in order to increase the engagement in the service and the benefits received (Tierney et al., 2022).

Social prescribing at its core is focussed on getting people back out into the community and increasing individuals' social connectedness. Research has shown that by being a member of a social group of any sort, including community groups and hobby groups, one's health and wellbeing can be improved (Wakefield et al., 2022). A study by Wakefield and colleagues in 2022 found that participants who joined social groups and activities had elevated levels of quality-of-life scores after 4 months and similarly after 6-9 months. Studies such as this give a good indication as to the health benefits that can be achieved from social prescribing services. Social prescribing has been shown to benefit vulnerable individuals, especially those experiencing social isolation and loneliness, (Buck & Ewsbank, 2020; Reinhardt et al., 2021; Holt-Lunstad, 2024). Increasing people's levels of social connectedness is of major interest to the public health sector both from a health promotion, prevention and treatment perspective (Vidovic et al., 2021). Sharing the Vision National Mental Health Policy identifies the three elements of emotional, psychological and social wellbeing as being important for overall mental wellbeing (Health Service Executive and Department of Health, 2022). Social prescribing has the potential to address all of these elements (Leavell et al., 2019; Morse et al., 2022).

1.2.2 Social Prescribing Theories and Concept

There are several theories that can be used to understand the mechanisms behind social prescribing. While Pawson (2006) has stated that every programme has a theoretical underpinning, whether it is made explicit or not, however, there is no one overarching theory that is used to explain social prescribing.

Salutogenesis theory, developed by sociologist Aaron Antonovsky, aims to explain how people maintain their well-being and health, rather than focusing on the causes and treatment of illnesses. The central idea of this theory is the sense of cohesion, which refers to the ability of individuals to understand the whole situation they find themselves in and utilise the available resources (Antonovsky, 1987). Improving an individual's sense of coherence is a key concept in chronic disease management. A study carried out by Wood and colleagues (2021) concluded that people with long-term health conditions, or those with chronic illnesses, can benefit the most from social prescribing as a result of salutogenic thinking. This way of thinking puts on an emphasis on the promotion of health and well-being rather than on symptom management. Through the various social prescribing activities, health and wellbeing can be promoted. The study by Wood et al., 2021 identified social prescribing as an intervention that encompass salutogenic thinking and that helps to increase an individual's sense of coherence.

According to Antonovsky's theory, sense of cohesion is a combination of three components: comprehension, meaningfulness, and manageability. (Antonovsky, 1979). Comprehension refers to the degree to which a person can understand the situation they are in, and how it relates to their overall health. This includes understanding the potential causes of health issues, as well as the resources that are available to help restore or maintain health. Meaningfulness is the degree to which a person can derive a sense of purpose or significance from the situation they are in. This involves finding meaning in the pursuit of better health and understanding how one's actions can contribute to achieving that goal. Manageability is the degree to which a person feels that they have the skills and resources necessary to manage their situation and achieve better health outcomes. This includes having access to the tools and resources needed to maintain health, as well as the knowledge and skills necessary to use them effectively. Overall, the salutogenesis theory emphasises the importance of understanding one's situation, finding meaning in the pursuit of better health, and feeling empowered to take action to manage one's health. By focusing on these elements, individuals

can maintain their sense of well-being and achieve better health outcomes over time. Holistic social prescribing has been described as driving a shift from a pathogenic, medical model to a salutogenic model that emphasises factors contributing to health and wellbeing (Howarth et al., 2020).

Salutogenesis also implies the capacity to exploit both internal and external resources to cope with stressful circumstances. Recognizing and utilizing these resources is essential for a sense of coherence. The study by Wood et al. (2021) found that social prescribing helped participants become more aware of their available assets and how to access them, which aligns with improvements in health literacy. Context plays a crucial role in determining which aspects of social prescribing work for whom and in what circumstances. The availability of and access to a supportive community can help bolster a person's sense of coherence throughout their life (Koelen et al, 2017). However, those with a weaker sense of coherence may struggle to access these resources on their own, and these people can particularly benefit from SP interventions. It is important to determine the appropriate intervention on a case-by-case basis while keeping the focus on the individual (Wood et al., 2021). Therefore, link workers and service users' interaction is central in ensuring people are supported to attend and understand what social prescribing is. According to salutogenesis theory, a strong sense of coherence is essential for promoting health while social prescribing, if it is person-centred and holistic, can help individuals with a weak sense of coherence to strengthen it (Wood et al., 2021). This can also enable them to access available resources and move toward a health-promoting and salutogenic direction. Wood et al. (2021) argue that social prescribing shares many features of the asset-based theory of salutogenesis (health promoting through building resilience resources). Asset-based theories and approaches focus on harnessing the assets available within a community and adapting these to fit the needs of the people within the community (Lunt, 2019). Salutogenesis promotes personalised care by centring the individual in decision-making and tailoring service provision to their needs. This approach emphasises an individual's strengths and capacities, facilitating access to resources that enhance health and well-being (Lindström and Eriksson, 2005).

Solution-focused theory is another theory used to explain the role of the link worker. A solution focused approach is a service user-led approach that promotes health and wellbeing. It is future focused and looks at the solution rather than the problem (Franklin et al., 2017). Solution-focused approaches are applicable to social prescribing as studies have shown that

it is an effective approach for service users experiencing adverse psychological experiences such as depression, stress and bereavement (Franklin et al., 2017), all of which are reasons people seek social prescribing (Griffiths et al., 2023). In the study carried out by Griffiths and colleagues in 2023, SPLWs followed core principles of a solution focused approach, including focusing on solutions, assuming positive changes are going to happen, collaborating with others and asking service users what to do rather than telling them. As a result, service users saw changes such as positive changes in behaviours, and engagement in activities (Griffiths et al., 2023).

Studies have found that the effectiveness of social prescribing can be attributed to the levels of self-determination a service user has when engaging in social prescribing. Bhatti et al., 2021 explored how self-determination theory (SDT) can apply to social prescribing, stating that SDT theorises that those who can be decisive and take control of their own life, have higher levels of motivation to be proactive about their overall psychological wellbeing (Bhatti et al., 2021). SDT is, therefore, relevant to social prescribing as it can be used to look at the role motivation plays in the efficacy of social prescribing (Ryan et al., 2024). SDT helps to explain that by meeting the needs of individuals, in this case social needs through SP, self- motivation is increased that can foster more positive behaviours (Evers et al., 2024). Self-determination can also be seen as an important component of a social prescribing intervention that aims to improve and maintain individual and community well-being (Bhatti et al., 2021).

Another theory that has been put forward by researchers as a way to explain and understand social prescribing is social cure theory. Social cure theory has developed in popularity over recent years, as it is a strand of the social determinants of health. Researchers have investigated how a person's social network can impact their overall health and well-being and, as seen in literature cited throughout this chapter, higher levels of social interactions are positively associated with better overall health outcomes (Vidovic et al., 2021; Wakefield et al., 2022). A study carried out by Wakefield et al., 2022 explored whether social cure theory could be used to understand how effective a social prescribing intervention is. This mixed-methods longitudinal study entailed carrying out in-person interviews over a two year period. Participants were interviewed prior to beginning their social prescribing interventions. Outcomes measured included type of social groups they are members of, a community belonging measure, a social support measure, a loneliness measure, and a health related

quality of life (HRQOL) measure. They were then interviewed again, with the same outcomes being measured at four months after the initial interview, and follow-up at six to nine months post the initial interview. The results of the study found that overall, participants' HRQOL improved from the first to the second time point and stayed elevated as seen in the third round of data collection. The study found that social cure theory provided a good explanation of the observed improvement in HRQOL for participants in this study, and that social prescribing was the mechanism that fostered the improvement (Wakefield et al., 2022).

Social capital is another construct that can be used to understand why social prescribing works. Social capital refers to the resources an individual has built up from their social connection (Evers et al., 2024) There are two main forms of social capital, namely bonding and bridging. Bonding refers to close connections built with people who the individual can relate to, there are common factors between the individuals, and the bond that is formed in strong. Bridging is a weaker connection with less commonalities but can be important for information and networking purposes (Tierney et al., 2020). Both of these forms can be seen within the social prescribing context, depending on which delivery model is being employed.

It is widely accepted that social connectedness is a key factor in overall wellbeing, but in particular, social wellbeing (Holt-Lunstad, 2021; Marmot, 2015) with research indicating that between 40-80% of health and wellness can be attributed to social connectedness (Holt-Lunstad, 2022). The public health restrictions as a result of the COVID-19 virus generated particular interest into this area and led to the development of policy changes to reduce social isolation and loneliness levels globally (Holt-Lunstad, 2022). Some researchers have coined the term "loneliness epidemic" to describe the increased levels of social isolation and loneliness seen on a global scale in recent years (--Lunstad, 2024).
There is a significant amount of research available that shows the association between social connectedness and mental health outcomes, with social connectedness playing a pivotal role in both prevention and recovery (Holt-Lunstad, 2024). A longitudinal UK study on the effects of loneliness and a lack of social connection on individuals found it to be detrimental to their health and well-being (Seifert, 2024). A meta-analysis carried out by Holt-Lunstad and colleagues in 2010 found that being socially isolated and having low levels of social

integration posed the same mortality risk as behaviours such as smoking and excessive drinking (Holt-Lunstad et al., 2010).

The concepts of health literacy and empowerment are also central to understanding the context-mechanism-outcomes that occur in social prescribing services, as both concepts are linked to the enablement process. Health literacy refers to the level of knowledge and ability an individual has to manage their own health and well-being (Liu et al., 2020). It represents the personal knowledge and competencies that accumulate through daily activities, social interactions and across generations. The health literacy of individuals and communities is mediated by organisational structures and the availability of resources that enable people to access, understand, appraise and use information and services in ways that promote and maintain good health and well-being for themselves and those around them – often described as organisational health literacy (WHO, 2025; Nutbeam, 2025). The person-centred approach of social prescribing services provides an important opportunity to empower individuals and to support their health literacy needs. Individuals with lower health literacy, often those from marginalised groups, may especially benefit from improved access to community resources and intensive personal motivational support (Roland, Everington & Marshall, 2020; Drinkwater, Wildman & Moffatt, 2019). Recent studies have shown that individuals who live in areas that are "resource scarce", meaning areas where there is a scarcity of local amenities that people can use, have been found to have poorer mental health than those in "amenity abundant" areas (Haslam et al., 2024). This is consistent with previous literature that examined the effects on overall health of people in disadvantaged areas and found that resource scarce areas are associated with higher rates of adverse mental health conditions such as anxiety and depression (Remes et el., 2017).

1.2.3 Growing Interest in Social Prescribing

The growth in social prescribing internationally indicates the health impact and relevance of non-medical needs (Morse et al., 2022). Social prescribing is gaining traction as healthcare professionals are pushing for a more holistic model of healthcare (Scarpetti et al., 2024). Scarpetti discusses the growing issues of social isolation and loneliness, and how it is becoming an increasing public health concern. Scarpetti and colleagues argue that by shifting towards a more person-centred approach to healthcare, the focus can be on health promotion, rather than just illness treatment, which would be of huge benefit to the individual (Scarpetti

et al., 2024). The National Academy of Social Prescribing in the UK has also highlighted the economic case for investing in social prescribing. A rapid review carried out by Polley et al., 2023 examined the economic benefits of social prescribing to health care systems. This review showed social prescribing in a very favourable light in terms of cost saving measures. Overall reductions in health and social care usage were identified in five out of the seven studies that conducted a cost assessment analysis of social prescribing. Regression models of analysis also showed that service users with high levels of engagement showed cost reductions of £77 per person on the healthcare system. Other methods of analysis such as cost-benefit analysis (CBA), and social return on investment (SROI) were found to yield mixed results (Polley et al., 2023). This review provides insights into the potential benefits of social prescribing in reducing the cost burden on the healthcare system and clearly depicts reasons as to why there is a growing interest into social prescribing. As of 2021, social prescribing is a part of health initiatives in 17 countries worldwide, which further highlights the need for non-medical models of intervention (Morse et al., 2022), in order to reduce the increasing burden on healthcare systems (Pescheny et al., 2018).

Studies have shown that up to 80% of medical outcomes in patients can be attributed to nonmedical factors such as where people live, what they work as and what exercise they do (Oster et al., 2023). Social prescribing recognises these non-medical, health-related social needs. Other key factors that can impact a person's health can include factors such as loneliness, isolation, and involvement with one’s community (Braveman et al., 2020). Studies have consistently shown that there is a negative correlation between levels of social isolation and a person's health (Freyne et al., 2005). Research shows that loneliness can have adverse effects on both mental and physical health, which has led to it been identified as a global health challenge (Thompson et al., 2023). A US study carried out in 2015 found that loneliness was positively associated with an increased level of primary care visits (GerstEmerson & Jayawardhana, 2015). The high levels of primary care centre attendance globally is one of the fundamental reasons behind the implementation of social prescribing services (Carnes et al., 2017), in an effort reduce these levels. Other examples of the social determinants of health include income, socioeconomic status and employment status (WHO, 2025). Social prescribing has also been reported to help to address issues relating to housing and poverty, which in turn can help to improve a person's health (Lawler et al., 2023).
The UK has always been one of the frontrunners for social prescribing, with many countries using the UK model as a basis when developing their own social prescribing (Oster et al.,

2023). Social prescribing was initially a bottom-up initiative, meaning it was a community-led, unstandardised approach. However, following its inclusion in the National Health Service (NHS) long-term plan in 2019, social prescribing became incorporated into the NHS, providing the service with more funding, and a more standardised delivery model, known as the NHS model (Moore et al., 2022). The NHS model is described as an integrated care, person-centred, GP-based model of social prescribing. Primary care centres are the main setting for social prescribing under the NHS model. Link workers typically sit in primary care networks (PCNs), and service users are typically referred to SPLWs from their GPs (Sandhu et al., 2022). The integration of social prescribing into the NHS has allowed for a streamlined "top down" model, whereby the service is governed by the NHS, and is delivered in the same way throughout the country (Moore et al., 2022). Figures from 2023 show that there were over 3500 SPLWs across the UK (National Academy for Social Prescribing, 2023

1.3 Development of Social Prescribing Services in Ireland

As documented in the HSE Framework document (HSE, 2021), social prescribing began in Ireland as a ground-up movement in partnership with the Health Service and the community and voluntary sectors. This resulted in the establishment of the first social prescribing project in Mayo in 2012. Since then, Ireland, similar to other countries, has seen huge growth in the number of operational services (Scarpetti et al. 2024). There are currently 44 HSE-funded social prescribing services in the Republic of Ireland. This figure is based on the funding of full-time link worker posts.

In 2017 there were 6 services, and by 2019 the number had increased to 17. The most recent available data reports that there are now 44 mainstream social prescribing services in Ireland (All Ireland Social Prescribing Network, 2025). The development of the HSE Social Prescribing Framework began in 2020. This framework outlines how HSE-funded social prescribing services should by delivered in Ireland. In 2020 a Minimum Data Outcomes Framework for social prescribing in Ireland was published, which outlined personal wellbeing and social connectedness as the two main outcomes to be measured by HSE-funded social prescribing services. The development of the Outcomes Framework was a crucial step in enabling evaluations of HSE social prescribing services to be carried out

(HSE, 2021). In Ireland, social prescribing services can now be accessed in every county (All Ireland Social Prescribing Network, 2025). While there is no one standardised way in which social prescribing services are delivered in Ireland, there are certain aspects that are consistent across all deliveries. These include the presence of the social prescribing link worker, referral pathways such as self-referral or through primary care professionals, and linking in with community activities (HSE, 2021).
There have been a number of studies on social prescribing carried out in Ireland to date. One of the first Irish studies to emerge on social prescribing was carried out in 2012 by Keenaghan, Sweeney and McGowan. This study on the development of best practice information and guidance on social prescribing for primary care teams described the importance of socialisation for mental health promotion and described the rising need for non-medical interventions to help promote positive mental health (Keenaghan et al., 2012).

A pilot study by Kiely et al., in 2021 explored the role of SPLWs who are based out of primary care centres, and how the social prescribing they deliver can improve health and social care outcomes for people with multimorbidity in socially deprived areas. This pilot study, which entailed a primary care-based SPLW working with a set of service users for six weeks, showed promising results with 13 out of 14 service users reporting being happy with the resources and support the SPLW gave them during the intervention (Kiely et al., 2021).

A 2024 study by O'Sullivan et al., reported on the effectiveness of social prescribing to manage long-term health conditions. This systematic review included 12 studies of multiple designs. Seven of the twelve studies reported on the effects of social prescribing on the service user's physical activity. The results from these studies showed that social prescribing had positive influences on physical activity, increasing both frequency and duration of activity levels. With regards to the effects on mental well-being, two studies found there to be no significant improvement, while one study where services users met in person with the link worker more than three times, did show significant levels of improvement (O'Sullivan et al., 2024)

Connolly et al., 2024 carried out a cross-sectional study of social prescribing services across Ireland. A survey was undertaken with different key stakeholders within social prescribing, the majority (47.6%) of whom were SPLWs, and others being SP coordinators and social prescribing managers. The study explored a variety of aspects of a social prescribing service.

The study reported that the mean age categories for service users accessing their service are 31-65 and 65+ years. The most common reason for service users engaging in social prescribing was due to loneliness, with over 95% of survey respondents reporting it as the main reason that people are referred into their service. Mental health reasons in general were the next most common reason for referral. The study also reviewed different aspects of the data collected by services in Ireland. The study found that 80% of respondents reported recording number of referrals and 74% document the number of no-shows in their service (Connolly et al., 2024). Studies such as this are extremely important as they provide insight into the way social prescribing services operate and who attends them. This can be seen in other Irish studies, such as the South Dublin County Partnership research (Gage, 2020), which found that social isolation and mental health are the main reason for using social prescribing services (TASC, 2024). The 2024 Clondalkin study also highlighted the core importance of the link worker role in the benefits service users experience. This report indicated that there were significant improvements seen as a result of social prescribing, with benefits experienced by service users including improvements in mental well-being, physical well-being, and social well-being (TASC, 2024). However, to date, no overall comprehensive evaluation of social prescribing nationally across Ireland has been undertaken.

1.3.1 Policy Context

Social prescribing has a significant policy mandate in Ireland. The 2020 Plan for Government sought to, "expand social prescribing where patients are referred to non-clinical activities, as a means of positively influencing mental wellbeing "(p. 49). It is identified as a key enabler for linking those with mental health difficulties to appropriate community supports in the national mental health policy, 'Sharing the Vision (Department of Health,2020). Social prescribing is also a core initiative of the national Sláintecare Healthy Communities programme, which targets disadvantaged areas for health and wellbeing improvement. Most recently, *Pathways to Wellbeing*, Ireland's first National Mental Health Promotion Plan, 2024-2030 (Department of Health, 2024) emphasises the importance of social prescribing services for its high-level goal of strengthening community belonging and connectedness. This plan aims to extend the reach of social prescribing for marginalised and vulnerable groups in the community as a vehicle for improving health. The National Mental Health Research Strategy, published by the Health Research Board in 2024, although not

explicitly referencing social prescribing, does emphasis the central role of Sláintecare for mental health care and support. Social prescribing has been shown to benefit vulnerable individuals, especially those experiencing social isolation, loneliness, multiple comorbidities, and frequent users of healthcare services (Buck & Ewsbank, 2020). The recently published report by the WHO Commission on Social Connection identified social prescribing as a key community intervention to address social isolation (WHO, 2025).

1.4 Evidence Base on Social Prescribing

A number of systematic and scoping reviews have examined the current evidence base available on social prescribing. A review carried out by Bickerdike et al., 2017 examined the evidence from 15 evaluations, the majority of which were descriptive reports (n=8), with 1 randomised control trial (RCTs), 1 non-RCT, 2 qualitative studies and 4 uncontrolled before and after studies. The review found that most of the evaluations reported positive conclusions, however, the findings also highlighted that most studies carried out on social prescribing provide limited evidence due to weak evaluation designs and poor reporting. Examples of this included use of uncontrolled deigns, small sample sizes, high risk of bias, an absence of standardised and validated measuring tools, missing data and short follow-up periods. This study also found that the scale of the studies was too small for meaningful results to emerge. As a result, the authors concluded that the review did not establish that social prescribing was either effective or ineffective, due to the low-quality evidence available. The authors suggest that in order for social prescribing to continue growing, more rigorous studies are required, with the inclusion of five essential evaluation questions relating to the why, who, how, what and when of social prescribing (Bickerdike et al., 2017).

Pescheny, Pappas and Randhawa (2018) carried out a systematic review examining the barriers and facilitators of social prescribing. This review of 8 studies reported on many of the same barriers and facilitators that were consistently reported across previous studies. Facilitators identified included; adopting a phased approach in terms of social prescribing interventions, ensuring that referrers provide service users with an accurate description of social prescribing, and that there is a mutual understanding between both social prescribing staff, referrers and community organisation staff on what can be expected of each party

(Pescheny, Pappas & Randhawa, 2018). Barriers that emerged included having too many stakeholders included in management plans, having rigid dates in which activities are to start, and funding issues.

Husk et al. (2019) considered the key reasons as to why there is such a difficulty in generating evidence on social prescribing services. These are primarily related to methodological issues which lead to challenges in establishing significant findings and difficulties in being able to apply the results to the general population. However, Husk et al. also contends that applying results more widely to the general population may not be appropriate in view of the way that social prescribing is operated, which is often quite specific to the given population and area in which it is located (Husk et al., 2019). Husk and colleagues also suggest referring to social prescribing as a system, rather than an intervention, as each section of the system may require its own evidence base. In this way, different methodologies may be required in evaluating these sperate evidence bases, in order to better understand social prescribing as a whole.

A systematic review examining the impact of social prescribing services on service users, was carried out by Pescheny, Randhwawa, and Pappas in 2020. This review focused on social prescribing services based in primary care and involving navigators. The majority of the 16 studies included in this review were mixed-method reports (n=10), with1 RCT, 1 pre-post study, 2 mixed methods studies, 1 uncontrolled pre-post study design, and 1 qualitative study. Overall, the findings were mixed with the qualitative studies reporting a number of positive service user outcomes in relation to health and well-being, health-related behaviours, self-concept and feelings, social interactions, and day-to-day functioning. However, the findings from the quantitative and mixed-methods studies were more mixed, with some papers citing service user well-being improving, and others reporting no significant changes. Improvements in health-related behaviours were reported across all study types, except for a quantitative study by Wigfield et al. (2015) that didn't find any significant improvements in healthy eating behaviour. Changes in perceived self-concept and feelings emerged primarily from the qualitative studies included in the review. Outcomes such as self-esteem and confidence were all reported to have improved as a result of social prescribing. Qualitative studies also reported improvements in social interactions. However, the RCT and uncontrolled study did not find any significant improvement in social interactions as a result of social prescribing. Improvements in day-to-day functioning were

reported across the majority of the qualitative and quantitative studies. Overall, this review presented mainly positive service user outcomes a result of social prescribing. However, it should be noted that different outcome measures were used in all studies, and that many studies reported small sample sizes and missing data, which could also account for the statistically insignificant results (Pescheny et al., 2020). Reviews such as this underscore the need for further studies with more robust sample sizes, and more streamlined research methods.

Social prescribing is a person-centred approach that is designed to be flexible to the needs of the service user. This inevitably means that different approaches are applied to different contexts. While the flexibility of the services allows for the link worker to adapt their service to the service user needs, studies have begun to investigate the impact that this has on the social prescribing link worker. A 2020 UK study found that there are differences in the scope and remit of the SPLW's role (Rhodes and Bell, 2020). They also found that there are differences in the training required to become a link worker, which also leads to discrepancies in the link worker's role and as a result, in their responsibilities.
In a 2024 study Tierney et al., coined the term *micro discretions* to describe this flexibility in the service that the link worker provides. This study found three broad micro discretions within the role of a social prescriber: the scope of the job description, link worker training and abilities, and adapting support for the service user (Tierney et al., 2024). This study also found that the nature of these micro discretions can impact on the link workers' experience, in some cases leading to feelings of being overwhelmed and lacking boundaries (Tierney et al., 2024). A qualitative study carried out by Wildman et al., (2019) explored what factors enable and prevent service user engagement in social prescribing. Link workers in England were interviewed to hear about their experiences and what they felt facilitated service user engagement and what hindered it. The result of this study also supports the importance of boundaries as a key factor for client engagement within the service. Wildman et al., 2019 concluded that it was essential to enforce boundaries, especially in line with service users' expectations of the service

A systematic review by Vidovic et al., 2021 examined whether social prescribing can foster individual and community wellbeing. This comprehensive review, which included 51 studies carried out between 2014 to 2020, found that most studies included in the review reported finding change after a social prescribing intervention, but not necessarily change that could

be attributed to the intervention. This was mainly due to methodological issues, with studies lacking robust designs that could measure change effectively, as well as not including enough detail on measurement. Types of studies included in this systematic review were pre/post design studies, surveys, mixed-methods studies, focus groups, experimental studies, and case study designs. The review reported evidence of change at the individual level with regard to loneliness and wellbeing outcomes, at the system level with regard to healthcare and at the community level concerning community resources. This review identified a gap in the evidence base as it reported that out of 51 studies, only 9 reported evidence that supported the claim that the observed change in participants was due to the social prescribing intervention (Vidovic et al., 2021).

Research carried out by Napierala et al., (2022) examined social prescribing as a community referral intervention and its level of effectiveness. This systematic review included 68 reports, that reported on 53 studies. The majority of studies included in the review were uncontrolled, before and after designs (n=50). This review reported that in shorter, non-controlled studies with short follow-up periods, there is evidence to suggest that social prescribing influenced well-being factors positively, for example, it was found that social prescribing can reduce symptoms of anxiety and depression (Napierala et al., 2022). However, the findings indicated that there is insufficient evidence from controlled studies to show that social prescribing improves different well-being factors such as mental health and well-being, general health and quality of life.

Cooper and colleagues (2022) carried out a systematic review investigating the active ingredients involved in social prescribing. Across the 17 studies included in this study, the results showed that the active ingredients identified included; person-centred approaches, behaviour change technique interventions, and a focus on well-being, as evidenced by the statistically significant improvements in well-being reported in these studies (Cooper et al., 2022).

A systematic review by Kiely et al. (2022) examined the effects of social prescribing link workers on health outcomes and costs for people in community settings. To avoid the risk of bias from poor quality studies, this review only included RCTs (N=5) or controlled before-after studies (N-3) that met the Cochrane Effectiveness of Practice and Organisation of Care guidance. Of the eight studies included, four involved participants experiencing

multimorbidity and social deprivation. Health related quality of life and mental health were the core outcomes examined, however, only two of studies reported on both of these. Overall, the review found that there was an absence of evidence concerning the impact of social prescribing link workers on patient-reported outcomes. Four studies reported no impact on health-related quality of life, and three of out of four studies that reported on mental health outcomes reported no significant findings. However, some evidence was found for improved self-rated health. With regard to people experiencing multimorbidity and deprivation, the review found evidence from US-based studies of reduced hospital admissions. Only one UK study was reported as showing a reduction in referral costs, but no cost-effectiveness or cost-benefit analyses were found. This review concluded that there was much variation in the intensity and level of support provided by link workers, who were located in both community and primary care setting. Likewise, there was heterogeneity in the study designs and variations in outcomes and how they were measured. Given the short timeframes of many of the studies, improvements in health-related outcomes were regarded as being possibly difficult to achieve. The authors called for further high-quality studies to determine the cost-effectiveness of social prescribing.

A mapping review carried out in 2023 examined social prescribing outcomes in 13 different countries, with the aim of identifying key outcomes (Sonke et al., 2023). The countries included in this review were Australia, Austria, Canada, England, Finland, Germany, Ireland, Japan, New Zealand, Portugal, Singapore, the Slovak Republic and the USA. This review of research papers (n=60), research protocols (n=6), and scoping and systematic reviews (n=21), identified 278 unique patient level outcomes, the majority of which were related to mental health outcomes (n=61). Examples of these mental health outcomes include loneliness, depression, confidence, and resilience. Other examples of patient level outcomes that emerged from this review are; lifestyle and behaviour, patient/service user experience, relationships and connection, and physical health. The review also identified 69 system-level outcomes, with healthcare and service utilisation as the most common. This review supports the findings from previous studies, such as the review by Polley et al. (2017), which also found that mental health related outcomes were the most commonly used outcomes in studies of social prescribing.

A scoping review by Wilson et al., 2025 investigated the impact of social prescribing on individuals with long-term health conditions. This review included 37 studies from both peer

reviewed (n=23) and grey literature (n=14) sources, 31 of which were from England, and the rest were from the Republic of Ireland, Northern Ireland Scotland and the USA. The review found that the percentages of individuals with long-term health conditions in the included studies was high, with some studies reporting 100% of service users having long-term health conditions. The majority of studies (27 of the 37) in this review reported having service users with long-term health conditions within their social prescribing service, including diabetes, arthritis, COPD, asthma and dementia among the 65 long-term conditions identified. This review reported a broad range of different referral agents referring those with long-term health conditions into social prescribing, such as GPs, nurses, psychiatrists, social care workers and outreach workers.

A UK study by Wilding et al., 2025 examined the impact the rollout of SPLWs nationally had on specific population outcomes. This study examined cross-sectional data from the General Practice Patient Survey between the years of 2018 and 2023, with over 4 million respondents. The study focused on five main outcomes; feeling supported by local community services, having a good experience at the GP, feeling confident to manage chronic health conditions, feeling their mental health needs were understood, and not feeling isolated. The results of this study found that for respondents with long-term health conditions, the rollout of link workers nationally was associated with a 0.07 percentage point increase in their confidence when it comes to managing said condition, and a 0.11 percentage point increase in reporting that they received enough support from local services.. Similarly, for respondents with mental health difficulties, the link worker national rollout was associated with a 0.14 percentage point increase in reporting that their needs were understood. While the results were moderate, they were still significant and positive for all outcomes except feeling less isolated. The study also reported that there was a positive association between reporting a good experience at the GP and being in in an area where there is a link worker. The odds ratio used in the report was 1.015 (95% CI: 1.004 to 1.027). While the effect sizes are small, with a population size as large as 4 million, the results are still considered meaningful as they show that there is an association between the national rollout of SPLWs and minor but significant improvements in patient experience (Wilding et al., 2025).

An exploratory RCT carried out by Kiely et al., 2024 examined the feasibility, potential impact and cost effectiveness of link workers for individuals living with

multimorbidity attending GPs in deprived areas. This study also entailed a cost utility analysis to determine the cost effectiveness of the GP-based link worker. The study demonstrated the feasibility of recruitment and retention of practices and link workers for the trial period. No significant differences in health-related quality of life and mental health outcomes for service users were detected in the primary analysis; however, preplanned sub-group analyses revealed an increase in activity participation for those who saw the link workers at least once and an increase in wellbeing for male service users. The results from the economic evaluation suggest that the GP based social prescribing link worker intervention is unlikely to be cost-effective under low threshold conditions. However, the study found that the cost effectiveness of social prescribing rises significantly when it operates at full capacity, with a 79% probability of cost effectiveness at a €45,000 funding threshold (Kiely et al., 2024). The result of this study demonstrates the potential of social prescribing to reduce costs on the health care system but highlights the need for more robust research in this area. Research published by the National Academy for Social Prescribing on the economic benefits of social prescribing (Kimberlee et al., 2022) also confirmed the potential of social prescribing to be cost-effective. Results emerging from studies carried out in 2021 by Foster et al., as cited in this summary, found that the social return on investment of social prescribing in the UK was £3.42 per £1 invested. Similarly, another English social prescribing project carried out an analysis of costs in 2018 and reported that the return on investment was £4.91 for every £1 invested, with savings related to improved wellbeing outcomes, reduction in crime and decreased falls (AGE UK, 2018), as cited in Kimberlee et al., 2022.

1.4.1 Adopting a Realist Approach to Evaluating Social Prescribing

It is clear from the reviews conducted to date that a broad and heterogeneous range of evaluation designs and methods have been used to evaluate a diverse range of social prescribing models and services. As pointed out by Elliott et al. (2022), this has resulted in an inconsistent and inconclusive evidence base for social prescribing, leading to gaps in our understanding of the impact of social prescribing and the mechanisms through which it works, for whom and in what circumstances. While randomised control trials are considered the gold standard for evaluating the effectiveness of a service, this design may not be considered feasible or ethical for social prescribing, as it would entail denying people access

to services and supports that may be essential to their health and well-being. Realist evaluations have, therefore, been identified as providing an alternative framework to traditional experimental designs in evaluating social prescribing.

Realist evaluations assume that the same intervention does not work for every type of person in every type of setting. A realist approach emphasises the importance of the context of the intervention for understanding how it works (Rees et al., 2024). A realist approach to research is rooted in the philosophical position of realism, which assumes that the social world has an objective existence independent of human cognition (Public Health England, 2021). Realist evaluations concern themselves with what works, for whom, and why. This approach is considered particularly suitable for complex interventions, for example public and community health interventions, and have become increasingly popular in health research in recent years (Rees et al., 2024). Key aspects of a realist evaluation include context, mechanisms and outcome (CMO) configurations and programme theory. The context of an intervention constitutes the conditions and background factors that can help determine whether the mechanisms of the intervention are successful or not. An example of context could be a geographic location (Public Health England, 2021). The mechanisms are the processes that occur to cause an outcome. An example of a mechanism is motivation levels (Pawson et al., 2005). The outcomes are produced as a result of the interaction that occurs between the context and mechanism (Rees et al., 2024), e.g. an intervention leading to improvements in an individual's health and well-being. The programme theory states how an intervention will cause outcomes. Realist evaluations test and refine the initial theories as the evaluation progresses (Public Health England, 2021). One of the main benefits of using realist methodology is the flexibility of the approach, with methods chosen to best suit the aims of the study (Rees et al., 2024).

A realist review examining how and why social prescribing evaluations work was carried out by Elliott et al., in 2022. This review included 83 studies comprised of qualitative (n=21), quantitative (n=14), mixed method (n=38) and reviews (n=10). An initial programme theory was developed, and CMO configurations were derived from an analysis of the data extracted from the 83 studies. Data synthesis resulted in five main themes, which underpinned the programme theory, as follows: coproduction with mixed stakeholder teams, alignment between the intervention and evaluation design, agency to make decisions, use of sequential, iterative design, and the integration of findings to produce a full picture. This realist review

highlighted the importance of a standardised evaluation framework and reporting standards for social prescribing. A series of recommendations were developed, based on the findings, for informing future social prescribing evaluations (Elliott et al., 2022).
Bertotti et al. (2018) also adopted a realist evaluation approach to investigate how a social prescribing pilot in London links primary care with voluntary sector support. This realist evaluation was comprised of qualitative interviews with service users and commissioners, a GP survey, focus groups and learning events for relevant stakeholders. The hypothesis for this realist evaluation was that social prescribing improves wellbeing outcomes for patients experiencing social isolation and mild mental health problems. Three stages of the SP pathway were explored in this study, covering the three interconnected processes of; referral by a GP, consultation with a social prescribing coordinator, and engagement with community organisations. The study findings suggest that that relationship between the social prescribing coordinator and patient/service user is a core mechanism underpinning service user engagement and well-being. A number of contextual barriers and facilitators were identified including GP awareness of community resources, time pressures in consultations, the location of the social prescribing coordinator, and funding of the voluntary sector organisations.

Realist evaluations are based on what works, for whom and why, as previously outlined. In the context of this realist evaluation, the findings suggest that social prescribing is most effective for those with complex, non-clinical needs, including individuals who are experiencing social isolation and those with mild to moderate mental health needs. Service users gain the most benefit from social prescribing when supported by a social prescribing coordinator who provides empathic and person-centred supported. In terms of what works, this study found that the most important mechanism for the success of social prescribing is a strong and trusting relationship between the social prescribing coordinator and the service user. With regard to for whom SP works, this study found that social prescribing is effective for service users who are commonly older, experiencing social isolation and loneliness, and are dealing with mild to moderate mental health difficulties. Why this intervention works, is suggested to be facilitated by the buy-in from GPs and the availability of local community organisations (Bertotti et al., 2018)

1.5 Conclusion

Social prescribing is a non-medical intervention, through which a SPLW helps to connect the service user with different amenities and activities within their community (HSE, 2021). Studies all around the world have explored what the commonalties are amongst different services, what elements work, and the reasons why they are working. Across the wide range of countries within which social prescribing is being delivered (Morse et al., 2022), similar findings have emerged. Multiple studies have shown that social prescribing can be used to address problems such as social isolation and loneliness (Bucks & Ewbank, 2022; Connolly et al., 2024). The research has also shown that social prescribing has the potential to reduce the burden on primary health care systems (Pescheny et al., 2018; Morse et al., 2022). The current literature on social prescribing outlines different theories that can be used to explain and understand the social prescribing process, such as salutogenesis (Antonbsky, 1979), social determination theory (Bhatti et al., 2021), social cure theory (Wakefield et al., 2019) and social capital (Tierney et al., 2020). There are also a number of evaluation studies and reviews that have sought to determine the impact of social prescribing for service users and providers. However, there are many gaps in the current evidence base that need to be addressed in order to inform the development of social prescribing services.

At present there are a limited number of published studies that have undertaken comprehensive evaluations of social prescribing. There is currently a lack of in-depth and robust evaluation studies, which are essential in order to establish the effectiveness of social prescribing and to examine how it works and for whom, under what circumstances it is most effective. Realist evaluations are increasingly being used to explore these questions. The present study aims to conduct a realist evaluation with key stakeholders nationally to address the question of what works, for whom, and why, in the context of Irish social prescribing. The details of the study are outlined in the next chapter.

CHAPTER 2: METHODOLOGY

2.1 Realist Methodology Approach

The current study adopts a realist evaluation approach. The objectives of the current study are: (i) to determine the active ingredients of social prescribing, (ii) to ascertain how social prescribing works for different populations, (iii) to identify facilitators and barriers of the implementations of social prescribing, (iv) and to determine the social, health and well-being outcomes that social prescribing is most likely to impact.

Realist evaluation is a theory-driven form of evaluation, which recognises that not every intervention will work for each person in the same way. This approach recognises that wider context influences outcomes (Pawson & Tilley, 1997). It focuses on identifying context, mechanism, and outcome (CMO) configurations as programme theories, which can be tested and refined against the study findings. Realist methodology aims to explain the underlying assumptions regarding the mechanisms by which programmes, or their components, might operate (Merton, 1968). Underpinned by the principle that context (C) will trigger mechanisms (M) to yield outcomes (O), a realist evaluation seeks to answer the questions – how, why, and when does the intervention work (Pawson & Tilley, 1997; Greenhalgh et al, 2017). Essentially, this approach is focused on answering the following questions: **what works for whom, under what circumstances, why, and how?** Table 2.1.1 below sets out the definition of context, mechanism, and outcomes, and provides examples of each relevant to social prescribing.

Table 2.1.1 Definition of Concepts Used in Realist Evaluation

Realist evaluation term	**Definition**
Context	Describes the background of a programme. It includes structural factors (such as social, economic, political and organisational aspects) and also individual factors (such as cultural, social norms, and relationships). Context influences whether mechanisms are triggered or not. Example: Social demographics of the service, such as urban or rural location
Mechanism	Mechanism describes how programme resources and contexts lead to changes in the reasoning and behaviour of individuals and lead to certain outcomes. They include cognitive or affective responses that individuals may or may not be aware of (such as the development of trust, increased awareness). They are generally unseen and are responsive to institutional factors. Example: Interactions between SPLW and the service user.
Outcomes	Mechanisms alter the behaviour of participants, leading to different outcomes within certain contexts. They can be intended, unintended and can occur at the micro-, meso, and macro-levels. These may be proximal (immediate) or distal (future). Example: Increased self-confidence of service user.
Context-Mechanism-Outcome Configuration (CMOC)	This is used to explain how and why an outcome comes about, such that a context triggers a mechanism, which then produces an outcome.

(Adapted from Elliott et al. 2022; Tierney et al. 2024)

This chapter presents the overall methodology for:
Phase 1: Development of CMO configurations and initial programme theory (IPT) underlying social prescribing services in Ireland.
Phase 2: Using the information from Phase 1 to guide development of interview protocols and overall study design.

2.2 Research Phases

2.2.1 Phase 1. Initial Programme Theory (IPT) and CMO Configuration Development

This realist evaluation followed RAMESES II reporting standards for realist evaluations as a basis of development of programme theory/ies (Wong et al., 2016).
IPT development began with detailed discussions with the HSE Health and Wellbeing Programme Manager and Programme Coordinator, as well as other key stakeholders, to articulate an understanding of the overall context of the social prescribing service in Ireland. Articulating the concepts and shared or contested understanding of the process considered an essential first step in theory building (Shearn, Allmark, Piercy & Hirst, 2017). Essentially, this is about addressing the following areas:

- What the programme is?
- Who is the supposed target?
- What is the supposed target?

The IPT was further developed through reviews of the literature on realist evaluation and realist reviews conducted on social prescribing services and other health and social care programmes (for example, Wood et al. 2021; Bertotti et al. 2028; Tierney et al., 2020). Informal discussions were also conducted with experts in the field, and an iterative process of discussions, feedback, and revisions of CMOs was undertaken with the HSE Social Prescribing Advisory Board and consultations with other relevant stakeholders, including service users, SPLWs, Health Promotion and Improvement Managers, and managers of host organisations (see Table 2.2.1 below for a list of stakeholders). These consultations allowed the research team to explore fundamental aspects of social prescribing in the Irish context, acknowledging that it differs from implementation in other countries (e.g., the UK, where the service is embedded in primary care). These consultations took place over a four-month period (March 2024-June 2024).

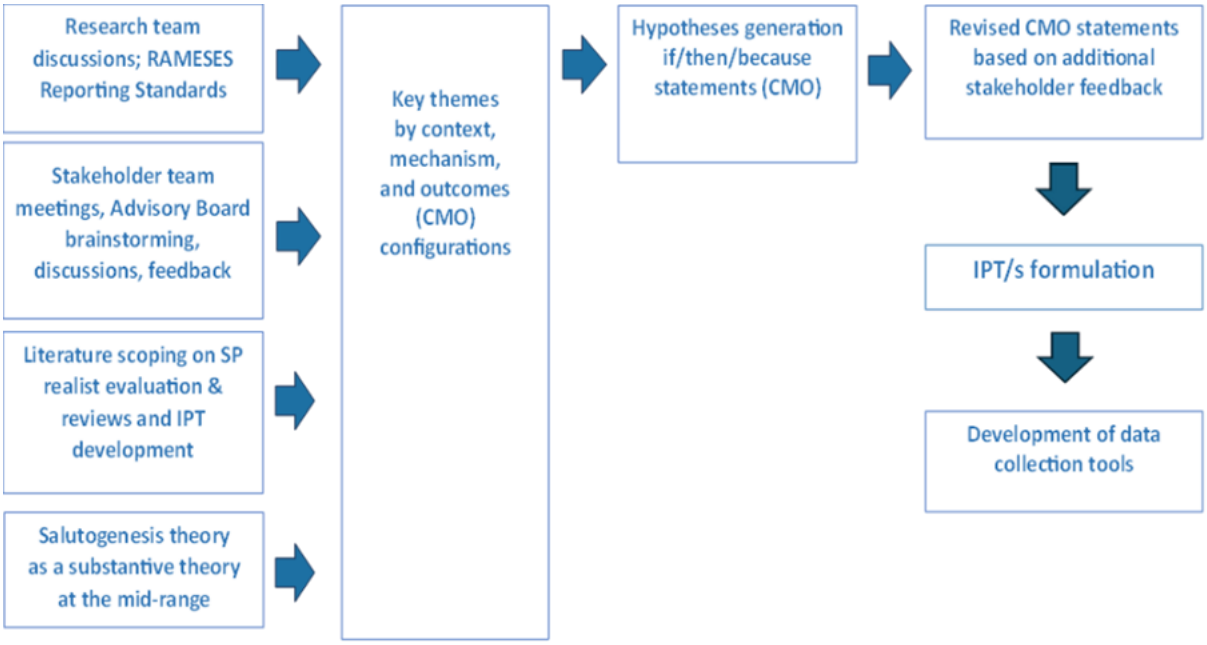
Table 2.2.1 Stakeholder Consultations on Initial Programme Theory (IPT) Development

IPT development consultations	**Number**
Social Prescribing Link Workers	4
Social Prescribing service users	2
Health Promotion and Improvement Managers	3
Health Promotion and Improvement Officers	1
Host Organisation Managers (including Family Resource Centres and Local Partnership Organisations)	3
Referral Agents	0
Academics with expertise in social prescribing services in Ireland	3
HSE Health and Wellbeing team	3

The development of the IPT followed an iterative process involving discussions with the Advisory Board and revisions to CMO configurations over several monthly meetings (Fig. 2.2.1). At each stage, to ensure accuracy, the IPT components were circulated to the Advisory Board members for feedback.

Figure 2.2.1

IPT Development Framework



A formal consultation took place using Zoom platform in April 2024, facilitated by research team members. Questions for the consultation drew on the RAMESS11 (Greenhalgh et al., 2017) guidance and the work of McEwan et al. (2023), and was based on questions aligned to the context, mechanisms, and outcomes associated with social prescribing. Prompts were also included. See Table 2.2.2 for questions.

Table 2.2.2 Questions Used for Consultations on IPT Development

Individual Group Consultations	
Context	What features of context affect how service users respond to the resources provided? In what ways do those features affect response? Who are all the stakeholders involved in the SP service?
Mechanisms	How is the social prescribing service supposed to work?

	How does it work? How does the referral process work? Is there a follow-up with the referrer? What does the social prescribing programme provide to enable changes/outcomes? How does it do this? What is the role of the Social Prescriber Link Worker? Who/what supports the programme working well?
Outcomes	What changes/outcomes does it intend to create? Who does it work best for and why? Who does it work least for and why?
Overall group feedback to identify global themes	
	What are the most important elements for our social prescribing theory to address?
	What information will be needed and could be collected about contexts, mechanisms, and outcomes?

Based on these discussions, the research team developed initial CMO configurations for the three stages of the social prescribing programme:

Stage 1. Referral of Service User to Social Prescribing services.

Stage 2. Interactions between Service User and the SPLW.

Stage 3. Interaction between Service User and community organisations.

See Table 2.2.3 below for a sample of CMOs by stage (complete set in Appendix A)

Table 2.2.3 Sample CMO by Stages

Stage 1 **Referral of Service User to SP service**	**Stage 2** **Interaction of Service User with SPLW**	**Stage 3** **Interaction of Service User with Community Organisation**
If the referrer (HCPs, etc.) clearly communicates to service users what the social prescribing service can offer them and why this may benefit them **then** service users will feel confident in their interactions with SPLWs **because** they are equipped with the appropriate expectations of the service	**If** the SP plan is Service user led and SP goals are set by the SU not staff **then** the Service user will get greater benefits **because** the activities are based on the Service user's individual needs, strengths, and interests.	**If** community activities, that are relevant and meaningful to SU, are available and accessible to them, **then** the service user will engage and experience positive outcomes **because** the service is meeting the SU's needs.

These CMO configurations were presented as 'if/then/because' statements, also referred to as hypotheses, and were framed around the theoretical relationships between and within CMOs that could explain the different outcomes of social prescribing services for service users depending on the context in which the services operate. The same iterative process - development of 'if/then/because' statements for each CMO configuration at three stages of the SP service, feedback from the Advisory Board, and refinement - was carried out in this step. A total of 28 'if/then/because statements' were developed reflecting the complexity of social prescribing services in Ireland (see Appendix A).

Based on an iterative process with feedback from stakeholders and refinement, the final CMO configurations with 'if/then/because' statements for the three stages of social prescribing service were developed, and the overall IPT was refined. The final overall Initial Programme Theory was developed as: *'The supportive interaction between link workers and service users, and the referral to appropriate community activities are central to empowering*

service users in addressing the determinants of health that are relevant for them to improve their health and well-being'.

2.2.2 Phase 2. Designing Data Collection Tools

Based on the overall IPT and CMO configurations, the research team drafted the interview guides for the following six groups of participants to capture both the strategic and operational aspects of social prescribing services in Ireland.

Participant groups:

- Social Prescribing Link Workers (SPLWs)
- Service Users
- Referral Agents
- Community Organisation
- Health Promotion and Improvement Managers
- Host Organisation Managers.

The drafts of interview guides were circulated to the Advisory Board members for their feedback and input, and final interview guides were developed for each of the six types of participants.

The interview guides were designed (where relevant) to address each of the three stages of the social prescribing services-the referral stage, interactions with SPLW, and interactions with community-based services. Interview prompts were also prepared for each guide. Please see Appendices B-H for copies of each of the interview guides.

2.3 Sampling and Study Participants

The study included 22 social prescribing sites from across the country. Based on HSE stakeholders' initial input, the number of social prescribing sites to be included in the study was set to be 17. However, additional interest in the research allowed this number to reach 22. Purposive sampling was used to recruit service users from HSE-funded social prescribing services. This sampling approach enabled the study to capture a wide range of variation within the social prescribing services such as geographic location of the service and demographics of service users. In order to maximise the recruitment of service users, it was decided to include both new and established services users.

Inclusion criteria for services:

- Social prescribing service to be established for 12 months or more by September 2024
- Distribution of sites across urban (town/settlement with population between 1,500 and 50,000), rural (area with a population less than 1,500 people) and rural towns (area with a population between 1,500 and 5,000) (Central Statistics Office, 2019)
- Inclusion of representation from Community Health Organisation (CHO) 1- 9*
    - Inclusion of both Sláintecare and non-Sláintecare sites

Inclusion criteria for SPLWs:

- Able to provide informed consent
- Based in the Community Health Organisation (CHO)

Inclusion criteria for service users:

- Able to provide informed consent
- Aged > 18 years
- Service users who were newly referred to the social prescribing service
- Service users who were using the social prescribing service for a number of months and had met with both SPLW and engaged in community activities.

2.3.1 Recruitment Process

Link Worker, Host Organisation Manager, and Health Promotion and Improvement Manager Recruitment Process

Recruitment of link workers, host organisation managers, and Health Promotion & Improvement manager*s* began in October 2024 and took place over a 5-month period. Link workers based in CHO 1-9 were sent an email by the Programme Manager of the HSE Mental Health and Wellbeing Programme inviting them to participate. If they were interested in participating in the research, they were invited to attend an information session held on Microsoft Teams in October 2024. The purpose of the session was to give an overview of the research that was taking place and to provide an opportunity to meet with the research team. Following this online session participants then emailed the HSE Health and Wellbeing team to indicate their interest in taking part in the study. Interested individuals were then contacted

via email by a research team member with a copy of the relevant Participant Information Leaflet and the relevant Informed Consent Form. They were asked to return the signed consent form to the research team if they wished to participate. The research team then followed up by email /telephone to schedule a suitable date and time to conduct the interview. The interview was conducted in the format preferred by the interviewee (online using MS Teams or Zoom, in person, or by telephone).

Service User Recruitment Process

Each of the participating link workers were asked by the research team to identify up to four services users to invite to take part in the study. To maximise service user participation, the research team decided to recruit both new and more established service users (refer to inclusion criteria above). If the service user was interested in taking part, they provided the link worker with permission to provide their name and contact details to the research team. A member of the research team then followed up by phone to discuss the study in more detail and answer any questions that the service user had. If the service user wished to go ahead and take part, they were then sent the PIL and ICF. Once the signed IFC was returned, further contact was made to set up a suitable time to do the interview. Again, service users were offered to select their preferred method for doing the interview.

Referral Agent and Community Organisation Recruitment Process

In order to minimise the tasks asked of SPLWs, participating link workers were divided into two groups, with one group asked to identify up to two referral agents and the other asked to select up to two community/voluntary organisations to invite to participate in the study. Interested individuals provided the link worker with permission to provide their name and contact details to the research team. A member of the research team then followed up by phone to discuss the study in more detail and answer any questions that the service user had. If the service user wished to go ahead and take part, they were then sent the PIL and ICF. Once the signed ICF was returned, further contact was made to set up a suitable time to do the interview. Again, individuals were offered to select their preferred method for doing the interview.

As recruitment of referral agents proved to be more challenging, the research team also drew on snowball sampling techniques to identify further referral agents through their own health and social care contacts as well as through the stakeholders on the Advisory Board.

2.4 Data Collection Methods

2.4.1 Interviews

Semi-structured interviews were used in this study. The question development was underpinned by the CMO statements developed in phase one. The interview process drew on guidance for interviewing in realist evaluation (Manzano, 2016). The interview guides were designed (where relevant) to address each of the three stages of the social prescribing services-the referral stage, interactions with SPLW, and interactions with community-based services. Interview prompts were also prepared for each guide. Please see Appendices B-H for copies of each of the interview guides. Interview guides for each of the participant groups were piloted to examine the operationalisation of the interview process and the coherence of the interview guide before commencement of data collection. See Appendix I for interview formats and average range and duration of interviews.

2.4.2 Service Level Data

In order to provide further contextual data on the social prescribing services, each of the host organisations' managers (n=11) was contacted and asked to provide their 2024 annual report aggregated data relevant to the social prescribing service. Aggregated data relevant to Sláintecare sites was collected directly from the HSE Health and Wellbeing Team. Data (where available) was collected for the following variables.

- Number of total referrals
- Number of referrals by healthcare professionals
- Number of referrals by self-referral
- Demographic data of service users (gender, age)
- Examples of community/voluntary organisations service users are commonly referred to (by category)
- Reasons for referral to social prescribing service

2.5 Data Analysis

Analysis was concurrent with data collection. Data collection began with interviews of HP& Improvement Managers and managers of host organisations, with frequent researcher meetings to discuss key concepts arising from the data. In this way, it was possible to ensure

that any emerging concepts could be addressed as needed in subsequent interviews with other participant groups as appropriate. Interviews with SPLWs, were followed by interviews with service users. The final interview groups were referral agents and community organisations. Participant interviews were transcribed verbatim, identifying information removed, and imported into the qualitative data management software QSR NVivo, version 1.7.1. Coding frameworks were developed for each interview type (e.g., service user interviews, SPLW interviews, etc.), which included deductive codes from the interview guides (based on CMOCs) and inductive codes from the data. Weekly researcher coding meetings were held. (Braun & Clarke, 2006) was conducted and discussed amongst researchers to ensure inter-rater reliability. Data triangulation involved comparison of findings across the various participant groups, as well as with the service's aggregated data, to develop a comprehensive understanding of social prescribing services in Ireland (Patton, 1999). Researchers' analysis discussions also involved an ongoing comparison of findings against the CMO configurations.

2.6 Ethical Approval

Ethical approval for the study was granted by the University of Galway Research Ethics Committee in June 2024 (Reference Number 2024.08.004). Informed consent was sought from all participants prior to participation in interviews. Participants received an information sheet, consent form, and a copy of the interview guide prior to participation.

2.7 Conclusion

The following Chapter 3 presents the demographic data from the social prescribing service and the participant profile data from this study. Chapter 3 also sets out the findings from the overall thematic analysis, while Chapter 4 sets out the findings in relation to the IPT and CMO statements.

*CHO regions 1-9 are now known as HSE health regions 1-6. At the time of recruitment and initial data collection, CHO regions were still in use, therefore are still referred to as CHO regions throughout the report.

CHAPTER 3: RESULTS

Findings from Stakeholder Interviews

3.1 Introduction

This chapter presents the findings from the interviews conducted with key stakeholder groups nationally. The profiles of the participant groups and of the services included are outlined, followed by the main themes that emerged from the thematic analysis of the interview data. The next section presents the findings of the overall thematic analysis across all participant groups. These data are presented for each of the three stages of social prescribing: referral stage, social prescribing link worker (SPLW) and service user (SU) interactions stage, and the interactions with the community organisations stage.

3.2 Participant Profiles

A total of 135 participants from the nine HSE Community Healthcare Organisations (CHO) were recruited to take part in a semi-structured interview with a member of the research team. Participants were recruited from the following stakeholder groups:

Table 3.2.1 Participant Profiles

Stakeholder Group	**Number of Participants (%)**
SUs	55 (41)
Social Prescribing Link Workers	30 (22)
Referral Agents	14 (10)
Community Organisations	16 (12)
Host Organisations Managers	11 (8)
Health Promotion & Improvement Managers	9 (7)
Total	135 (100)

Service Users

Of the 55 SUs who completed a semi-structured interview, 37 (67%) were female and 18 (33%) were male. The mean age of SUs was 52 years (SD=16), with ages ranging from 19 to 78 (See Appendix I, Table 1 for an individualised breakdown of SU demographics).

The majority (85%) of SUs identified themselves as being White Irish (n=47), with 9% identified as being White Non-Irish (n=5), 4% being African (n=2), and 2% being Asian (n=1). Just over half (56%) of SUs reported that they did not live alone (n=31), while the remaining 44% stated that they lived alone (n=24).

Table 3.2.2 Profile of Service Users

Education Completed	**Frequency (%*)***
3rd Level Degree or Higher (NFQ Levels 7/8/9/10)	12 (22)
3rd Level non-degree (NFQ level 6)	11 (20)
Technical/Vocational (NFQ level 4/5)	8 (15)
Upper Secondary (Leaving Certificate)	10 (18)
Lower Secondary (Junior Certificate)	11 (20)
Primary education	3 (5)
Total	55 (100)
Employment Status	
Full-time employment	5 (9)
Part-time employment	7 (13)
Retired	20 (36)
Semi-retired	4 (7)
Unable to work due to illness or disability	8 (15)
Unemployed	4 (7)
Full-time carer	3 (5)
Student	3 (5)
Sick leave	1 (2)
Total	55 (100)
Referral Pathway	
Self-referral	17 (31)
General Practitioner	13 (24)
Healthcare Professional	5 (9)
Physiotherapist	4 (7)
Mental Health Nurse	3 (5)
Non-Governmental Organisation	3 (5)
Social worker	3 (5)
Counsellor	2 (4)
Occupational Therapist	2 (4)
Dietician	1 (2)
Practice Nurse	1 (2)
Psychologist	1 (2)
Total	55 (100)

As shown in Table 3.2.2, 23 SUs indicated that they had completed tertiary education. In contrast, only 3 reported leaving school after primary education. Just over one third of SUs (n=16) reported that they were working, whereas the majority (n=39, 71%) stated that they were not working. Just under a third (n=17) of SUs stated that they self-referred to their social prescribing service, while the remaining (n=38) stated that they were referred by a health or social care provider.

Table 3.2.3 Geographic Location of Service User

Geographic Location	**Frequency (%)**
Urban	37 (67)
Rural/Rural town	19 (33)
Total	55 (100)

Social Prescribing Service Location

The majority of SUs (n=20) who participated in the study were based in Dublin, which aligns with the greater availability of social prescribing services in the region; the higher concentration of SPLWs in Dublin likely contributed to increased participant uptake (See Appendix I, Table 2).

Social Prescribing Link Workers (SPLW)

The majority of SPLWs (n=21) were based out of Sláintecare Healthy Community (SC) sites, while the remaining 9 were based in non-Sláintecare (non-SC) sites. In addition, the majority of SPLWs (n=17) were based in urban cities, with 12 based in rural towns, and only 1 based in rural areas (See Appendix I, Table 3). However, it is important to note that many SPLWs stated in their interview that their work could be spread across urban and rural sectors. Also, while the study included interviews with three SP Coordinators, for reasons of confidentiality their data have been anonymised and included in the table below. All three were provided with SPLW identification.

Table 3.2.4 SPLW Service Information

SPLW ID	Urban/Rural/Rural town	CHO	Sláintecare/Non-Sláintecare
SPLW01	Rural town	8	Non-Sláintecare
SPLW02	Urban	2	Non-Sláintecare
SPLW03	Urban	5	Sláintecare
SPLW04	Rural town	4	Non-Sláintecare
SPLW05	Urban	4	Sláintecare
SPLW06	Rural town	5	Sláintecare
SPLW07	Urban	9	Sláintecare
SPLW08	Urban	9	Sláintecare
SPLW09	Rural town	1	Non-Sláintecare
SPLW10	Rural	1	Sláintecare
SPLW11	Urban	9	Sláintecare
SPLW12	Rural town	2	Non-Sláintecare
SPLW13	Urban	6	Non-Sláintecare
SPLW14	Urban	9	Sláintecare
SPLW15	Urban	9	Sláintecare
SPLW16	Urban	5	Sláintecare
SPLW17	Rural town	2	Sláintecare
SPLW18	Rural town	8	Sláintecare
SPLW19	Rural town	2	Sláintecare
SPLW20	Urban	9	Sláintecare
SPLW21	Rural town	7	Sláintecare
SPLW22	Rural town	3	Non-Sláintecare
SPLW23	Urban	7	Sláintecare
SPLW24	Rural town	5	Non-Sláintecare
SPLW25	Rural town	5	Sláintecare
SPLW26	Urban	9	Sláintecare
SPLW27	Urban	9	Sláintecare
SPLW28	Urban	9	Sláintecare
SPLW29	Urban	6	Non-Sláintecare
SPLW30	Urban	4	Sláintecare

SPLW Host Organisation

Both Local Community Development Partnerships and Family Resource Centres served as the host organisation for 12 of SPLWs respectively. The remaining 6 were based in Community Development Projects. Additionally, 5 of the SPLWs interviewed for the study also worked part-time in a primary care setting (See Appendix I, Table 4).

SPLWs by Community Healthcare Organisation (CHO) Area

Just under half (n=13) of SPLWs were recruited from CHOs that incorporated regions of Dublin city and county. Factoring in SUs and SPLWs, all CHOs are represented in the data.

Table 3.2.5 SPLWs by Community Healthcare Organisation (CHO) Area

SPLWs by Community Healthcare Organisation (CHO) Area	**Frequency (%)**
CHO 1: Donegal, Sligo, Leitrim, West Cavan, Cavan, Monaghan.	2 (7)
CHO 2: Galway, Roscommon, Mayo.	4 (13)
CHO 3: Clare, Limerick, North Tipperary/East Limerick	1 (3)
CHO 4: Kerry, North Cork, North Lee, South Lee, West Cork	3 (10)
CHO 5: South Tipperary, Carlow Kilkenny, Waterford, Wexford	5 (17)
CHO 6: Wicklow, Dun Laoghaire, Dublin South East	2 (7)
CHO 7: Kildare/West Wicklow, Dublin West, Dublin South City, Dublin South West	2 (7)
CHO 8: Laois/Offaly, Longford/West Meath, Louth, Meath	2 (7)
CHO 9: Dublin North, Dublin North Central, Dublin Northwest	9 (30)
Total	30 (100)

Referral Agents

Referral agents included individuals from a variety of health and social care professions, including general practitioners, clinical nurse specialists, occupational therapists, and dieticians, as well as homelessness and domestic abuse support workers (See Appendix I, Table 5).

Table 3.2.6 Referral Agent Location

Referral Agent Location	**Frequency (%)**
Dublin	5 (36)
Galway/Roscommon	4 (29)
Westmeath	2 (14)
Cork	1 (7)
Limerick	1 (7)
Wexford	1 (7)
Total	14 (100)

Table 3.2.7 Community Organisation Information

Community Organisation ID	Role/Title
ComOrg01	Women's Shed Coordinator
ComOrg02	Peer Recovery Educator
ComOrg03	Community Health Worker
ComOrg04	Peer Support Coordinator (Mental Health)
ComOrg05	Library Coordinator/Librarian
ComOrg06	Nutritionist
ComOrg07	Adult Educator
ComOrg08	Women's Community Group Coordinator
ComOrg09	Family Support Worker
ComOrg10	Men's Shed Coordinator
ComOrg11	Community Garden Coordinator
ComOrg12	Pastoral Centre Support Staff
ComOrg13	Adult Education Manager
ComOrg14	Adult Education Manager
ComOrg15	Social Inclusion and Community Activation Client Support Officer
ComOrg16	Community Education and Development Officer

Table 3.2.8 Host Organisation Information

Host Organisation ID	Role/Title	Organisation	CHO
HostOrg1	Manager	Community Resource Centre	5
HostOrg2	Employment and Enterprise Coordinator	LCDP/Rural Development	5
HostOrg3	Director of Services	Community Resource Centre	5
HostOrg4	Project Manager	Family Resource Centre	5
HostOrg5	Manager	LCDP/Rural Development	2
HostOrg6	Director	Community Centre	6
HostOrg7	Health & Wellness Coordinator	LCDP/Rural Development	9
HostOrg8	Chief Executive Officer	LCDP/Rural Development	2
HostOrg9	Education & Wellness Manager	LCDP/Rural Development	9
HostOrg10	Manager	Family Resource Centre	2
HostOrg11	Manager	Family Resource Centre	1

Local and Rural Development companies accounted for just under half (n=5) of the Host Organisations who took part in this study.

3.3 Social Prescribing Service Level Data

For the purposes of this report, we collated the data that was commonly reported across all services, which included: number of referrals, breakdown of referral agents, common reasons for referral, and participant profile data including gender and age information. In total, 15 social prescribing sites provided data for 2024. Of these, 11 were located within SC sites, and four were in non-SC sites. As there are currently no standardised data collection procedures for social prescribing services in Ireland, it was challenging to obtain streamlined and comparable datasets across sites.

It should be noted that the service level data collected by the social prescribing sites in 2024 had many inconsistencies. There are gaps in the data, with missing information on the gender, ethnicity, age ranges, and both reasons and source of referral. Therefore, for the purpose of this report, these data were not included. In the initial stage of data collection for service reports, we requested data on health and well-being outcomes, waiting list numbers, number of no shows, and the activities that SUs are commonly referred in to. As only a small number of services provided us with these data, they are also not included in the report.

Health and social care professionals (HSCPs) were the most frequently reported referral agents, a pattern consistent across both SC and non-SC sites. Only four services reported a different primary referral source: two identified self-referrals as the most common, and two identified “other” community-based referral sources (e.g., Men’s Sheds, community services). The most common reasons for referral to social prescribing were also broadly consistent across sites. Social isolation and loneliness, as well as mental health-related issues (including depression, general anxiety, and social anxiety), were cited by all services that provided relevant data. Chronic or long-term health conditions were also frequently reported as reasons for referrals.

SU profiles showed participation across all adult age groups, ranging from 18 to 75 years and older. Most services reported that the majority of their SUs were in older age categories, with only one site indicating that most users were in the 25–34 years age group. Gender data, where available, indicated that SUs were predominantly female. Only two sites reported a roughly equal gender distribution, and one site reported a greater number of male SUs.

In summary, the data collected from individual social prescribing sites illustrates that social prescribing services in Ireland engage participants from a wide range of age groups, with a predominance of female and older adult SUs. The most commonly reported reasons for referral were loneliness and social isolation, mental health-related issues, chronic or long-term health conditions, and stress or life events. The variation and inconsistency in data reporting could be explained by the lack of a harmonised and standardised approach to data collection across Irish social prescribing services.

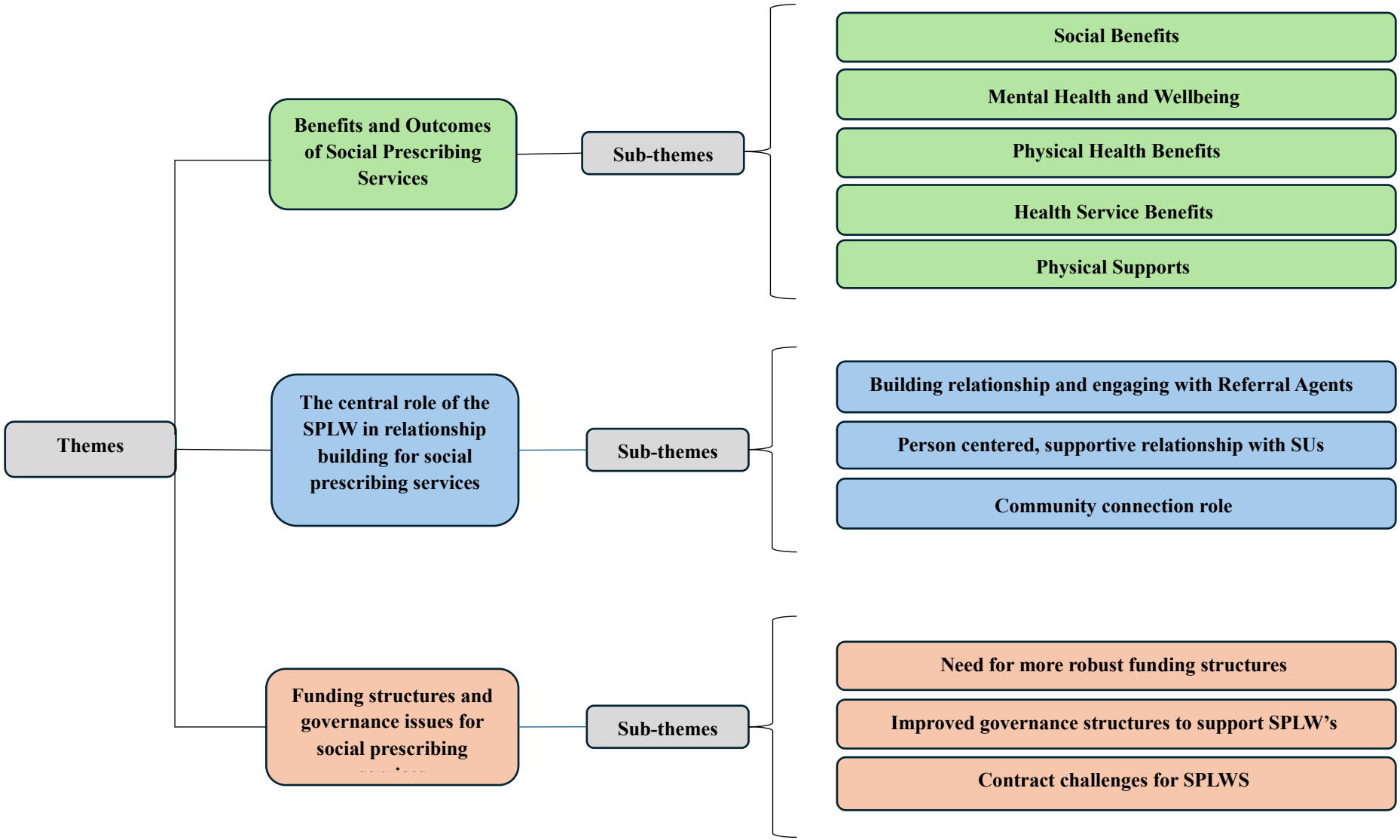
3.4 Results of Thematic Analysis

The thematic analysis of the data set, across all stakeholders interviewed, identified three overarching themes, each aligning with a specific context-mechanism-outcome configuration.

1. Benefits and outcomes of social prescribing services (Outcomes)
2. The central role of the SPLW in relationship building for social prescribing services (Mechanism)
3. Funding structures and governance issues for social prescribing services (Context)

These themes and related subthemes are set out below.

Figure 3.4.1 Overarching Themes and Related Sub-Themes from the Thematic Analysis



Theme 1: Benefits and Outcomes of Social Prescribing Services

All participants unanimously recognised numerous benefits for SUs arising from their involvement in the social prescribing service. The types of support that SUs received through social prescribing varied from opportunities to engage in meaningful and enjoyable activities that enhanced their overall well-being to accessing locally available and affordable options that promoted exercise and healthy eating, as well as assistance with everyday practical challenges and access to a range of local services to support their independent living (see Appendix J, Figure 1). Participants described experiencing immediate or proximal outcomes leading to more distal or long-term outcomes such as improved quality of life, enhanced mental health and emotional well-being, and, in some cases, a reduction in the use of healthcare services. This section sets out the findings across the following subthemes:

a) Social benefits
b) Mental health and wellbeing
c) Physical health benefits
d) Health service benefits
e) Practical supports

Social benefits

Reduced social isolation and loneliness

The most common theme identified from the interviews was improvement in social connections and reduced isolation and loneliness. SUs discussed how the SP service had changed their ability to cope with situations, as they no longer felt isolated or alone with their problems. People talked about feeling like they had someone to turn to and could reach out to them.

"…they got [SPLW] to give me a ring and I got in touch with [SPLW] and met with her, and she just kind of opened this whole world of stuff that was going on in the community to me. I had no idea of anything that goes on in the community, no idea whatsoever. So, in that respect, she has opened a whole new world to me because now I can go out two or three mornings a week if I want to. I could be doing something every single day if I wanted to

instead of just sitting at home here on my own, you know, because my husband does work all day, I have no kids, so it was just me." (SUEst61)

"It means that I'm getting out. Getting out with people and meeting people that I never knew before, even though we live in the same town, I never knew them, I never met them. So, that means I have a lot more friends now and, you know, we all get on very well together and I enjoy going every week to the courses." (SUEst50)

This improvement in socialisation was in some cases a result of engagement with the service rather than its direct function. For example, an older woman who was engaged in social prescribing and learning to use technology, after completing the social prescribing sessions went on to take her learning further and learn how to make online video calls to her family.

Building a sense of community

Many individuals noted that, along with the increased opportunities for socialisation, a sense of community was crucial to their experience of social prescribing. This sense of community was often derived from a feeling of shared similarity with other members of their group. Participants found comfort and reassurance in simply being around others who shared similar challenges. Thus, a significant perceived benefit of social prescribing was its ability to reduce social isolation by creating a sense of belonging.

"It's opened up kind of me getting back into society because prior to me going I cared for my mom, and she was 24/7 care. So, I had my own little bubble of friends. So, I've actually made friends through it. ...it was all age groups, all genders, like disabled people there, there was one guy in a wheelchair, you know, we were all coming from different backgrounds, but it didn't matter. While sitting down, we were all chatting. We were all it was like what you'd imagine Ireland years ago. You know, when the open-door policy was there, you know. It is more like a neighbourhood, like more than a community." (SUEst09)

"Yes, so she's just a really good example, I suppose, of how she's felt the benefits of social prescribing and one of the things she said which sounds, I suppose, very basic for many people is that when she comes into town now, and she does her shopping, she's meeting people in the supermarket or in the shopping centre that she's met through the group. And she stops and she's having a chat and there's a bit of a social connection there when she's out and about which she said she never had." (SPLW18)

One of the SUs described social prescribing as a ‘stepping stone’ for connecting with the community.

“I would say it's kind of a link into community. Yeah, it's a stepping stone into the community. If you become isolated for whatever reason, whether it's an actual physical isolation, or whether it's like a social anxiety thing. It's a helpful stepping stone to get you to the community and to see what is out there in the wider world. Yeah, that you might not feel that you can access otherwise.” (SUEst33)

Forming friendships and support of peers

Many SUs admitted that before engaging in social prescribing, they found it difficult to initiate social interactions. After joining, they gained confidence in talking to others and forming connections. Furthermore, SUs often formed friendships with their groupmates and expanded their interactions beyond the social prescribing activities, such as meeting for a coffee and chatting, or going to various places together.

“And some of them like, some would have a similar interest, and dogs seem to have, a lot of people in the group seem to have an interest in dogs. And as well as that, Park Run, a running group, or a walking group, has become a result of our meeting at [SP Service]. There's a walking group on a Saturday morning now” (SUEst42)

“I mean, the most important benefit is social connection. Like I cannot push enough value on the camaraderie and the friendships that they build out of it and their sense of purpose. It might be once a week that they have something to go to, but they know on a Tuesday they're going to the sewing class or the art class, whatever. So aside from the skill, that is nearly the last thing that we're looking at them getting, it's connection with others, friendships, like-minded people, a sense of purpose, you know, getting out in the day. So, it's all of those benefits which are fantastic.” (ComOrg17)

A SU who had difficulty making friends in the past was able to create a circle of friends through the social prescribing activities.

“I thought it was really a great idea. I'd never heard of the idea of it, but the fact that something like that existed, I'm like, oh, this is like a matchmaker for friends or something. Somebody who can tell you like what types of things you should go to in order to find your people, because I've been looking for like a close friend group for a long time, and I've only recently started being able to actually achieve that. And I was never any good at making

friends. I was bullied as a child… And I have like a party coming up later in the month where I'm inviting some of the friends that I've made through events that I've started going to because of inspiration I've taken from the ideas of the social prescriber." (SUEst05)

Many SUs described how they were able to relate to each other and receive peer support on issues important to them.

"It's socialising, it's learning, it's teaching, and it's helping you along the road of being a bit better, you know, being that more confident in yourself, you then you learn to maybe eat a bit healthier." (SUEst63)

"But the incidental peer support is there from the moment they walk through the door, almost. They're providing it, so just being there gives peer support to other people because they are no longer on their own. So many people with mental health difficulties think, "I thought it was just me like this. I thought there's something wrong with me", and when they start seeing that, you know, recovery approach, and say, "It's not's what wrong with me; it's what's happened to me", and, you know, our mental health difficulties are a natural response to what's happened to us in the past, people start to think, "Oh, I'm not broken. There's not nothing wrong with me. It's something that's happened that I can recover from." (ComOrg02)

Mental health and wellbeing

Participants highlighted the role of social prescribing in supporting mental health and emotional resilience in SUs.

Sense of purpose and structure

One of the prominent themes identified from the interviews with various participants was that having scheduled activities and interactions provided a sense of purpose and something to look forward to, making it easier to get through the day. The SPLWs and host organisation managers described that the common outcomes for many people that have taken part in the social prescribing programme had the opportunity to find something that helps them to get out of the house regularly. Likewise, SUs described how social prescribing helped people regain structure and focus in their lives, and regular activities created a sense of stability and

gave their lives meaning, particularly those who felt adrift due to life changes, bereavement, or job loss.

"Well. Some other life events have happened, so I'm back. I have resumed my course at the university. I have a routine, you know, like I'm back to my normal life, so to speak, but I think social prescribing was crucial for me when I was in that time period a few months ago, where I was in that slump. I suppose, you know. It was really important that. It was the only good thing going on for me at the time." (SUEst03)

"Yeah, I think just kind of having a sense of purpose and even you know that there's something coming up and that I'll enjoy it and I can look forward to it, you know, because some days you'd feel them. But then when you know that's something good and that's something you enjoy is coming up. Yeah, and it kind of makes you makes the day's a bit easier, the other days maybe." (SUNew01)

Participating in the groups provided SUs with an opportunity to take part in community activities and sometimes play a meaningful role in society. For example, one SU said, *"I was absolutely lost. You don't know what you're about, you don't know what you're getting up in the morning for, you don't know. Like we define ourselves by our jobs. And then you're not that anymore. So, what are you? You know? Yes, I'm fine now by a lot of different things that I'm doing. And I'm a retired person who does a bit of this and a bit of that and a bit of the other. ...I started teaching English to migrants." (SUEst34)*

Beyond structure, social prescribing encouraged personal growth and self-discovery. Participants explored new activities and hobbies they had never previously tried. Individuals reported taking steps towards further education and self-improvement as a result of their involvement.

"I kind of cut myself off due to mental health reasons for a long time, and it was just I kind of got a wakeup call, and it was trying to OK you can't carry on like this, so I need something. And I was very anxious about getting back into the community so and putting myself out there. But if this service wasn't there, I wouldn't be as far along as I am like. I have an appointment next week at MTU about further education and stuff like that. I wouldn't have done that. Yes, this helped me to get to that." (SUEstt06)

"Because I think then confidence will grow. You know, like you may get some of the SUs then saying to themselves, oh, "I'd like to do Level 3 Horticulture or maybe I'd like to be able to go to some of those workshops. I wouldn't feel out of place."" (ComOrg11)

Reduced feelings of anxiety and depression

Many participants described experiencing low moods, anxiety, and isolation before engaging with social prescribing services. Some SUs described being emotionally 'stuck' or being in a downward spiral, and how social prescribing helped them to get out of that state and maintain a more positive view.

"I describe myself as a deflated balloon or a flat balloon, and I need to reflate. And that's what that does for me. It keeps my spirits up. It's maintenance, I think if I didn't have it I'd be going downhill, but this way I'm, you know, I'm maintaining, and it's dreadfully important that I do because I can't afford to slump, you know" (SUEst01)

Many participants described how SUs experiencing social anxiety were able to overcome it and join groups with encouragement and support from a link worker.

"Their affect changes, you know, over time, their attitude to life changes, they become more social. You know, like we have a woman who, again really depressed, now still attending mental health services, but she has become… she's part of our choir. She goes to social events. She does most courses that we do. And the change in her, she was afraid to put her name down for things, and now she's ringing us and asking us. Like even that, it speaks volumes when you see that person." (ComOrg08)

"…like when I came out of that and going back to work, I felt like I was starting all over again and I had lost, you feel like you've lost contacts and you're not seeing people and you're not as active, you know I wasn't as active as I was, ringing my friends, you know. I just felt like I was a bit of a downer. …you would be talking to yourself saying what the hell, what's going on but anyway, yes since I started there I kind of came out of my shell and back to kind of, my normal self, almost." (SUEst36)

Other important mental health improvements in SUs included enhanced general wellbeing, overall quality of life, and ability to manage psychosocial needs.

"And when people engage in the process and go on to make some changes, or engage, you know, lifestyle changes or make connections or get involved in an activity or upscale or

explore new hobbies, whatever it may be, then the impact is it ripples throughout their whole well-being." (SPLW19)

"Like we all go through difficult times. I was not in a great place when I started with social prescribing and. It gives you something to do, you know, like somewhere you have to be, a reason to get out of bed possibly. And you don't necessarily have to make friends, you know, just being around other people, it changes your mood just by being around other people." (SUEst03)

Increased confidence and empowerment

Some participants mentioned that, over time, they started independently attending activities, finding new opportunities, and reintegrating into their communities.

"It's like you know, having been on a few of the courses now, been more comfortable with meeting people, with being in a group of different people, it might be 10 or 15 per cent [more comfortable because LW Is there] but generally, it would be myself. Like if [SPLW] sent me a message about say snooker, or say painting and she said now I won't be at it, now I have other things to do, I don't think that would put me off you know?" (SUEst02)

"It's like an inner glow that could they kind of develop. They wouldn't meet your eye but they'll be not as confident, maybe as they could be, but by the end of the course, they all meet your eye, it's incredible. And they're much more chatty and they're all going to tell you about how much they love the course, and could they have it again, and, you know, it's just amazing to see the transformation in almost all of them." (ComOrg07)

"They felt the confidence to talk to people they didn't know. They realise there's other people in the same situation. There are other people in the same age group, maybe, or maybe older, or a little bit younger, or whatever, you know, that they can connect with, that they live locally, so they're able to make friends outside. You know, they're able to see these people outside. They might meet them in the supermarket then, and they can stop for a chat and all of that." (SPLW26)

"It gives me more confidence, I'd lot of confidence before, but then as is life happens, you know, you kind of lose a bit of confidence. And then when you know you can kind of socialise again with people you know and yeah, that's nice. And that's your groups out there you can just take it out of the house too, because I do get out of the house. But you know it's kind of nice to actually go out and just to have something planned to go to." (SUNew01)

In some cases, the friendships formed during social prescribing activities resulted in individuals starting their own initiatives, such as forming new craft groups or projects. Furthermore, stories were shared where SUs were becoming leaders of a walking group or community shed, or getting involved in volunteering, even after their initial engagement with social prescribing had concluded. In these situations, this appeared to be a result of the boost in confidence and skill enhancement gained during their experience with social prescribing. Many SUs noted that their experiences left them feeling more motivated and empowered, which would likely further improve their mental health. LW acted as a catalyst for change, giving individuals the encouragement they needed to take control of their own social and emotional well-being.

Physical health benefits

Improved health behaviours

Participants described many cases where their physical activity increased because of engaging with social prescribing and community organisations. In most cases, SUs engaged with physical activities as a way of meeting new people, but still experienced the benefits of a walking group, gym session, or yoga class. As a result, many described becoming more active in their daily lives. For some SUs, engaging with SP helped them achieve a physical health goal.

"there was other things as well. Like I think I was interested in trying out something with kind of yoga or just general sort of calisthenics for just general fitness and she was able to put me on to where those are in town and stuff like that as well." (SUEst37)

"And I suppose my physical health, and I've also joined classes now and I will park my car in the centre of town and walk to the class that might be half an hour away so I'm kind of gaining, you know, I'm getting an hours walk in as well so from a physical point of view." (SUEst51)

In some cases, engaging with SP and the physical activities provided by community organisations resulted in participants noticing improvements in their health conditions, such as lower blood pressure, wight loss, and pain reduction.

"Another gentleman recently, he had been referred in by his GP. He was quite overweight, had no kind of daily routine. His eating was all over the place. You know we got him into the Healthy Food Made Easy and got him going to the gym and yes, he was really excited. Like in a very short space of time he'd lost kilos" (SPLW20)

"I would say it's a great way to make new friends, to be part of a group, to socialise, to learn something new especially, and, you know, it really made a difference in making me fit, and that because of those classes. I mean, my overall health has improved. I mean, it could be remarked how much like blood pressure and all that it's gone down, especially because I had such a serious heart operation, I had very clear but yeah, it's come on and leaps and bounds now" (SUEst52)

The mental benefit of physical activity

Many participants described the reciprocal relationship between physical and mental health. They noted improvements such as improved mood and increased confidence to take care of oneself and having a more positive outlook on life.

"One of the things we talk about in the college a lot is changing our lives, but recovery is about having your life where you want it to be, and that means often making practical changes as well as psychological changes. Often when we make the practical changes, the psychological changes look after themselves. So, getting involved in the community, doing things that we want to do and the social prescribing gives people a path into all kinds of things that they might not have tried out otherwise." (ComOrg02)

"...when I started working on myself and through the mindfulness it gave me and getting out there, and the courses themselves helped as well. Like, yeah, the Tai-Chi. I found something that I haven't found that I love so much in a long time. You know, it's, and then obviously getting better and feeling better has led to me thinking more positively, acting more positively, and hence thinking, yes, I can go back to work, right? I have to go back to education because I don't really have one, but like I can contribute and everything." (SUEst06)

A referral agent spoke about the positive impact of social prescribing for a SU who was on methadone.

"That methadone patient that I talked about. I suspect it was the increased socialisation and getting confidence to go out and meet people and do things that led her to come off methadone about a year later" (Ref08)

Health service benefits

Improved health literacy

Participants highlighted how engagement with social prescribing has led to improvements in how SUs understand and manage their conditions and new learning in how to navigate the health system. For example, in relation to managing diabetes and chronic obstructive pulmonary disease (COPD).

"Like one guy came back and when I first saw him, he wasn't checking his blood sugars at all, but he came back. He was checking a good bit. And I was like, oh, you're checking a lot there. And he goes, oh, yeah, the lads in the group kind of encouraged me to check if I'm not feeling well or, you know, they kind of they kind of said it so I think from an encouragement point of view as well, it's been good". (Ref12)

"Like, we have COPD clients when we link them in. So, basically, I kind of go back and forth a little bit. So, when COPD is presented to us, sometimes they are not always engaging in the COPD rehabilitation clinic. And [name] Social Prescribing have an excellent relationship with the Primary Care. So, we are able to refer back in and we are able to connect with respiratory. We are also able to connect with the self-management team. When we get that person cared for by either going into their home for their COPD to show them how to use their apparatus, that changes things. They feel well, they start to feel like they have -- they can walk a bit more. They can get the bus over to the COPD clinic. It all kind of has a chain reaction." (SPLW11)

Reduced healthcare visits and reduced appointments

Referrers provided examples where they clearly saw the potential of the social prescribing service for reducing numbers of repeat appointments and hospital admissions.

For example, one OT provided an example of a SU, where increased social connection and sense of meaning also reduced the large amount of time that the health care service were spending on a particular case.

"And like, as I said, just for example like for that other gentleman, the amount of time that he was wasting for him, for us and then you're going out to see him and there's nothing wrong

and you know from his GP and from the whole other services. And now that he's found his meaning and he's out and he's social like it's just changed his life as well .” (Ref13)

A clinical nurse manger in mental health services described how the need for their services declined as the client became more involved in the community through social prescribing.

“So, you might get a reduction in needs to come and use services here, but also people's lives, their quality of their lives would improve. You know what I mean? Their mental health would improve, but they don't need to be in the service a lot of them once they, because it's loneliness. Or once they're busy and enjoying things, their depression lifts. It's usually because of circumstances that their depression is the way it is. So once things change and they link in with things in the community, you know, a lot of them won't need to be here” (Ref14)

Social Prescribing as a wraparound service

Participants also highlighted the potential of SP as an important wraparound support service.

“It means it's people who engage with social prescribing and have an open door then into all the other services that we provide. So there's a wrap around. So if people, if people need them or would like them to know, so it's worked very well for us.” (HostOrg04)

“Oh, I think it just gives them an alternative option to you know. I think it's kind of a wraparound service for them. In my experience of it anyway, when they when they decide to engage with it, I think it can open up such a wealth of benefits for them provided they're engaged. ...Complete psychosocial, complete physical and psychological as well. Overall, you know a positive health experience really, their general wellbeing.” (Ref05)

Some participants also noted SP’s additional benefit for SUs in recovery, and as an important support where SUs were on waiting lists for further mental health supports.

*“Psychologists, that's a huge one. Psychology would refer, because we would get an awful lot of anxiety presented to us from psychology. So, in order to -- we'd work with the individual while they waited for engagement for other services. Mental health, that's a huge one. Psychiatry, they send an awful lot of people our way. Because they see the power of engagement while the person is seeing them as well. So, you know, there' s a whole piece around tha*t.” *(SPLW11)*

"A mental health patient who attended psychiatry as well as myself [OT]. And she went and she got linked in with the knit and natter group. And that made a big difference to her. Got her out every week. And you know whether it yeah, it prevented admissions to hospital. I think in her case." *(Ref08)*

Social prescribing is particularly valued for the support it provides for HSCPs in areas of greater disadvantage where meeting the needs of SUs can be complex, compounded by the stress of disadvantage. Referrers also value the fact that social prescribing can often provide a benefit to SUs where other avenues of care have not met their needs.

"Because I'm part of this 'deep end' group that works in areas of disadvantage. So we're out hunting for services all the time. Our patients have no money and cannot pay for anything. And our work is much easier when we have the support of people like the social prescribers. (Ref08)

"Then there's another group. And I don't really know what would help them, but I know that they need support in some way, and you know, I'll recognise that socially, maybe they're isolated or they've got mental health problems, they don't really want to go for counselling, they don't qualify for the psychiatric service, which is 99.9% of them. And you know, if I can persuade them to just have a chat [with SPLW] ..very often in areas of disadvantaged, people's lives, they're very complicated and busy and stressful. And getting them to go somewhere even once is, the trick is sort of bargain with them. Just meet this one. She's lovely and she'll help you. And what I've been taken aback about and slightly injured in terms of pride is about how they have sometimes identified interests or needs that the patients have that I had missed." (Ref08)

HSCPs also highlighted how social prescribing can improve the service they bring to their SUs.

"Social prescribing provides a means of supporting SUs who otherwise you wouldn't [be in a position to support] because there's some people that we don't, you know, there's some people who are quite isolated. You don't know what you can do for them. And I don't know if we didn't have this, what else I could have offered them. You know, that kind of way". (Ref12)

"They're very proactive the social prescribers. So, I might send somebody and say, you know, is suffering from mental health problems, has a lot of stress at home, you know, could do with

meeting other people or anything else you can come up with and then they might say, well, you might like this WRAP programme". (Ref08)

Some referrers will also link directly with the SPLW for advice on accessing a particular support/community-based group.

"And so, I mean, if I have somebody who's kind of you know, going through a depression and starting on medications and yes, I'd like them to do something social. But what I really want is for them to find a counsellor say, yeah or a support group for people who, you know parents of children with drug users, or you know, something like that. Well, I would ask for that. I would actually get in touch with them for that. Any kind of support group is there anybody you know? I will sometimes refer them to parents of children with autism and say, you know, can you put this parent in touch with other parents or a support group or something like that?" (Ref08)

Another highlighted the importance of SP as a viable alternative to medication for some patients.

"I don't have to medicate everyone, because sometimes we think that the only thing that we can do as a doctor is medicating people and I hate that, especially for mental health, because if they can get better with exercise, with changing social activities and everything, like why would I medicate someone and expose you to side effects? And it gives me that tool to prescribe to people who I think they are not going to benefit from medication, but they need something to improve their mental health and also in people who need medication whenever they get a bit better and they have this enough strength in order to start doing the effort of attending activities, facing the fear that they may have from meeting new people and something that they don't really know what's about. That's when I think they can benefit from that." (Ref04)

Practical supports

Practical, everyday supports

SPLWs noted that, alongside supporting wellbeing and community connection, many SUs require assistance with practical aspects of everyday life, such as form filling, accessing entitlements, and application support.

"I often find as well, again with maybe a cohort of clients we get, that sometimes if something that's stressing them out, that you can do an initial support with, I find a lot of time, it's housing applications, or it's checking are they on the right benefits or it's… So, trying to figure out those little pieces first with them. And that can actually help build a bit of trust and you do something quite tangible straight away with someone, and not feel well, that this isn't my role, but actually until you kind of support them with this, they're not going to move on to anything else, because this at moment is what's stressing them out, and being able to recognise that as well." (SPLW08)

"I got through to [Council Employee] and I was trying to inquire with [City Council] about his housing application and where that was heading and that sort of stuff. So, eventually [Council Employee], they finally got back to him, and he was finally moved out into his full accommodation." (SPLW27)

SUs reported using SP for a variety of practical matters, such as sourcing or moving accommodation, starting or leaving an employment, financial support, CV drafting support, interview preparation, as well as other tasks such as photocopying, writing emails, and filling out applications.

"But I'm a very sociable person, so I needed to use the services for other things. So, it was filling in forms and all for... I've since got a house from [County Council], and...Yes, I have gone out in the community and all, but I was helped greatly with form filling and photocopying and all that I could not, I could not have done on my own, so, that was huge in helping me get on in my life." (SUEst38)

"If you need to know something, like with [SPLW] now, like about a stair lift, you know. She put the application in, you know, she did that. Didn't have to do it, but she done it. You know, that's what you need...If they asked her a question, if she can't answer it, she'll find out for you, you know. And she won't let you down. She'll go back, she done it for me. She came back to me about the scooter, and the OT in [Location] rang me a few weeks later, says, 'SUEst66, you'll have that scooter after Christmas'. Just like that." (SUEst66)

Route towards lifelong learning

Additionally, participants found that SP served as an avenue towards education and lifelong learning. Engagement with community organisations through social prescribing referrals frequently introduced SUs to a range of educational and skill-building opportunities,

including computer courses, IT literacy courses, language classes, and life skills or soft skills programmes. Over time, participation in these activities was seen to spark curiosity, self-belief, and motivation to learn, sometimes leading people to pursue further education or vocational training.

"So these are workshops, soft skills, life skills, kind of pre development type courses. They're not accredited, but they are designed very much to support people who may be experiencing things like, you know, the digital divide might be holding them back from employment or holding them back from achieving their potential. So they may be struggling with technology so we have a workshop around everyday Internet skills." (ComOrg16)

"I would say no more than our own students, adult education can change their life. They have something to come to. They, you know, the whole work we do helps people advocate for themselves. They can then make connections, they're more confident even like you know, you're the simple thing of like your you phone, learning to use your phone. So, I mean, we wouldn't have had hundreds you know. I think they've been appropriate referrals, and I feel the prescribers feel we are a centre, that they can refer people to that can work for them." (ComOrg13)

Summary

Participants in this study have highlighted a wide range of positive benefits associated with social prescribing. Many of the outcomes identified can be considered as proximal outcomes that are important prerequisites for longer-term (distal) outcomes such as improved mental health and wellbeing. These include improvements in feelings of confidence and increased social connection. Outcomes related to health literacy in terms of managing health conditions and navigating the health system were also provided.

Theme 2: The central role of the SPLW in relationship building for social prescribing services

Another theme identified from the findings is that the SPLW is central to the effective implementation of social prescribing services through building and maintaining relationships with all the key actors in this complex programme. This is a key active ingredient of social prescribing services in Ireland. This focus is evident throughout all three stages of the social

prescribing service (referral, interactions with SUs and interactions with community organisation). Further, this central role of the SPLW is pivotal in bringing about the many positive benefits and outcomes associated with the social prescribing services. Relationships with referral agents and community organisations rely on open communication channels where the SPLW provides ongoing and consistent promotion of the service with a range of HSCPs. In addition to facilitating and supporting SUs' use of community-based resources, the SPLW also works with community organisations to identity potential areas of development for additional resources for SUs. For SUs, findings indicate that it is the quality of the supportive relationship with the SPLW that is central to their perceptions of the benefits they have received from engagement with the social prescribing services. The subthemes related to this overarching theme, encompassing each of the stages of social prescribing services, set out both the facilitators and barriers associated with the work of the SPLW:

a) Building relationships and engaging with referral agents
b) Person-centred, supportive relationships with SUs
c) Community connection role

Building relationships and engaging with referral agents

This subtheme presents findings relevant to the role of the referral agent and their interactions with the SPLW. It includes data on factors such as level of awareness about social prescribing services amongst HSCPs, including its benefits and the factors that influence the engagement of referral agents and SUs.

Trusting relationships

Referrals by HSCPs are highly regarded by SUs due to the trust of SUs in their provider. HSCPs, including GPs, believe that they have a positive reputation among patients, which can positively influence the likelihood that SU will attend the initial appointments with the SPLW and their willingness to engage with SP services. Referrers highlighted the importance of the trust that that SUs place in the HSCP as an important facilitator, which translates to trust in the service they are being referred into (social prescribing).

"If the clinician has a good rapport with the patient, I think they see it as 'oh the doctor recommended it, so it must be good'. So, I do think if we kind of bring it up, it does improve the engagement." (Ref12)

I think more than that is a personal relationship that you have with your patients. I think it's a little bit of, 'I trust in my GP and if she thinks it's going to be good for me, then I'm going to try and see exactly what this is' (Ref04)

Referrers noted the importance of the patient having trust in the HSCP but also highlighted this in the wider context of the referrer's relationship with the SPLW. Having a good understanding of how the SPLW engages with SUs and being able to explain this to their patients is also important for building the confidence of SUs to attend SP service. Another important point highlighted was ensuring that the SUs understood the nature of the service and that it was separate from other HSE services.

"It's all really about relationships. So, it's about my relationship with the patient and my relationship with the social prescriber as well. I think that's huge because then you know, I think if the patient trusts me that I'm going to send them to a service that's going to look after them, and I know the service, the person that's providing them social prescribing, I think that's the key piece." (Ref05)

"But yes, I think being able to explain that to patients is important because there's always the fear of, "are you just fobbing me off to another service here?" You know? "Are you trying to get me out or get rid of me?" And I think they really respond to our confidence in the service." (Ref02)

The referrer having an insight into how the service works is also important to encourage SU to engage with social prescribing.

"I usually say something like there's a really good person in the community. She's called a social prescriber now she's not a social worker. And she's got nothing to do with Tusla, which generally aggravates people. And she'll help you. You know she'll meet you for a chat about what might you know, help to improve things for you. You know, about 'What are you interested in? 'Or 'do you like gardening' or 'are you into art?' or 'what about a walking group?' There's this lady called the social prescriber and she'll be in touch with you, and she'll help you get to the class." (Ref08)

This sense of trust is reiterated in the views of SUs.

"Just took what he [GP] said because I know him years, so I trust him." (SUNew02)

"So, then she [GP] explained, and then set up the meeting, referred me to the link worker and my GP is a great advocate for that service. And yeah, and then the first meeting happened." (SUEst27)

Lack of integration across health and social care services

The referral process is complex with multiple referral pathways, including self-referral which is possible in the Irish context. Study participants reported varying levels of awareness and knowledge about the availability of social prescribing services among referral agents, with 'pockets' of referral agents, who may then act as 'champions' or 'advocates' of social prescribing in a local context. Limited integration of health and social care services in the Irish context is linked to limited integration of promotion across services. Referral agents who have both a hospital and community remit also highlighted a current gap in hospital staff knowing about and using social prescribing. Some referral agents, working with multidisciplinary teams (MDT) or staff teams highlighted a lack of knowledge amongst their own colleagues often working within the same building. In Ireland, the integration of social prescribing into primary care practice is only in the early stages of development.

"So I'd say in the community we're probably good at promoting it and knowing about it, but I would say in the hospital setting, we're not and it would be better, probably be more useful in the hospital setting because you have people who present a lot and perhaps if they had a stronger community support or a link that might reduce the amount of admissions so I would say that we're not great as a whole as healthcare professionals at promoting it".(Ref12)

"They don't know about it necessarily. So, I suppose they're relying on people championing it within services. So, I'm kind of going around and giving leaflets out to other staff members, but until you've put a patient through it, I think there's always a bit of nervousness about -- there's a bit of unknown here, like I don't want to refer a patient to something that mightn't be very good. So, there's bit of work to be done, I think." (Ref02)

The lack of integration across health and social care services can impede an overall cohesive approach to promotion of social prescribing services. This can result in disparity, in that all potential SUs will not have the opportunity to be referred to the service.

"I think it's also, the people who are benefiting most, I would think are people who have an active GP who sees the opportunity for social prescribing. We see a lot of bringing people in

for that first initial referral is down to that initial conversation with the health professional or with the community development worker or whoever might be, to try and say, "well look, will you try this? Will you just meet this person? So, they're the people who I suppose who benefit. So, some of it is down to chance. If they're lucky enough to come across people who are, who have good communication skills and who are able to refer them in."(HPIM08)

Currently in Ireland, there are only a small number of SPLWs located in primary care or GP clinics. Five of the SPLWs interviewed in this study had some part-time hours in primary care settings. Having this set up was viewed favourably in terms of improving access for SUs.

"And so I suspect that having the social prescriber based in the practise would make a difference. It will be more to the front of your mind and the patient would not have to go somewhere strange and they would be very comfortable. You know, we have got, say, addiction workers and domestic violence workers come into our practice because the patient has been very wary of going somewhere else and seeing other people and being seen going into the addiction service and this kind of stuff." (Ref08)

Promoting understanding and awareness of social prescribing

Some referral agents may lack sufficient knowledge of social prescribing, while others may have a greater awareness of the process and consistently refer SUs. Some HSCPs, including GPs, may not have enough understanding of the referral process to explain it to their patients, largely due to frequent staff turnover and the presence of new staff members. Therefore, host organisation managers and SPLWs emphasised that it is important to continue to contact referrers, reiterate, and constantly update them about the social prescribing service and the referral criteria. This need for consistent ongoing promotion of the availability of the service to HSCPS and to the general public was highlighted as an important role taken on by SPLWs and other stakeholders.

"Because HCPs change all the time, it's really important that social prescribers go back in and present and reiterate who we are, what we can take, who we can see, why we have exclusion policies. You know, we have to be very firm, I think. And that for me is a huge thing, it's just going back to re-educate." (SPLW11)

"I think there's an ongoing role in talking about what we do. Do you know, it's not just a once-off. Like, you tell the story, but by the time the person might be coming to you, some staff has moved somewhere else, and a new person is in, and they don't know. So,

like there's a constant need to be updating that kind of message of who we are, what we are and what we offer". (HostOrg10)

Referral agents want to know how the service works and what the benefits are for their patients/SUs. Many health care providers highlighted the value of using case studies amongst colleagues to illustrate the positive benefits of social prescribing, noting that it was sometimes difficult to refer into a service with limited knowledge about the service itself.

"I suppose flagging, and maybe them [SPLWs] coming into a team meeting or just sharing what they do and some case studies and things. Because I think they'd be really keen to promote it. They [colleagues] were delighted when I told them what it was and that patients could access it. They were like, "My God, I can think of patients this would be brilliant for." But they don't know about it necessarily." (Ref02)

Stakeholders highlighted that there is not widespread awareness amongst GPs about the availability of SP services. Linked to that is a limited focus on the role of social determinants of health in addressing health issues as a routine training for GPs.

"First of all, it's not part of their education, you know, and it's not actually communicated within the GP movement. They haven't actually endorsed it or bought into it in any significant way. They haven't been really consulted on it. And there's confusion amongst the GPs. Is it credible?" (HPIM04)

"I think that it's [social prescribing] a very, very interesting tool and I think it's been under used by most of my colleagues. I'm the only GP using social prescribing in my practise and we are 7 doctors. I think because I don't know that we've been educated in a way where, when you go to college everything is medication, counselling. That's it for mental health.
You don't have any other options, although we know that exercising, lifestyle changes, social prescribing can help them improve them and more than medication and other things.
But that's not an approach that we are used to use in general practise, so especially for older GP's who are not that used to using different tools, it's a little bit more challenging." (Ref04)

Others saw the value of social prescribing for improving quality of life.

"I suppose if I pick up that they're socially isolated, if they've got a lot of, you know, health problems that are kind of intractable and difficult to resolve and you know. And I'm thinking, you know, things are not going to really improve here. So, we need to kind of think about quality of life and how can we improve quality of life." (Ref08)

"So I suppose it would be mainly for support and also to avoid isolation so that they know there's certain groups or certain things that they can that are in their communities to stop them getting isolated and things like that." (Ref12)

Many participants noted that there is a low level of awareness among SUs regarding social prescribing services. They identified several reasons for this, including the relative novelty of social prescribing in Ireland, confusion over the term itself, which contributes to a lack of public knowledge, as well as heath literacy challenges among SUs. Another factor is that GPs often do not have enough time during consultations to explain what social prescribing is and how it can benefit SUs due to the limited duration of their appointments.

"I think maybe if the referrers had a little bit more time to explain, you know, what the service was about… GPs are very pushed for time, they don't always have the time." (SPLW03).

When GPs explain social prescribing to their patients, some individuals may not fully absorb the information due to heightened anxiety about their health conditions at that moment. Another issue raised is that social prescribing can carry a stigma, which may result in decreased acceptance of social prescribing among potential SUs. SPLWs recognise the importance of addressing the stigma associated with being referred to social prescribing and have proposed solutions to tackle this issue.

"One thing I would say to improve would be to expand the definition. I suppose it might break down the stigma in that someone doesn't need to be depressed or have anxiety to access the service, they can just be experiencing those feelings, and I suppose that it's a preventative service, that it could stop somebody reaching the level of depression if they access the service on time."(SPLW24)

Participants highlighted that SUs' health literacy can play an important role in their awareness and acceptance of social prescribing. HPIMs highlighted that health interventions, including social prescribing, often fail to reach those most in need, such as individuals with low levels of education or living in disadvantaged. While motivated individuals might benefit from health initiatives, those with lower literacy or complex health issues can often remain unaware of available resources.

"At the moment it's [SP] like every health intervention. We have one model, one leaflet one pathway. So how do we tailor that to reach people? For instance, the Traveller population don't avail of social prescribing; the migrant population typically. So, you know,

people who are released from prison, they don't avail of social prescribing. So, you know, the people who are most deprived and most in need don't know about it. It's classic, with every health intervention this happens, you know, and are you, do you simply compound disadvantage then because of this approach you know?" (HPIM04)

Several SPLWs also stated that enhancing SUs' awareness of social prescribing is a health literacy issue, and the primary responsibility resides with those who possess the information, thus critical consideration should be given to the manner in which information is communicated to people Participants described many instances when SUs attend a consultation with SPLW despite not knowing what SP is.

"And then somebody will come down and they mightn't have a clue why they're here or in some cases they say I don't know why I'm here, the doctor just said I've to come, and you know the way some older people in particular will do exactly what the doctor tells them, you know, and in that case the link worker would be very mindful to talk it through, explain what it is, and not to force." (HostOrg09)

"So, this is kind of a little bit like the health literacy piece where, yes, the onus is on us as patients to ask questions, but the biggest onus is on the people with the information. So, it's how you give somebody the information." (SPLW28)

Understanding the referral process

SPLWs consistently highlighted that the timing of engagement is crucial to whether the intervention is effective. They described how a person's readiness for change determines how well they respond to social prescribing supports. This readiness to engage can be influenced by a myriad of factors such as one's personal circumstances, mental health, or stage of recovery. SPLWs noted that some people come to the service when they are *ready and motivated* to make changes, recognising that the change must come from the individual, and pushing someone before they are ready is unlikely to succeed.

"I suppose the way I look at it is a lot of social prescribing is around the timing. So it depends at what stage in person's life or in their illness or in their mental health. But... you know some people the timings, right. And they're coming out of maybe a depression and they're really want to do something, and they're all kind of... motivated to take part in something. And for other people, maybe they're on a kind of a downward wave, and it's just not the right time so." (SPLW03)

"So it works the best for somebody who wants to make a change to themselves. Who's willing and able to make a change to themselves, really willing and able.. The person's got to want to make a change themselves, and if they don't want to make a change or if it's only the people around them that want to make a change, I'm happy to talk to them I'm happy to give them leaflets but it doesn't really tend to go anywhere." (SPLW04)

Consequently, referrers must evaluate the appropriateness of referring an SU to a social prescribing service. The referral agent plays an important role in assessing SU's readiness to engage with social prescribing and making an appropriate referral. Having access to clear criteria for an appropriate referral is important at this juncture. Another important factor is the referrers' knowledge of the SU. However, it was also acknowledged by participants that not all referrers may have a long-term knowledge of the patient, which is important for this decision-making process.

"I would normally have seen people for a period of time and gauge if it's appropriate. Not every clinician has got that opportunity. But I think there is a place for it probably across a wide variety of professions, but I would say it needs to be done mindfully." (Ref02)

Referral agents also spoke about the importance of making a formal referral on behalf of the patient rather than just giving the person information to follow up themselves.

"You have to be curious about what the person needs and if it's the right time for them in order for it to be successful, because yes, you can, you know, signpost people in, but they may never do anything about it. So, I generally ask the person's permission." (Ref02)

"The key thing being that the social prescriber contacts them after they get the referral. That is super important. You know, if I had to give them a number and say I want you to ring this woman and she's going to help you, that'll never happen. So, it's a really important positive thing that they will ring the patient themselves. So, the prescriber will make contact. I always put their referral in for them." (Ref08)

The importance of this approach was also emphasised by SUs.

"He [GP] said to me, I have something here that might be of interest to you, social prescribing, and he said I can give you the name of the person or I can get the person to contact you. And I said ah give me the name of the person and then I thought no, you contact her, if he gave me the name, I might never contact her" (SUEst02)

Several stakeholders raised concerns about a lack of clarity on what the social prescribing service is. SPLWs, host organisation managers, and HPIMs reported that social prescribing is often seen as a service 'for all needs' or a last resort where there are no other services available to refer a client, which resulted in inappropriate referrals. Social prescribers and managers conveyed that social prescribing should be seen as "*just one type of professional service among many"* specialised services *(SPLW04)*.

"The biggest [challenge] is this idea that it's a panacea, and it's not, you know, there has to be a kind of recognition of what it is, and what it isn't. That needs to be clear, and for everybody and for social prescribers as well, and for health professionals. So, I think that piece of marketing the programme, we need to be careful about it." (HPIM09)

"I think… a referrer should look at a client and think OK if they need help with their diet, community dietician. If they need help with their mobility, use your OT, or if they need help with socializing, social prescriber. We should just be one form of professional or one service among many. And people then should get whatever service they need. But this idea that social prescribers can do everything is ridiculous." (SPLW04)

Often times SP is confused with crisis management or counselling services, resulting in patients with acute mental health crisis being referred to SP. Across all stakeholders there was agreement that SP referral is not appropriate for those who are experiencing an acute mental health crisis/episode but that such individuals can be informed that the door is open for them when they are able to engage with services at a future date.

"I suppose social prescribing is a tier one intervention, and we have to be very clear about it. We can't work with acute mental health needs" (SPLW11)

Referral agents also highlighted a need for additional clarity on referral criteria, particularly in relation to mental health issues. However, overall, referral agents in this study reported a good understanding of the criteria for appropriate referrals. They highlighted a nuanced approach to the factors that might deem a referral to be inappropriate. Referrals were not deemed appropriate for those with "a*ctive addictions, too physically or mentally unwell". (Ref08)*

"Yeah, I know that there's the criteria of who's not suitable. Someone who can't leave their house, and don't want, they don't consent to the referral and then someone who is suitable is someone who can leave the house and is open to the referral." (Ref13)

Concerns about the safety issues and duty of care in relation to referrals and recognition of other referral pathways, for example, for those with severe cognitive impairments, were also acknowledged.

"If I had any safety concerns in relation to, like if I was going out to someone and I had to make sure that there was someone with me when I was going out to someone or if there was any issues like that. Like I have referred people with cognitive issues before, but maybe mild as opposed to severe, you know cognitive issues cause there's a different pathway for that really. Yeah, like I really successfully referred someone that had mild cognitive impairment before. Yeah, probably more safety issues, I would think, yeah". (Ref13)

"Obviously I suppose if I felt someone was a bit overly aggressive, you know I wouldn't want to put someone in a dangerous situation either. So, if I felt someone was aggressive. And if I felt someone was racist or misogynistic or something, I wouldn't, you know, I wouldn't, I wouldn't refer someone that I would be afraid to that they might cause offence are, you know, or be aggressive with a person. That would be the only type of person. I wouldn't, but I haven't come across it yet." (Ref12)

Variation in operationalising the referral process

GP referral agents emphasised the importance of having access to an online referral system as being key to promoting use of SP amongst the GP community.

"It's just like we've just so much paperwork. So, you know, you could have someone and you're not only doing a referral to the social prescriber, you could be doing it to the physio, to the public health nurse to so. It's not that there's no answer to it. I think doing the online and being able to e-mail it is really beneficial. So, it's just we're just so paperwork heavy." (Ref13)

"Nobody gets what it is that GP's do…if something needs more than 5 or 6 computer strokes and needs to be printed out and, in the envelope, addressed and put in the post, all of it's not going to happen. GPs will not engage comprehensively with social prescribing until it's on Healthlink, I would say." (Ref08)

There is variation in how referral agents engage in the referral process, with some having access to online referral forms.

"There's a referral form. So, I just fill in, like I get consent from the person first and then fill in the referral form and then I e-mail it. There's a centralised e-mail. I think it's XX social prescribing at HSE something like that, yeah .. It's just an online document, so that's not through website or anything, but no. And then I printed out for my file, Yeah, it's an online form." (Ref13)

So, we have kind of the emails and the contacts here that the other services would have used. So either myself or my nurse specialist would, you know, use those channels to refer people as well. I've always found it very easy now, we've never had any, you know, issues around referring or you know it's always been very straightforward (Ref12)

Another important factor to enhance referrals among HSCPs is the provision of feedback to confirm receipt of referral and also to provide follow-up information on how the SU fared with the SP service. This is another way to ensure that referrers receive information on the benefits of the social prescribing for the SU. This kind of feedback mainly operates in an informal capacity.

"So, like it would like, we don't really get sort of like discharge letters when they finish it, we don't really get a response and what happened you know, so we don't then no we don't get feedback on well was it worth referring that patient you know. Now I'm conscious that takes more work on their time as well you know so there's pros and cons to doing it, but it would potentially if we got sort of feedback on how it went and what was done for patients, then you'd be more likely to continue to refer." (Ref06)

Another important aspect of feedback is going back to the referrer where an inappropriate referral has been made. In some instances, this is taken on by the local HPIM.

"And if they go outside it, I go back to them. But it's me who goes back to them because the social prescribers say, "I'm after getting another inappropriate." But we've set it up now that they can also get back to say, "listen that person is inappropriate." So that feedback system, back to the referrer." (HPIM09)

Summary

One key active ingredient of social prescribing services in Ireland is the SPLW. The SPLW is identified as playing a crucial role in engaging with referral agents and building trust to ensure that SUs are referred into the service in the first instance. This encompasses getting to know the HSCPs to promote both awareness of the availability of the service as well as its

benefits. One barrier to this in the Irish context, is the limited integration of services, including community and hospital-based services. In many instances the promotion of social prescribing is also provided by referrers who have seen the benefits first-hand themselves. This finding also highlights the need to actively provide referrers with qualitative case study information on benefits and positive outcomes experienced by SUs. While many referrers have a good understanding of what constitutes an appropriate referral, more work needs to be done to provide standardised referral criteria at a national level. Finally, at the time of the interviews there was no standard operating procedure for making a referral.
Some were made using an online referral form, while others used using email or were paper based. GP referral agents in this study clearly articulated the need for social prescribing services to be integrated into the existing Healthlink referral system for GPs, which would enable them to engage more effectively with social prescribing. Again, a standardised referral form had been introduced by the HSE as the data analysis phase of this project was being undertaken.

Person-centred, supportive relationships with SUs

Many SUs highlighted that the relationship between the SU and their link workers is one of the most important aspects of their overall experience of social prescribing. When individuals perceive their link worker as approachable and non-judgmental, they are more likely to feel heard and understood. Beyond simply referring individuals to activities, link workers offer encouragement, practical support, emotional reassurance, and a pathway to community connection. The empathy, non-judgmental attitude, and encouragement provided by the person-centred approach of the SPLW is identified as a central mechanism of the social prescribing service. Many participants emphasised how their SPLW made them feel heard, valued, and supported, which was crucial in helping them take the first steps towards social engagement. This person-centred approach also impacts on the SPLW's perceptions of the acceptability of using more standardised assessment tools and outcome measures that are recommended as tools for evaluating SP services.

Qualities of the SPLW

SUs spoke very highly about their interactions with their SPLW, emphasising both the personal qualities and professionalism of the SPLW in earning their trust:

I found her very warm and accepting and also very knowledgeable about different events that are going on around me in these areas. And things that I didn't know about, so that was that was helpful" (SUEst04)

"I found her particularly professional -- A tremendous aid and very efficient and affirming. She was a very good listener and present to me and held my hope." (SUEst30)

" I think, in the first instance, it comes from the relationship between the social prescriber and the individual because, I mean, some of these people haven't been out for a long time or haven't had much interaction, and, you know, maybe their doctor is the only person that listens to them, and this -- you know, , so building up the relationship with this person and feeling listened to and feeling heard, I think, is very important." (HostOrg09)

SUs consistently described experiences of feeling genuinely heard, understood, and accepted. This active listening by SPLWs created a sense of trust and emotional safety that encouraged people to open up and engage with the service.

"I felt listened to and I didn't feel I had to talk about my mental health and things like that. I felt very relaxed when I went, like I could be myself, not someone I wasn't, you know?" (SUEst29)

"I felt like there was a lot of communication. Like I felt very listened to. Like I thought she was there for only." (SUEst28)

Several participants described feeling vulnerable when they first engaged with the service, but the LW's understanding response helped ease that discomfort.

"And my first meeting, we sat down and we went through our goals and aspirations, and it was very good to sit with her. She has a lovely way about her and I'm very good to sit down with her. Of course it was buckets of tears, because the tears had started to come. Don't ask me why I was crying, but there was tears. She was there and took all of that on board. And then she emailed me our notes and what the goals would be and the goals we need to try and socialise a little bit more and find something that would be of interest to me at that time and also see a very gently going back towards a path to work." (SUEst27)

"I said earlier that I felt she was present to me. And I think trust would be very much part of it. I think, you know, when you build a relationship of that kind with someone, and you're, you know, I suppose when I met with her first, I had to state that I was out of work and so I was a

little bit humbled and vulnerable by that. And yet, there was no hesitation and there was an understanding and a support." (SUEst30)

Promoting empowerment, agency, and motivation

A key mechanism underpinning social prescribing is enabling the SU to bring about change in their lives based on what matters to them. This approach is based on promoting agency and motivation and empowering the SU to have more control over the factors that are impacting on their health. Participants appreciated that social prescribing adapted to their individual needs and that it was "*genuinely an understanding service" (SUEst45)*. SUs felt valued, being able to choose activities that suited them rather than being assigned to a programme. Link workers listen to SUs' feedback on what worked or did not work for them and supported them with any challenges they may encounter.

"Many people in many ways are quite prescriptive and it doesn't always work, but she wasn't like that... She merely made me aware of what was available... And, like I say, time off to figure out which.....she was encouraging. She simply wasn't going to push me into anything." (SUEst13)

"I've had various psychologists I've dealt with, , didn't do me any good but I think I've come out the other end. A lot of them said the same things to me. -- Whereas this was a different approach. It wasn't saying, you've got to do this or that. This was saying, "listen, there are these options. You can try some of them and see if they do you good". And I would say they've done me more good than all the psychologists I've met put together." (SUEst34)

The approach of the SPLW will often include an emphasis on the agency of the SUs, that this is their time to use well and this is done through motivating the SU.

"It was more with the social prescriber, that she sort of, there was a proactive interaction and highlighting, 'hey, what do you want to get out of today's session? You know? What do you want to get out of the next hour we're going to be meeting? And highlighting, 'hey, it's your personal responsibility to figure out these things'. But I realised what her motivation was, she wanted me to be getting out and doing things and she wanted me to be motivating myself." (SUEst22)

Sessions with the SPLW give time and space to explore the SU's current circumstances and needs. SPLW supports the SU in creating an individual plan for addressing their needs and

improving their mental health and well-being. It is a 'bespoke service' as described by one of the SPLWs:

"It's the stuff that's on your doorstep. Not your GP, not your physio, not your consultant, none of those. They don't do it. You see them for four and a half minutes, and it's a production line. Social prescribing cannot be a production line. I cannot stress this enough. You are building your relationship with an individual. It's a bespoke service. You are respondent to what they want. They're not doing what they think you want them to do. They're actually doing stuff they want to do, because that's where the real impact is. So, the benefit is that it's on people's doorstep." (SPLW28)

"But being able to sit down and somebody listen to you here and just point you in the right direction, show you what's out there and just let you choose what you feel you need. It was very easy to use the service" (SUEst06)

SPLWs use a health and wellbeing plan at the initial meeting and this is viewed as a very useful tool to engage with SUs and identify what their interests are.

"It's a great way to engage where they're at and what they really know, I suppose, about themselves and what their interests are. And it is, I always find that question, just asking them, what is it that just gave you that bit of joy? And it's amazing when someone's asked that question how it changes because they sit back and go, "no one's ever asked me that question", you know, or you can see them thinking about it. And then they'll throw up something, you know, and I'll go "yes, we can find out if it's going on, if it's not we'll see if we can match something to it". (SPLW16)

Reflecting on identifying which elements of social prescribing are most relevant for the user (interacting with the SPLW/community activities), participants highlighted the importance of the SPLW in this regard.

"So, I think it's a very tailored programme that's very bespoke for each individual. And when you meet with the client and each client then gets a bespoke service. So, I think that's it's that one to one support that becomes very clear when we hear back from clients speaking whether on seminars there or give us feedback and they always acknowledge the role the social prescriber has on their journey and the invaluable role and that there were the difference between them moving forward, yeah." (HPIM02)

"I think it's a combination. You can't really have one without the other. Like the SPLWs role was imperative like you need to be in touch with her so she knows where you are kind of in life, what you can handle, what you're interested in, let you know what opportunities that are out there and then it's the activities themselves. And also, it was nice that she would show up in a lot of the activities most of the time. She would show up because you know to have a familiar face."(SUEst03)

Impact of assessments on SPLW/SU relationship

Findings show variation across SPLWs in how initial assessments are undertaken and when these occur. Variation in types of measure used and the acceptability of measures was also evident, as was understanding the purpose of using the measures with one SPLW describing the situation as a *"minefield" (SPLW01)*. SPLWs emphasised the importance of understanding where the SU is at, which determines both the timing of using assessments and how these are implemented. For example, SPLWs highlighted how use of some outcome questionnaires can change the dynamics of the relationship between the SU and SPLW, noting that the Short Warwick-Edinburgh Mental Wellbeing Scale (SWEMHBS) is not suitable for all SUs, especially for those that are more vulnerable.

"I think it's [SWEMWBS] just a bit harsh, I think that's the thing. When you are meeting people with a history of trauma or a recent bereavement, things like that it is just a bit like black and white. They are kind of upsetting. That question about 'do you feel close to other people'? is the one that I lose most people on. I'm not able to complete the SWEMWBS with that question usually. Something, like I know we use the Well-being Star in addition, it's just more gentle." (SPLW22)

"So, I try when I meet somebody for the first time … you know, it's all about trying to create, I suppose a nice comfortable space and making people relaxed, so I certainly wouldn't be taking out any forms or paperwork. So, if I do at the first meeting, it's usually very near the end." (SPLW15)

Other SPLWs gave examples of working with particularly nervous or distraught SUs and so did not bring out the questionnaire until "*three or four meetings in"*. In such cases they pointed out that.

" *I suppose, you're not getting a true reflection then of where they were at when they first met you,, you know, so, I suppose, you kind of go, well, how relevant is this now, like, you know you'll be kind of saying to yourself -- because obviously they've come on."(SPLW16)*

"I'll be honest with you, I have a few files that I didn't fill anything in because the person was so distraught that I just thought, "oh, no this is not going to work."(SPLW15)

SPLWs will often incorporate assessment questions into conversation with the SU instead of form-filling because sometimes it might be "*off putting"* for SUs *(SPLW16)* Another highlighted that conversations are more powerful than "*ticking the boxes*"*(SPLW17).*

Another SPLW questioned the utility of mental health and wellbeing measures where SUs were primarily referred from the mental health services.

"So it's more of a conversation and personally on my own side because of the nature of the clients I was getting, I'd say 90% come from the Mental Health Service, I didn't want -- a lot of the questions I looked at for the wellbeing skills, I didn't really want to open up me, them believing I was a counsellor because a lot of the questions, even the smaller ones, were asking very personal questions about people's mental health and I was already getting those sort of conversations like suicide thoughts, things like that which were coming up or bereavement and I didn't really want to open it up". (SPLW12)

Summary

The individualised person-centred approach undertaken by SPLW is a central mechanism to the effective implementation of social prescribing services in Ireland. The approach is enhanced by the skills and qualities of the SPLW.

While the importance of needing boundaries was raised, this is challenging given the flexible and individualised nature of the work. Services users highlighted a wide range of personal qualities and skills of the SPLW in ensuring that they feel supported and understood. They also often recognised that the link worker was working to motivate them to identify what matters to them and enabling them to make changes. The individualised approach is reflected in variations in how assessment and outcomes measure are used in practice with many SPLWs voicing concerns about using measures that are more mental health focused rather than oriented to general wellbeing. This has implications for the monitoring and evaluation of the service.

Community connection role

Findings from the data illustrate the role that SPLW's play within their communities across three categories corresponding to three specific functions of the SPLW

Knowledge resource for stakeholders

Participants consistently described SPLWs as centralised sources of knowledge, situated within a web of community-based relationships. SUs, referral agents, and community organisation representatives regularly characterised SPLWs as individuals with a deep awareness of the range of supports and services available within their locality, and who could efficiently direct others to appropriate options.

"I knew there was kind of courses and classes and things out there, but I suppose like a lot of people, it's what I loved about social prescribing is [SPLW] is kind of like a centre point of a tree. The trunk of a tree and she has branches off it, and I didn't know the branches that are there for me and available to me. It's great because she knows what's available." (SUEst63)

This quote highlights a common sentiment that SPLWs function as central access points to the broader system of local services. Their awareness of services and of individuals' needs was cited across interviews as a key mechanism through which people accessed previously unknown resources. Community organisation representatives and referral agents also described the practical benefit of engaging with Link Workers who possessed extensive knowledge of local services.

"[SPLW] breadth of knowledge of what's available in terms of well-being supports in [Location] is just encyclopaedic, like [SPLW] is one that we would go to if we were like, have you heard of such a service that might do this? and she'll be able to rattle off, you know, places that we can refer to" (ComOrg16)

"*I definitely think that it frees up a bit of my time because the times that I'd google or Facebook certain things, but I can't find the things that people want. When I go to social prescribing, they know exactly what's in the community, and they know straight away what's there." (Ref14)*

Through their regular engagement with SUs, referral agents, community organisation agents, and other link workers, SPLW's accumulate a vast database of community contacts, services, and activities. While they work to help SUs navigate and engage with relevant community

organisations, they also become a strategic resource for these community organisations and other working professionals active in their community.

Referral agents spoke about the importance of having the SPLW to support SUs to access community resources as they lacked the knowledge and resources to be able to do this for their SUs. There are many community organisations and that presents challenges for referrers in tracking the available resources within the community. Therefore, having social prescribers who are actively engaged in the communities and have knowledge of these activities is of great importance. Social prescribers fulfil a vital function in bridging the divide between awareness of available services and facilitating SUs' access to and engagement with those services.

"You know like when I meet my GP colleagues trying to persuade them to refer to this, that and the other service, they start screaming at me and they say no, we can't cope with anything more. So, the Holy Grail for us is a single point of referral where somebody else sends it on. And that's why the social prescribers are, I find them, you know, they're pretty good for that." (Ref08)

"…there's hundreds of them [community organisations], and we just never could keep track of what was available. So, we'd always have the same ones you'd send people to. So, to have people who are embedded in the communities and know what's out there is just really invaluable. And I think the biggest part is having the person, you know, because you can hand someone a list of things to do, but they [SPLWs] seem to bridge the gap between knowing what's out there and actually getting in and doing it." (Ref02)

Cross-sector collaboration

The data conveys that SPLWs were commonly approached not only by SUs but also by professionals working in healthcare, social care, and community organisations. Their role extended beyond direct client engagement to include supporting others in the system to network and identify appropriate services. Some participants described SPLWs as central points of contact for up-to-date local knowledge and network sharing. Their familiarity with community assets, coupled with ongoing relationships with clients and providers, enabled them to connect individuals and organisations that might otherwise operate in isolation. Additionally, some participants reflected on the disjointed nature of health and community services in Ireland, and the bridging role that SPLWs provided.

"When you think about it, like the amount of a sort of disjointedness ,that goes on within services like the left hand doesn't know what the right hand is doing a lot of the time, and they could be under the same roof. So, within the HSE, it's such a huge animal you know, they often don't have a clue what's going on in the next department over… it means that there's a lot more joined up thinking. When you have somebody who's sort of floating over everything and can see everything, it's definitely very useful. (ComOrg16)

"It's a whole help situation. So, instead of focusing on one thing at a time, if we can bring all these organisations together -- and sometimes being in the community but under the HSE, you have the ability to bring organisations together… I would kind of see myself as the middle point with a lot of branches coming off from other services -- that maybe the doctor wouldn't speak to the reflexologist, or the physio is not speaking to the nurse, where you're the one that sometimes brings them links together. So, really, it's a whole-life picture rather than mental health, wellbeing and emotional health. . So, I'm hoping that's what social prescribing is doing for many people." (SPLW10)

Informal service feedback process

Participants also reported that SPLWs' ongoing engagement with clients often positioned them to gather informal feedback on SU experiences. Through regular contact, Link Workers developed an understanding of whether clients perceived services as accessible, appropriate, or beneficial. This information, when shared with community organisations, was described as contributing to the refinement or adjustment of activities and supports.

In several interviews, community organisation representatives explained that suggestions or observations from SPLWs had directly influenced the design or delivery of their programmes. By integrating feedback from local clients, these adjustments were considered more person-centred and better aligned with the specific needs of the community. This feedback process was generally described as informal and reliant on a trusting working relationship between the SPLW and the organisation.

"We had a lot of things born out of those conversations because we're all together. [SPLW] will say, like, 'A lot of older ones here that they're cooking for one', or 'I'm worried about this group here'. And come together with ideas. That's probably the most valuable for us, she might have a concern about somebody, and we'll create something that will address that. And we've done that several times." *(ComOrg06)*

"Then they run for six weeks, and then after six weeks they're over. Towards the end of the six weeks, [SPLW] would come up to me and she'd say, 'What are you running next?', so it could change. You know I might drop something or add something. So, she would say to me, 'Could I offer it to clients that come in now?'" (ComOrg03)

Some participants also highlighted the financial constraints under which many community organisations operate. Within this context, the feedback shared by SPLWs was viewed as a useful input in ensuring that limited resources were directed toward services with the greatest perceived value or demand.

"The link worker to say [to HSE] "Well, there is no walking group in this area. What can you do about that?". And then for the person in the partnership can say, "Well, actually, I do run a lot of groups. Sometimes I don't get numbers and they don't start. So, if I know that there's a core group of X amount here". So, I think there's a great capacity by better communication to not waste limited resources and, and kind of give things a better chance of success" (SPLW30)

"Absolutely, and that's the reason why I suppose a lot of our all of our work is collaborative work. We won't duplicate any work. We're very clear in what we can do and we try and leverage money from other organisations in order to deliver our work and, the social prescribing has added another support for us. I would say within our organisation it's just another programme that helps us to deliver." (ComOrg17)

SPLWs were consistently positioned as embedded, trusted intermediaries within their communities, whose knowledge, relationships, and day-to-day interactions enabled them to serve multiple stakeholder groups. Their ability to connect individuals positioned them as facilitators of information flow, collaboration, and service adaption. These findings highlight SPLWs value within the community setting, emphasising their multi-dimensional contributions to the sector.

Theme 3: Funding structures and governance issues for social prescribing services

Improving current funding and governance structures for SP services emerged as an overarching theme that was perceived to impact the capacity of SPLWs to meet the needs of the SUs, as well as the potential to expand the service and ensure its sustainability. From a strategic perspective, both HPIMs, host organization managers, and link workers reflected

on current funding and governance structures and highlighted challenges in this area. The subthemes are:

a) Need for more robust funding structures
b) Improved governance structures to support SPLWs
c) Contract challenges for SPLWs

Need for more robust funding structures

Lack of funding

Social prescribing is currently contracted out indirectly by the HSE, which leads to inconsistencies in the delivery model. Funding is provided to agencies that then employ staff, but these agencies are often underfunded. This potentially raises significant risks for the continuity of services, as current funding may not be sustainable. Participants reflected on the need for an overall national structure for coordinated delivery of social prescribing services, as well as the need for interdepartmental funding at government level. Managers of host organisations and HPIMs spoke about current funding models and reflected on how these could be improved. Suggestions included bringing SP into the mainstream of HSE services and looking for intersectoral funding for the services aligned with a social determinants of health lens. Participants reflected on other potential funding models to grow the reach of the service and therefore, make it more sustainable.

"Social prescribing is kind of contracted out at the moment indirectly. The HSE get funding, they give the money out to an agency who then employ the person indirectly. So, this leads to further inconsistency in the model. It also has huge risks at the moment because these people aren't being properly funded. The agencies don't have enough money to pay them, and it may well all fall apart if the money, if the funding is not embedded. So, this practice of subcontracting is, as it were, by the HSE has inherent risks. l". (HPIM04)

"*Again, I think there should be more funding rather than the Department of Health. Maybe the Department of Justice are coming in with some funding as well, depending on the area. Do you know? Everyone comes back to the HSE and the HSE say we've no more money. The impact of this work impacts right across other sectors. So, it could well be Department of Education, particularly Department of Justice, Department of Social Protection, the local authority and creative arts. There should be a pot of money nationally*

that they can pull from so we can have a more robust programme, is what I would say, you know? So, I think build it and govern it then, you know have that governance that reflects those different sectors." (HPIM09)

Participants highlighted that funding is needed to increase the number of SPLWs across the country and also to enable SPLWs to provide the necessary supports for services users, particularly in areas where limited transport options and community resources are a challenge.

At present, funding does not cover programme costs. Host organisations are described as constantly working across other funding streams to provide "*added on funding" (HostOrg06)* to support delivery of social prescribing services. These additional funding sources include, for example, Creative Ireland, Leader Project and Pobal. Additional funding was identified as being important for supporting transport costs for SUs and providing admin support for the SP service. In some areas additional funding is also viwed as being needed to support the delivery of activities for SUs where there may be limited community resources available, particularly in rural areas.

"The funding model doesn't include programme costs, and areas are very different. In some areas there will be lots of services that social prescribing participant can make use of, but in others they don't exist, and the social prescriber might need to set up a group or set up a programme, and that takes their time and maybe their budget from other programmes and even things like the bus. You know, if transport which is consistently coming up as an issue for people, if we don't have a budget for transport, it's another access barrier for them." *(HPIM07)*

Funding issues were also raised by community organisations where limited funding can impact on their ability to meet the needs of a local social prescribing service. The financial barriers to SUs is also recognised, in some instances the community organisation is able to assist with transport associated costs, but this is not aways the case.

"We don't have enough. We don't have enough capacity. So, literally yesterday one of the social prescribers sent me the names of two people looking for something and I'm putting them on a waiting list and there'll be nothing for them till September because our funding, like the funding from the HSE, is very minimal, but that looks after most of the well-being, but we just we have no, most adult and community education organisations have no core funding". (ComOrg14)

"I would imagine there's a need for more social prescribing. I don't know what their capacity is like obviously, but I would imagine so, their weekly programmes that they run themselves seem to have a great impact. And again, I only know that from going and speaking to the people in them. The coffee mornings and the social activities, again, these are underfunded things because it's very hard to convince governments that, you know, coffee mornings are so important in terms of what we do. I would love to have the capacity to run more well-being and health-oriented courses, because I see a need coming from social prescribing" (ComOrg14)

we're paying for bus tickets for them because they're going to struggle to get there otherwise, and so it's like that programme is flexible enough that we can do that kind of thing, which is brilliant, but financial barriers are huge for people that if they want to link in with something, it's going to cost them even though they know it's going to be better for them" (ComOrg16)

Lack of clarity and integration

Managers of host organisations and HPIMs highlighted that the current funding structures for SP services need to be improved to grow the service and provide a sustainable population-based service. Participants felt there was a lack of clarity in how the social prescribing service fits into the overall funding and service delivery model of the HSE and that there were opportunities to look at alternative funding structures. The limited number of SPLWs, many of whom work part-time, makes it challenging to ensure reach across large areas and can present workplace challenges for SPLWs. In terms of the overall social prescribing service, the area of more robust funding for supporting community-based activities was identified as also needing attention.

"I think one of the biggest challenges is that we just have enough funding for one SPLW and that's something that the team really battle with and it's something that we really would love to address going forward. So that's a real barrier towards not being able to reach everybody in the county. And at the same time you have to make a decision that protects the programme and protects the staff as well because if they're trying to be all things to all people they're not going to achieve what they need to achieve, and that's not going to be good for the participants or their own mental health." (HostOrg06)

"I suppose the challenges would be funding, if you know like we all have intentions of running certain programmes to help people, but sometimes we don't get the funding, and

sometimes other organisations that reach out and say look, we're thinking of doing this, what do you think, and we go oh yes, that's perfect, we might have a few people in mind, and then it just doesn't happen, because of funding." (ComOrg09)

From a SU's perspective, investing more in healthy communities has far-reaching benefits.

"I think that the government needs to fund it more. And not just this, but all community-based things. Like but that's a bigger issue. Again, you know, like, I feel like governments need to invest more in their people and creating healthy communities, and you know, healthy communities help create healthy individuals, and the individuals are who make up this country or any country really." (SUEst03).

Rural challenges for social prescribing

Issues around accessibility and transport are of particular relevance to services located in rural and more isolated areas.

"If you're rurally isolated and you don't have transport, then you're limited to the supports that you can get, as opposed to someone that lives in a more urban area, you know? Location is key, or transportation and access is key. If you're living in somewhere like [location] there's nothing for you, there's very little there." (HostOrg05)

"W*e only have one vehicle, and if my husband is working then I can't get access so that's the biggest drawback, and taxis are hugely expensive as you can imagine, cause of obviously the rural area that we are, you got to get there and get back, so …the only sort of really big drawback is the travel aspect. And I think that is for anybody who lives in the middle of [location] or anywhere rural like that is going to really struggle if you haven't got transport yourself.". (SUEstt33)*

Regrettably, some SUs stop attending social prescribing activities due to transport problems. *"I didn't follow it up because of the travelling up and down…" (SUEst35)*

Another challenge with rural social prescribing services described by participants is that even if social prescribing is implemented, there's often no available network or community services, which poses a significant problem. Without places for social connection, social prescribing cannot be effective.

"…what needs to be considered really is, maybe research what is the best models for social prescribing, like the feasibility of having a social prescribing service in a very rural area

when you don't necessarily have networks. And do we need to first work on networks? I suppose it's that question." (HPIM08)

The current model was also seen as not being best placed to identify and target social prescribing services for areas of most disadvantage, a role that may be better fulfilled by community-based organisations already embedded within those communities.

"So, what often determines our social prescribing area might be deprivation profiles. However, there's deprivation in rural areas, but it won't necessarily be caught in a deprivation index because the population is too dispersed. And so, they may not need a service, but however, a local agency on the ground might see the need, and they might be prepared to seek funding from wherever to fund the service. And I think what we need to be looking at is some kind of an umbrella organisation that the HSE is part of but not owning, that gives guidance on setting up a social prescribing, the model of what works and what doesn't work and it allows other organisations to set up social prescribing services in the areas that we can't". (HPIM08)

Administrative support

Funding for the provision of administration support for the work of the SPLWs was perceived as a major challenge. Some organisations have been able to fund admin posts though local Community Employment (CE) schemes. However, other SPLWs have no such admin support. Participants highlighted that having admin support is crucial for the SPLW to be able to really focus on the direct work they do with SUs.

"I do believe there needs to be clerical support for all social prescribing services because I think it helps with efficiency in terms of service delivery. It makes sure you reach your targets. The quality of the service is supported and the worker is supported …so they don't have competing priorities in terms of or the admin that they have to do and then trying to give someone a quality intervention I suppose." (HostOrg04)

"I mean [SPLW] has 71 open cases at present and that's quite a number for one person and no admin, you know that's a lot" (HostOrg01).

Admin support was also reported as occurring on an ad hoc basis.

"Where possible -- we don't have any funded admin support, you know, -- any admin support funded through Healthy Communities or Sláintecare, but we're a very integrated

organisation, and they will get a dig out where we can possibly give it, you know, in terms of recording and stuff like that. Like, somebody from another funded programme would help if they had the capacity and the time." (HostOrg09)

Improved governance structures to support SPLW's

Referral criteria

SPLWs also reported a need to enhance current referral forms to clearly communicate the referral criteria for referral agents. In the absence of a national standardised referral form, different social prescribing services have developed their own forms for referral agents to refer into SP service. However, it was acknowledged that variations in these forms can lead to discrepancies in referral criteria across areas, which in turn can impact on equity of service access. Some stakeholders expressed their anticipation for the release of a new national referral form and favoured increased governance around the referral process. Integrating social prescribing into the existing GP online referral software, *Healthlink*, was also highlighted as an important area for development to increase the number of GPs who will refer into SP.

"And I find between all the social prescribers around the country; we all have so many different criteria. Like one social prescriber might see something that a client will be acceptable, whereas I mightn't see that client as acceptable. So, it needs to be really generalised, we need to have the same path because we're all kind of going on different train lines and its madness." (SPLW06).

"And I suppose then it's that piece of us doing something locally, but that needs to be reflected at the national, say, 'these are the structures, yes, this is the right way.' And so, I think to me that's the biggest concern, you know? I think social prescribers will roll in behind whatever structures is there and their training and that. It's the piece of just getting that right around referral and it would be really useful to get them [SPLWs] on Healthlink." (HPIM09)

Having a national form with agreed referral criteria was also seen as beneficial for promotion of SP services.

"So, I think maybe it's about having the same consistent message from national, I think having that same referral form or you know the same criteria is really useful. That will help us be really clear with promoting the service" (HPIM07)

Referral agents need clarity on acceptable criteria, including exclusion criteria, for making referrals into SP service. Including relevant contextual information on the SU (for example in relation to mobility, cognitive issues, language barriers) is an important part of the referral criteria that may often be missing. At present variation in referral forms means that different referral agents are providing different levels of contextual information on referrals. This results in challenges for SPLWs and the needed follow up is time consuming,

"Sometimes somebody referring might give you way too much information, information that you really don't need nor shouldn't know, and then somebody else will give you very little. So that can be a bit of a challenge in terms of having to draw all that information out. (HostOrg9)

"I suppose thatsome referrals that,I wouldn't say they were inappropriate referrals, but there was key points of information that were not shared on the form that would have been very helpful for the social prescriber to know... So, there is no exclusion criteria at the moment." (SPLW30)

The importance of recording geographic information was also raised. For example, a SU receiving a referral in hospital may not live in the SP catchment area.

"I was getting as many referrals outside my catchment, as I was for inside my catchment [because of a referral form that this link worker found unhelpful]" (SPLW15)

Participants reflected on an overall lack of a national governance structure for service delivery, which results in variation in how services are rolled out in different areas. One of the challenges with a flexible person-centred approach is the maintenance of boundaries for interactions between the SPLW and SU. This has implications for the number of sessions that the SPLW meets with the SU and duration of interactions before cases are closed. Participants also commented on the issue of taking on complex cases although they may not meet the referral criteria for an appropriate referral.

"The thing I loveand struggle with social prescribing is, I love the… madness or… not the madness but that it's unstructured and it is so person-centred. It's about that person and you know, it can go in any direction depending on the needs." (HPIM01)

"So, how long?, it depends on the individual themselves and the support they need. Some I might only meet three times... Others I might meet more than, I mean I could throughout the six months of the year,I could meet them maybe six times. Kind of once a month to see

how they're -- but it could be through, like I could be contacting them on text or phone. I might not necessarily be meeting them face to face but on the phone or just checking in with them to see, you know if something's come up". (SPLW14)

Depending on the skill set of the SPLW, they may be equipped to deal with a more complex case than another SPLW. Complex cases were seen as presenting a challenge to the referral pathway into social prescribing. The lack of set boundaries to service provision, in addition to the often-complex nature of cases, were viewed as highlighting the need to ensure that appropriate supports, including formal external supervision, are available for all SPLWs.

"This link worker was maybe taking on too much, but that happens too quite a bit. You know that the social prescriber ends up maybe doing more than is the social prescribing role in the absence of other services, particularly in rural Ireland. But sometimes people can get themselves into a little bit, you know, through the best intention in the world, bogged down and stuck, and they're doing work that really is somebody else's" (SPLW30)

"Obviously, they have to have boundaries of some sense, but they do give them that kind of space at the start to really kind of delve into what's going on, and I think they go above and beyond sometimes, and that's what can be tricky with them with, with the boundaries is that they want to, like, solve and really help everybody. But some things aren't within the remit of social prescribing, but they'll do their very best to support that person" (HPIM01)

Continuity of SPLW and SU relationship

The lack of governance around duration of cases was another factor that was seen as impacting on the service provision.

"The other thing I suppose is the keeping on of SUs for a long time. And it's a really difficult one....some people do require more support, so there needs to bea deeper understanding into- somebody comes in to a service with this level of complexity, they should be given a minimum of this amount of time. And somebody coming with this level of complexity, they should be given this amount of time… I know it's a new field and we're all trying to understand it a bit more but there's definitely levels of complexity in terms of response that are required." (HPIM08)

The complexity of this was highlighted in terms of equity in the provision of services, for example, some people may need more one-on-one sessions with the SPLW, but his can then

impact on another SU waiting to access the service. For some SPLWs, in practice they do act as a longer-term support for some SUs, based on need.

"I have come across some of them don't want to be closed. So, it's usually six months they say, but it's six months to a year. And then I have so many who are still over a year with me. I have closed them in the background, but they still engage, they're just on their own, they need that support. If I can fit them in, I will fit them in if needs be."There's no fit, it's just down to the individual and if a person who's been isolated for years needs that, you know security blanket to know that, look you're just there in the background, I'm giving them that". (SPLW14)

"I said this at a meeting the other day. I said, "nobody wants to say it, nobody wants to admit it." And I know other SPLWs have people for a couple of years on their [caseload] because people are constantly going on hold for something, they don't want you to let them go, because they do want to engage, but life can be so multilayered for people. So, you don't actually just completely discharge them. You might hold them." (SPLW28)

External supervision

SPLWs deal with a wide range of issues with the SUs they work with. Many cases are complex and can be quite sensitive in nature, such as SUs who have experienced severe trauma. Participants highlighted the importance of SPLWs having access to external supervision for debriefing on cases. Findings in this study highlight variation in access to this form of supervision for SPLWs. Instead, the provision of external supervision can be ad hoc depending on the location of the SPs services and on the resources available in the host organisation.

"And I suppose that's one thing that stands out for me with the social prescriber link workers. You know, they listen to a lot of issues and trauma, mental health difficulties as well. So just how do they mind their own health and all of that? So, I think there needs to be support for the social prescriber debriefing." (HPIM06)

"Some changes need to be addressed, because I think some social prescribers are really out there on their own. They don't have all the support that they could have. And that's very challenging in itself because of the complexities of the people that are presented to us." (SPLW11)

However, it was noted that SPLW's do have the opportunity to avail of a less formal peer-led support network.

"And then we meet every four to six weeks for peer support meetings in a different location. And that really opens up where we might have learned some things over the last six weeks, say if we wanted to give mental health information to each other. They're very good... Supervision, like even in peer supervision, it's very open and loose. And while we get a lot from it, I think it would be better if cases were able to be discussed that way the learning would be there of who we could and cannot, and the challenges, yes." (SPLW30)

This is used to varying degrees by SPLWs.

"That was something we looked at and why people weren't, some were, some weren't. But they are, they are all availing of it. Yes, some more so than others. Some would do it as a well-being kind of tool on a regular basis and others would do it as something arose. But we, we were encouraging people to avail of it." (SPLW30)

SPLWs were very supportive of the HSE run ECHO sessions, which provide a further source of peer-led guidance as well as been able to input into the topics that are delivered.

Training and development of SPLWs

SPLWs come from a variety of professional and educational backgrounds, each bringing their individual skills and perspectives to the role. SPLWs also complete a wide array of training which aim to further enhance their practice and build their confidence in supporting individuals with varied needs. A two-day essential skills training is made available to all SPLWs and is typically delivered via the online learning platform for SPLWs known as ECHO. SPLWs consistently highlighted the ECHO network as a valued resource, appreciating the opportunity to connect with peers, share experiences, and access continuous learning in a flexible and supportive environment.

"So even the essential skills training. I thought was very good for the role, a really good kind of initial training to get you started and then the training that we have done through the ECHO network has also been reallyseful and helpful, very practical training which is always very welcome. And then I did the coaching workshops as well and I find" (SPLW18)

"I suppose like the social prescribing, the network, the ECHO programme, HSE have developed the ECHO programme, and I think that in itself is a fantastic resource to have to

be able to tap in and out to…. I think that has been invaluable to, you know, us as SPLWs but for me to be able to implement different things into my working day as well." (SPLW09)

Additionally, many SPLWs noted that while they benefit from the training provided via the ECHO platform, they also benefit from trainings provided by their host organisation, or trainings that they have sought themselves to help them improve their skills for working with a particular client cohort. Moreover, many SPLWs come into the role having completed trainings from previous employments which they deemed as advantageous to their new role. These trainings included solution-focused training, suicide prevention training, domestic violence training, cultural awareness training, compassion focused training, mental health support training, as well as trainings designed for working with people experiencing grief or bereavement. SPLWs also appreciated the ability to access refresher courses after completing the initial training.

"The organisation I work for, they put on their own training. Like, we recently did domestic violence training, we did dealing with challenging behaviour training…. I have a sort of a personal desire for some training around grief. We would work with a lot of clients who have experienced grief. Now, I do the Lunch and Learn with Hospice. They've done a series throughout the year. It's an hour here and there. You do pick up a lot, you learn a lot, but I think I would like to do some sort of in-depth training around grief. It kind of comes up for me a lot." (SPLW07)

"I've done training such as ASIST and those kind of things. They just give you a bit ofsecurity in terms of when you're working with people that you have that bank of knowledge or skills or tools with you, you know, if you need to draw on them." (SPLW18)

"We do a lot of training in-house, in the HSE...So, I am always developing. I'm always educating, and I believe with this position you have to because your tool kit has to get bigger and bigger…. Training that I suppose that would be more beneficial to social prescribing, because I feel that sometimes social prescribers don't come in with a heavy toolkit like others, areas such as domestic violence, sexual abuse. Training like solution-focused training could be a really good tool to have. Just a lot of areas, migrant training, definitely. Like, you have to, like. The world we are living in and changing." (SPLW11)

However, some SPLWs argued against the extensive number of trainings being provided to, and completed by SPLWs, stating that a line must be drawn on who SP is for. Additionally, some SPLWs expressed a desire for boundary-setting training to help them establish and

maintain clear, professional boundaries with clients, ensuring that support remains effective while protecting their own wellbeing and role clarity.

"And I think some social prescribers think we can work miracles, basically. I mean somebody with you know, severe bipolar or who's been overweight for 60 years. I got referred for this guy and all the GP had written was client needs or patient needs to lose weight. Like, I'm not Weight Watchers. I don't have that skills or training or like." (SPLW04)

Even so, SPLWs did speak about trainings and courses that they would benefit from which are currently not available, or that are only available to a select few SPLWs depending on where they are situated. One SPLW thought the development of an SPLW mentoring program would also benefit the service.

"And I think the other important bit, and actually kind of perhaps training as well, would be that I really think that social prescribers should, as standard, get a really good overview over how the different departments in the HSE works: how primary care is structured; how, you know, so things like getting in touch, for example, with the social work team." (SPLW28)

"I'd encourage that, you know, we'll say somebody who's new in the role, maybe to link with somebody who's six months in the role, but to have a full training, professional training, I think that would be a positive, yes, most certainly. You know, tooling people up to the situations they'll encounter, how to promote the, you know, how to maximise all of the elements that would lead to a really good service would be of benefit." (SPLW30)

The role of the SPLW in service monitoring

Findings show that there is variation in understanding on the use of outcome measures for the purpose of evaluation among SPLWs.

"No I don't [use any wellbeing questionnaires] and the reason being that I attended the Essentials Skills for Social Prescribers quite early on in starting and it was advised at that time, don't worry about evaluation to the point that if you're not evaluating don't start now because we're going to bring in national [evaluation framework]. So, I just figured, we're told to hold on, I'm going to hold on, you know that kind of way?" (SPLW17)

"So on the initial meeting we would do the SWEMWBS, the wellbeing scale, but we do the health and wellbeing plan first. So, the initial, on the first meeting, it has been drummed into us, that's what we need to do". (SPLW14)

Others use their own tools to get feedback on the service itself in addition wellbeing focused questions.

"Well, again then I have an end of programme. I suppose it's a personal evaluation for somebody and a part of that then is about SWEMWBS but I've a few other questions on it as well, because what I am trying to look at, at that stage, is not only how the person is feeling now in terms of their wellbeing but also I'm trying to look at, you know, the social prescribing service, the process for them, how was that, did they feel comfortable in it, did they feel that it was a welcoming service, you know." I (SPLW18)

"So, I use the SWEMWBS, and I use community questions, and then I also ask them what matters most to them. What do they think -- what basically are the three things they could do themselves to improve their health and wellbeing. I ask them things like what can stop them getting to do what they want to do; that kind of thing. And I also use the Five Ways To Wellbeing... And beside each way, I have a prompt of all the different activities that would fall into connecting or would fall into physical exercise etc." (SPLW13)

Where outcome measures are recorded, this is typically done at the second meeting after rapport has been established with the SUs. Some link workers highlighted that outcome measures should be focused on well-being, not on mental health, and called for the existing measures to me more tailored to social prescribing.

"I suppose it would be fantastic if there was a tailored questionnaire for social prescribing, because... sometimes it's not always appropriate and then it makes it difficult to standardise it when it's not always appropriate for people." (SPLW24)

It was also noted that the data collected is quantitative and that this does not reflect the qualitative work done between the SPLW and the SU.

"I think it's lovely to see lots of graphs and lots of graphics, and all the rest of it, but it's very hard to capture, capture how a person's self-esteem and confidence has come on, using numbers." (SPLW02)

"I'm not sure if it's the way forward, to be honest. Anyway, obviously, we need data, and we need forms, but I don't know whether it really captures the essence of what we're trying to do, but then how do you capture it?" (SPLW15)

A need to make the questionnaires used more inclusive was also highlighted. Some SPLWs highlighted that the SWEMWBS was too focused on mental health as opposed to general wellbeing, which they felt was more appropriate for social prescribing.

"So, there's no set agreement as to the evaluation tool we use. A lot of people are using SWEMWBS, but I found that was very mental health orientated, and social prescribing in my opinion is for everyone. So, I started to use the Pillars of Positive Health assessment.... It's like a spider web and you can use that at the start and at the end. And you can pick three of the areas that you'd like to focus on throughout the course of our work". (SPLW01)

"I do understand the importance of it and at the moment I don't have a measure of how successful my social prescribing service is, but I understand that. Maybe this is just the wrong questionnaire for me to ask people. I need one that's more focused on well-being as opposed to mental health." (SPLW03)

In addition to the challenges of using the different types of measures, collecting post-outcome data is also challenging due to the flexible nature of the service and the fact that there may be no specific closing session for many SUs.

"I'm actually wondering am I the best person to do this or should the referrer who is sending the client to me, should they be doing this questionnaire because then at the end of the whole thing, because quite a lot of my clients kind of just disappear at the end. I don't always have a chance to ask them this. I stop seeing them and then I don't always get a chance to ask them the questionnaire the second time around". (SPLW03)

"I don't call it an end of programme evaluation. I kind of call it an individual review or *whatever... because I want people to know that if they need to re-engage that they're very welcome to do that and I don't want them to feel that they have been signed off and they can't come back to me if they feel they need to, because re-engagement is, you know ... it happens regularly". (SPLW18)*

Contract challenges for SPLWs

Existing contract challenges

Existing employment contracts for SPLW were considered by participants as an ongoing challenge to retention and recruitment. SPLWs are generally on contractual employment typically for one year (year-on-year roll on). Participants reported that this pay does not consider living cost adjustments. Participants highlighted that such factors could discourage SPLWs to work for a longer time, with many SPLWs staying in the employment for an average of two to three years only. The precarious nature of SPLW contracts means that often they will choose to move on to another employment with better terms and conditions.
An additional challenge identified is that current employment contracts afforded by Section 39 funding are a barrier to recruitment in the community and voluntary sector.

"So, first on the individual, on the social prescriber, the community organisation, to give a permanent contract where there is yearly funding is all that's available because then they are liable for redundancy payments if something should happen. I mean, that's aside from the rights to a CID, you know after four years, but generally social prescribers don't tend to last more than two or three years because it's a great training ground for them. And they move on to better terms and conditions within a couple of years under their belt, you know taking all their experience and knowledge with them". (HPIM08)

"We put a lot of resources into training social prescribers, having them in post, and there's a challenge around their funding and their posts generally. Like it's the year-on-year grant aid funding. Now I know that rolls on but I just think if there's probably something around longer contracts for the funding, you know, so this is going to be more consistent, maybe three or five year funding. And with that provision for increments for the social prescribers. So again, just that the terms of their employment are in line with the health service staff? And, the other side of it then in terms of the program I mentioned before, program costs do come up quite a lot. And the funding model doesn't include for programme costs". (HPIM07)

Another challenge related to this when a SPLW leaves the service, is the loss of a tremendous source of local knowledge and experience. More robust contracts were suggested as a way of countering this challenge.

"I think what is a strength and a weakness of the of the design of the project of the programme is that you have basically all the knowledge of what's happening in the voluntary

and community sector, all the all the knowledge of where to signpost people to, and then relationships with those places in many cases are held within the social prescriber, and if that person leaves, then you've lost that. So, it's kind of a central place where a lot of knowledge and understanding is held. But then that's also can be quite movable, which is a weakness as well." (HPIM03)

Expanding the number of SPLWs

The need for increased numbers of SPLWs to meet growing demand and ensure equitable access across Ireland also came up in the data. Participants highlighted that current provision is limited, often with only a single SPLW covering large catchment areas, and that this constrains the reach and impact of social prescribing services. As one referral agent put it *"there's only one in [Location], and I think you know I think it would be a huge help [To have additional SPLWs]" (Ref05)*

The lack of sufficient SPLWs was seen not only as a capacity issue, but also as a source of pressure for those already in post. Participants spoke about growing demand and awareness without corresponding increases in staffing or resources.

"So, it's something that I think will eventually work out but as one person on one team on my own, I've managed it all myself, I've done all the promotion. I've done my leaflets, my posters, everything myself. I can't fight as one person, that's why I'm fighting for more social prescribers. So we'd become more of a team. And have the same sort of level as the other teams because I'm the only person, that's one person in the organisation." (SPLW12)

"So, a lot of people who need services are getting referred in but we only have limited services. So that's a challenge. Capacity is a challenge. And what they have done nationally, they've looked to put one social prescribing service in every county. But it doesn't cover the whole county. So, it typically, if we're lucky, it might cover, and I'm guessing here, a population of maybe 70 to 100,000, and that would be at best. So, that's a challenge because the regions are bigger than that. And so, you have lots, you have created an inequality or an inequity there in terms of service provision." (HPIM08)

Participants also pointed to a growing tension between raising awareness of social prescribing and the system's current capacity to respond. While national and local promotion efforts have successfully increased visibility and enthusiasm, this has also created unmet expectations in areas lacking coverage.

"kind of we had grown quite quickly and we made ourselves known and we were very happy with that, but then the funding didn't follow in the way that we hoped, if that makes sense. Like, we would have liked to be at a point where we have maybe two or three social prescribers already" (SPLW29)

"And I think again, it's not just funding. It's kind of at the 'which comes first, the chicken or the egg'. We need to promote the service to make sure the most appropriate person or the person that can benefit the most gets access to it. So, we need to promote it. But then are we overwhelming the existing services by getting more people referred in?" (HPIM07)

A lack of funding for SPLW positions was flagged by multiple participants, and that expanding the number of SPLWs may need to be focused on areas where need is higher.

"I think we need to look at a population-based approach to our health services and have social prescribing included in that. And what that would likely mean is that we need more funding for social prescribing. I think it's evident with our services being full and the positive outcomes. We need more social prescribers in the area and we need more funding to do that." (HPIM07)

Summary

Funding of social prescribing services is considered a key ingredient for effective implementation of services in Ireland. A lack of robust funding means that there are inconsistencies in how social prescribing is delivered from service to service. HSE funding typically covers only the cost of yearly contracts for SPLWs, with the host organisation having to address the challenge of securing additional funds for programme delivery costs. The limited availability of administration supports is also viewed as a real barrier for SPLWs in managing their caseloads. SPLWs are typically offered year-on-year rolling contracts with less than favourable terms and conditions, which is perceived as a barrier to retention, further recruitment, and ultimately the sustainability of the service. Participants agreed that the number of SPLWs in the service needs to be expanded to ensure equitable reach across all regions. The current funding structure through HSE is challenging and more needs to be done to identify additional robust funding and to identify an overall model of service delivery. Participants suggested that a sustainable,

mainstreamed funding model for social prescribing across Ireland is needed for its effective and efficient implementation

Given the wide range of often complex cases that SPLWs deal it, participants expressed the view that external supervision should be mandatory, as it is for other HSCPs. Currently this only happens on an ad hoc basis if a particular host organisation has manged to secure fundings to provide this service or has an in-house counsellor. All SPLWs do have access to a peer-led support service, which many do use and find to be a positive resource. However, this cannot be used to replace the need for external supervision. The HSE-led ECHO virtual learning network for social prescribers is also positively regarded by SPLWs.

CHAPTER 4: RESULTS

Context, Mechanism and Outcome Configurations for Social Prescribing Services and Barriers and Facilitators of High-Quality Implementation of Social Prescribing in Ireland

4.1 Introduction

This chapter considers the study findings with regard to the context, mechanisms and outcome configurations for social prescribing in Ireland. The realist evaluation approach seeks to identify what aspects of social prescribing work for whom and in what circumstances, in other words, to gain a better understanding of the mechanisms of action for social prescribing and provide greater clarity about who can benefit from it, and why. Ultimately, the findings will help prioritise referrals and ensure that those who will benefit the most from social prescribing are given priority.

In realist evaluations, middle-range theories are theories that provide the framework to explain how specific mechanisms operate within a given context to produce certain outcomes. From a Health Promotion standpoint of social prescribing in Ireland, it seemed natural to regard the theory of salutogenesis as a middle-range theory for this realist evaluation study. The salutogenesis theory, developed by sociologist Aaron Antonovsky, aims to explain how people maintain their wellbeing and health, rather than focusing on the causes and treatment of illnesses. The central idea of this theory is the sense of cohesion, which refers to the ability of individuals to understand the whole situation they find themselves in and utilise the available resources (Antonovsky, 1983). As outlined earlier in this report, sense of cohesion is a combination of three components: understandability, meaningfulness, and manageability.

Comprehension is the extent to which someone understands their current situation and how it affects their overall health. It includes recognising possible causes of health problems and being aware of the resources available to maintain and improve well-being. *Meaningfulness* refers to how much purpose or value a person finds in the situation. It includes seeing significance in the effort to improve health and understanding how one's actions contribute to that goal. *Manageability* is the degree to which a person feels equipped with the skills and resources needed to handle their situation and work toward better health

outcomes. this includes having access to appropriate tools and support, as well as knowing how to use these them effectively.

Salutogenesis aims to clarify why some people do not react to health information provided by professionals. According to the salutogenic approach, this should not be viewed as an individual's failure, but rather a failure of the healthcare system to offer clear information to them (Eriksson & Lindström, 2006). In the interviews conducted in the present realist evaluation study, service users discussed how the social prescribing service had changed their ability to cope with situations, as they no longer felt isolated or alone with their problems. They received support from their social prescribing link worker (SPLW) as well as peer support, and, along with the increased opportunities for socialisation, a sense of community and belonging was crucial in reducing social isolation and loneliness. Our findings show that an individualised person-centred approach undertaken by SPLWs promoted service users' empowerment to have more control over the factors that are impacting their health, and motivation to make positive changes in their lives towards better health and wellbeing. Thus, the context significantly influences which elements of social prescribing are effective for different individuals and under what circumstances. The presence and accessibility of a supportive community can strengthen a person's sense of coherence throughout their life (Koelen et al, 2017). Nevertheless, individuals with a diminished sense of coherence may find it challenging to access these resources independently, and they can greatly benefit from social prescribing services. Consequently, it is essential to identify the suitable intervention on an individual basis while maintaining a focus on the person (Wood et al., 2021).

According to the salutogenesis theory, a strong sense of coherence is essential for promoting health, and therefore, social prescribing can help individuals with a weak sense of coherence to strengthen it. This can also enable them to access available resources and move toward a health-promoting and salutogenic direction. Therefore, we hypothesised that SPLWs and service users' interaction is central in ensuring people understand what social prescribing is and how it can help them to access available community resources to address their needs. This interaction between the SPLW and service user can help service users to understand their current situation, find meaning in the pursuit of better health, and feel empowered to take action to manage their health and wellbeing. We also hypothesised that SPLWs play a central role in increasing the sense of cohesion in service users through a personalised approach to their needs and supporting them to engage with community resources.

4.2 Context, Mechanism, Outcome (CMO) Configurations

Using an iterative process with feedback from stakeholders and refinement, the hypotheses, or initial CMO configurations with 'if/then/because' statements for the three stages of social prescribing service, were developed (Table 4.2.1). Based on these CMO configurations, the final overall Initial Programme Theory that helps to explain how specific intervention mechanisms operate within a given context to produce certain outcomes was developed as:

'The supportive interaction between link workers and service users, and the referral to appropriate community activities are central to empowering service users in addressing the determinants of health that are relevant for them to improve their health and wellbeing'.

After conducting data collection from six groups of participants, the initial CMO configurations were tested against the collected data and thematically analysed, resulting in their acceptance or refinement. Of the total initial 28 CMOCs, 22 were accepted, 5 were refined, no CMO configurations were refuted, and one new CMO configuration was created (Table 4.2.1). For each CMO configuration, barriers and facilitators to effective implementation of the social prescribing programme were identified.

Table 4.2.1 Refinement of CMOCs for Social Prescribing services and Barriers and Facilitators of High-Quality Implementation of Social Prescribing in Ireland

Stage 1. Interaction between the service user and the referral agent		
Initial CMO configurations	**Revised CMO configurations based on interview data**	**Barriers and Facilitators to effective implementation of the Social Prescribing service**
SUs' awareness about social prescribing	**CMO1.** ***Refine:*** **If** service users are aware of the availability of SP service and	**Barriers:** Low levels of awareness about SP services among service users are attributed to its novelty in Ireland, confusion over the term, and health literacy challenges. Additionally, SPLWs perceived that GPs often lack the time

CMO1. If service users are aware of the availability of SP service and understand what the service can offer them, **then** they will be able to make an informed decision to engage with the service **because** they have the appropriate information available to them.	understand what the service can offer them, **then** they will be more motivated to engage in activities for improved health and wellbeing **becaus e** they have the appropriate information available to them and an understanding of SP benefits.	during consultations to explain social prescribing and its benefits due to short appointments and stigma service users may associate with being referred to the service. Referrers must evaluate the readiness of an SU to engage in the social prescribing service. **Facilitators:** A better understanding of SP helps service users to acknowledge the benefits of using community resources for improving their mental health and wellbeing. Promotion of SP among referral agents and among the general public during community events facilitates awareness and understanding of SP among individuals who can potentially benefit from SP. SPLW plays a crucial role in engaging with referral agents and building trust to ensure that service users are referred into the service.
Referrers' knowledge about social prescribing **CMO2. If** the referrers clearly communicate to service users what the social prescribing service can offer them and why this may benefit them, **then** servi ce users will feel confident in their interactions with SPLWs **because** they are equipped with	**CMO2. *Refine:*** **If** the referrers clearly communicate to service users what the social prescribing service can offer them and why this may benefit them, **then** service users will feel confident in their interactions with SPLWs and more	**Barriers:** Varied knowledge of SP among referrers, compounded by a limited time for GP visits, result in referrers providing SUs with minimal information about SP, resulting in less interest and engagement of SUs in SP. **Facilitators:** Social prescribers build relationships and carry out promotional activities among referral agents to raise their knowledge about SP, and provide them with written information, e.g., posters and flyers/ leaflets about SP that they can hand out to their patients. There are SP champions in various health and social care settings who

the appropriate expectations of the service.	willing to engage with social prescribing **because** t hey are equipped with the appropriate expectations of the service.	advocate social prescribing among their colleagues. In addition, once SU is referred to SP, link workers explain SUs at the initial meeting about SP and how the service can benefit them in improving their health and addressing their needs.
Referrer's role in SU engagement with SP **CMO3. If** the endorsement of SP referrals is provided by credible sources, **then** acceptance of SP by patients may be enhanced (e.g., GPs, other HCPs). **CMO4. If** GPs engagement with SP service is increased, **then** the number of referrals will increase **because** GPs are seen as a credible source by SUs.	***Refine:*** CMO3 and CMO4 were combined into a **CMO3:** **If** HCPs become more involved in the SP process and endorse SP to service users, **then** the number of referrals will increase **because** SUs view HCPs as a credible source.	**Barriers:** Due to a lack of knowledge of referrers about SP and, therefore low engagement with SP, referrers are less inclined to refer their patients to SP. **Facilitators:** A trusting relationship between a referrer and service user and their strong reputation among service users positively influences service users' attendance of an initial appointment with a link worker and their willingness to engage with SP as this trust in referral agents translates to trust in the SP service they are been referred into.
	New: We developed a new CMO to incorporate the findings about the situation with the	**Barriers:** At the time of data collection there was no standard operating procedure for making a referral. Therefore, some referrals were done using an online referral form, while others are email- or paper-based. A new standardised referral form has since been put in place. Currently, social prescribing is not

	electronic referral system: **CMO4*: If*** social prescribing is integrated into the existing online GP referral system, **then** the number of referrals is likely to increase **because** it becomes easier for GPs to implement referrals.	incorporated into the existing GP online referral software, HealthLink. **Facilitators:** This integration may significantly increase the number of GPs who refer their patients to social prescribing services, as it presents a facilitator for the ease of making such referrals.
Referrers' overly clinical outlook **CMO5. If** the GP has skills limited to clinical training, **then** this will influence referral numbers **because** the GP will have an overly clinical outlook on the patient's condition.	**CMO5.** ***Accept*** (remained unchanged)	**Barriers:** Lack of awareness and knowledge of SP among GPs. **Facilitators:** Promotion of SP among referral agents serves as an important means for educating referrers about social prescribing as a legitimate alternative to medications or clinical interventions.
SPLWs' communication with referrers		**Barriers**: There is a lack of communication with referrers, particularly GPs due to the limited time available to them. When referral agents leave posts or change jobs, new HPCs are not aware

CMO6. If SPLW maintains persistent communication with referrers to 'remind' them of the availability of the service and highlight SUs' positive experiences, **then** the number of referrals will increase **because** referrers will be aware of SP service and its benefits.	**CMO6.** ***Accept*** (remained unchanged)	of the SP, and the continuity of referrals is interrupted. The lack of integration across health and social care services hinders a cohesive approach to promoting social prescribing, leading to disparities in referrals. **Facilitators:** Some SP services are located in primary care clinics, which enables easier communication with GPs. Consistent and effective communication between SPLWs and multidisciplinary teams and presentations at regular healthcare team meetings can help to promote SP among HCPs.
Host organisations' role in SP promotion **CMO7. If** host organisations engage in the promotion of SP services, **then** HCPs are more likely to make appropriate referrals **because** they are aware of the service.	**CMO7.** ***Accept*** (remained unchanged)	**Facilitators:** Host organisations are settings that are embedded in the community and connected to community resources; therefore, these organisations can provide HCPs and other referral agents with comprehensive information about the existing community resources and their potential benefits to service users.
SPLW based in primary care **CMO8. If** the SPLW is based in a primary healthcare clinic, **then** more service users will engage with SP service who would not	**CMO8.** ***Accept*** (remained unchanged)	**Barriers:** Only a small number of SP services are located in the primary healthcare clinics in Ireland, as the integration of social prescribing into primary care practice is in the early stages of development. **Facilitators:** Referral agents reported that their referrals help more people engage with the SP service due to their reputation among

otherwise self-refer to the service **because** a strong reputation of GPs ensures greater compliance from service users and improved attendance to SP consultations.		patients. Good communication between GPs and link workers, and link workers making time to explain the SP service to GPs and patients, facilitates this engagement, and this increases appropriate referrals. GPs can provide additional support to link workers for complex cases.
Stage 2 - Interaction between the service user and the social prescribing link worker		
Initial CMO configurations	**Revised CMO configurations based on interview data**	**Barriers and Facilitators to effective implementation of the Social Prescribing service**
The context of SU's referral **CMO9. If** the SPLW has a knowledge of context for referral, and a wide range of coaching skills, **then** they are able to refer the service user to appropriate community/statutory organisations and activities **because** they can provide personalised support.	**CMO9.** ***Accept*** (remained unchanged)	**Barriers:** Varying referral forms and a lack of clear referral criteria result in different referral agents providing different levels of contextual information about SUs on referral forms. Availability of local community/statutory services, or lack thereof, influences the referrals of SUs to community services and groups by SPLWs. **Facilitators:** SPLWs have a deep knowledge of community resources and possess a wide range of skill mix, many of them having counselling, psychology, and community development backgrounds, while also engaging in Continuing Professional Development activities. Appropriate referral from HCPs facilitates referral of SUs to appropriate community services based

		on SUs' individualised approach. Setting clear expectations with the SU about what to expect and what could be achieved and having a policy of outlining key criteria that are critical to enable SUs to engage fully, e.g., being able to attend community activities outside of their home, availability of transport, etc.
Central role of SPLW and person-centred approach **CMO10. If** SPLW provides personalised support to SU, **then** SU will gain a greater benefit from the SP **because** this will facilitate better SU engagement. **CMO11. If** the SP plan is service user-led and SP goals are set by the SU, not staff, **then** the service user will get greater benefits **because** the activities are based on the service user's needs. **CMO12. If** appropriate supports for non-direct work (admin, promotion) are provided to the SPLW, allowing them to provide more one-to-	**CMO10**. ***Accept*** (remained unchanged) **CMO11.** ***Accept*** (remained unchanged) **CMO12.** ***Accept*** (remained unchanged)	**Barriers:** Currently, there is no sustainable, mainstreamed funding model for social prescribing across Ireland. HSE funding typically covers only yearly contracts for SPLWs, leaving host organisations to find additional funds for programme delivery and admin support. SPLWs' high workload due to the shortage of SPLWs, high population to SPLW ratio, and limited admin support can take away from SPLWs' in-person time that they can spend with service users. **Facilitators:** The central role of SPLW in achieving SU's wellbeing and mental health outcomes was emphasised by all participants, with many service users highlighting the relationship between the service user and their link workers as one of the most important aspects of their overall experience of social prescribing. SPLWs make SUs feel valued and promote their empowerment, motivation, and agency by encouraging them to be actively involved in discussions on their wellbeing plans and preferences for the available social prescribing options.

one meetings with service users, **then** the service users feel empowered to make changes **because** they are provided with individualised support.		SPLW's person-centred approach is a central mechanism of the social prescribing service. This approach focuses on addressing the individual needs of the person, which can be profoundly impactful, as it may represent the first instance in which they have received dedicated attention and resources specifically tailored to them.
SPLWs' skill mix and training **CMO13. If** the SPLW receives appropriate training and support, **then** they will be able to effectively manage the interaction with SUs **because** they have a good skill mix necessary for the effective implementation of SP service activities.	**CMO13.** ***Accept*** (remained unchanged)	**Barriers:** External supervision happens on ad hoc basis depending on the location of the SPs services and on the resources available in the host organisation. **Facilitators:** The individualised, person-centred approach used by SPLWs is enhanced by their skills and qualities. The fact that the link worker has time to sit with the service user and explore key areas requires good interpersonal and coaching skills. Many training opportunities are available to help SPLWs develop their skills, such as active listening, non-judgmental communication, motivational techniques, and other core competencies. HSE's ECHO sessions serve as an educational resource and also allow SPLWs to input into the topics that are delivered. Generally, host organisation managers provide supervision to SPLWs. Additionally, SPLWs can join a less formal, peer-led support network where they can discuss daily challenges and get guidance and support.

Community connector role of SPLW **CMO14. If** the SPLW acts as a 'community connector' by linking service users with community resources, while also building and maintaining connections with key stakeholders, **then** it will lead to better outcomes for SUs **because** it enhances trust in SP service and promotes collaboration among all stakeholders. **CMO15. If** SPLWs are able to 'negotiate the communication' across sectors, **then** different stakeholders can be brought closer **because** SPLWs' negotiation will foster understanding and acknowledgment of the specific contexts and challenges they face.	**CMO14.** ***Accept*** (remained unchanged) **CMO15.** ***Accept*** (remained unchanged)	**Barriers:** The lack of integration across health and social care services in Ireland is due to poor communication among the services and their key stakeholders. There is a disconnect between the HSE, host organisations, and community groups. **Facilitators:** SPLWs' role as central points of contact and a reliable knowledge resource for all stakeholders enables them to facilitate cross-sector collaboration and serve as a 'bridge' between health and community services. This allows them to build the links between the key stakeholders and break down barriers that exist for SUs to connect with the community. Through regular engagement with various stakeholders, SPLWs build an extensive database of community contacts and resources, becoming valuable assets for both service users and organisations.

SPLW as an intervention **CMO16. If** there are no appropriate community-based services to refer SU into due to a lack of funding**, then** the SPLW becomes the intervention **because** she/he will act as the ongoing support for the SU. **CMO17. If** the SPLW becomes the intervention, **then** the overall resources may become exhausted **because** this is time-consuming and takes away from other activities of the link worker.	**CMO16.** ***Accept*** (remained unchanged) **CMO17.** ***Accept*** (remained unchanged)	**Barriers:** Lack of adequate funding leads to inconsistencies in social prescribing services delivered, which vary from one service to another. The SP funding models do not cover the programme costs, therefore, a lack of funding or temporary funding can negatively impact both the relationships and the trust in the service as it can disrupt the continuity of services. Availability of community-based resources is particularly challenging in rural areas, and often, the rural areas are left to set up groups themselves, adding to the pressure and the workload of the SPLWs. **Facilitators:** The flexibility of social prescribing in providing the service to SUs in terms of time, location, duration, available funding, and community activities allows SPLWs to exercise their discretion over these aspects. Host organisations seek additional funding from alternative sources to meet the needs of a local social prescribing service.
Flexibility of SP service **CMO18. If** SPLW is allowed flexibility and authority to develop their own micro-solutions to problems as they emerge, **then** SUs will benefit most **because** the	**CMO18.** ***Accept*** (remained unchanged)	**Barriers:** Currently, there is no cohesive national governance structure for SP service delivery, resulting in variation across service delivery. A key challenge of a flexible and person-centred approach is maintaining boundaries in the interactions between SPLWs and service users, including the number and duration of sessions. SPLWs may take on complex cases that may not meet

service will be more personalised for them.		their appropriate referral criteria or excessive responsibilities that exceed their remit, especially in rural Ireland, where other services, such as community resources, are limited. **Facilitators:** The diverse needs of SUs, combined with various social prescribing models, funding sources, settings, and the availability of community resources, require flexibility in the work of SPLWs. SPLWs have significant flexibility within the program regarding the boundaries and scope of their work, which enables them to effectively meet people's needs and support them appropriately. Empowering link workers to use their autonomy to create tailored solutions is crucial for effective social prescribing, as it allows them to address the wide range of needs presented by service users. However, flexibility in delivering services to SUs—including factors like time, location, duration, and the alignment with community activities—can present both opportunities and challenges.
Appropriate referral of the service user to community organisation by SPLW		**Barriers:** Various challenges that SPLWs face in effectively delivering their service, reduce the time they can spend in person with service users for the co-production of the SU's wellbeing plan. **Facilitators:** Appropriate referral from SPLWs to community organisations is made

CMO19. If an appropriate referral to CO is made by SPLW based on the co-production of a wellbeing plan, **then** SU will get the greatest benefit **because** the activity will meet SU's goals, needs, and interests.	**CMO19.** ***Accept*** (remained unchanged)	possible based on an individualised, person-centred approach used by SPLWs. SPLWs build trusting relationships with SUs, making them feel valued, supported, and motivated for change. The increased trust, hope, and self-esteem that result from interaction with SPLW facilitate access to further support from community/statutory organisations that bring about more positive outcomes. This support is tailored to the goals, needs, interests, current mental health status, and readiness of the SU to engage in community activities.
Stage 3 - Interaction between the service user and community organisations		
Initial CMO configurations	**Revised CMO configurations based on interview data**	**Barriers and Facilitators to effective implementation of the Social Prescribing service**
Availability of community activities **CMO20. If** there is a variety of activities available at community services, **then** the service user is likely to engage **because** they are more likely to find an activity suitable to their needs and interests.	**CMO20.** ***Accept*** (remained unchanged)	**Barriers:** A wide range of SUs' needs necessitates the availability of diverse community activities, which poses challenges in finding suitable options for specific population groups. For example, there are limited community activities tailored for younger individuals, whose interests often differ from those of older adults. Additionally, working individuals benefit less from social prescribing and community activities because most of these events occur during working hours. Another challenge is the scarcity of community groups in rural areas, where issues

		of social isolation and loneliness tend to be more prevalent**.** **Facilitators:** Conversations with community organisations revealed a wide range of roles and environments, encompassing social inclusion, peer recovery, adult education, community development, and initiatives focused on community health. Places like libraries, community gardens, and men's and women's sheds further demonstrate this diversity. The diversity among service users creates multi-faceted relationships between service users, social prescribing, and community organisations, where service users interact with other stakeholders in various ways. This highlights the many options available for service users.
Engagement in community activities **CMO21. If** community activities are relevant and meaningful to SU and SU receives support to engage in these activities, **then** the service user will engage and experience positive outcomes **because** the service is meeting the SU's	**CMO21.** ***Accept*** (rem ained unchanged)	**Barriers**: Service users may face challenges in engaging with community activities due to mobility issues, anxiety, complex needs, or mild cognitive issues. Language barriers can hinder communication for non-native English speakers, and mothers with young children often lack childcare to support their attendance of social prescribing or community activities. Additionally, new users may struggle to integrate into established social circles, potentially disrupting group dynamics. **Facilitators:** SPLW's involvement helps service users to take a first step by

needs and they can fully engage in the activities.		encouraging service users to participate in group activities and play a crucial role in promoting social inclusion. Skill-focused environments offer a gentle introduction to socialising, boosting confidence, and fostering personal growth. SPLWs develop a trusting, supportive relationship with their respective community organisations that enhances communication on feeding back on SU's progress with the service and supporting tailored activities that meet the needs of SUs, fostering a collaborative approach.
Community activity leaders **CMO22. If** the activity leader is skilled in facilitating the activities effectively and creates supportive atmosphere, **then** the service users may be more likely to attend **because** the activity is of good quality and benefits SUs.	**CMO22.** ***Accept*** (rem ained unchanged)	**Facilitators:** While community activity facilitators or tutors may not have a direct role in the social prescribing process, their impact on service users' experiences is significant. Community organisations use various methods to recruit facilitators for activities and workshops. Some work with service staff or involve service users in co-creating sessions, fostering ownership and connection. Others bring in external facilitators like freelance professionals or specialised training providers. While it is crucial for facilitators to possess the necessary skills and knowledge to effectively lead activities, participants highlight the social dynamic of facilitation as the most important. The ability of facilitators to create an inviting and supportive atmosphere can greatly enhance participants' engagement and

		satisfaction, reinforcing the importance of social and interpersonal connections in these community activities. Barriers: ?
Training of community organisations **CMO23. If** community organisations receive appropriate training on addressing SUs' needs, **then** the SU is more likely to maintain attendance/be engaged **because** their needs are understood.	**CMO23.** ***Refine:*** **If** community group leaders are able to foster an inclusive environment, **then** the SUs are more likely to maintain attendance /be engaged **because** they feel welcomed.	**Barriers**: Community organisations are not always aware that some of their clients attending their groups or activities are SP users, as, in certain cases, it can be difficult to distinguish between SP users and those who access services through other pathways. SPLWs usually inform organisations about referrals, but identifying individuals who enter through social prescribing can be challenging. This may be due to factors like high attendance, lack of direct link worker introductions, or the informal nature of services like men's sheds, where tracking referrals is not standard. **Facilitators:** Participants emphasised that activity leaders should possess approachability, warmth, and the ability to read social dynamics of the group to foster a more inclusive environment.
Accessibility of community services		**Barriers:** The SP funding models do not cover the programme costs, while accessibility and transport issues, especially in rural areas, remain the biggest challenge for many service

CMO24. If the activity is accessible to the SU, **then** they are more likely to attend **because** it is easy to do so.	**CMO24.** ***Accept*** (rem ained unchanged)	users, which negatively impacts their engagement with SP services. **Facilitators:** Host organisations seek additional funding from other sources to enhance social prescribing services. This funding can help cover transport costs for users and other solutions to improve accessibility to community activities when feasible.
Service users' benefits **CMO25. If** the service user is engaged in the SP service, **then** they take better care of their health and wellbeing **because** they improve their coping skills and self-confidence to take control over their lives, health, and circumstances. **CMO26. If** the service user attends community activities with other service users with similar contexts, **then** their social networks will increase, and they may get peer support **because** they have meaningful interactions with other service users.	**CMO25.** ***Accept*** (rem ained unchanged) **CMO26.** ***Accept*** (rem ained unchanged)	**Barriers:** The service users' motivation and readiness to change influence their willingness to engage in community activities. Service users are more likely to engage in social prescribing when they feel ready to connect with community services and interact with others. Conversely, if individuals face challenges such as social anxiety, personal circumstances, or bereavement, this can affect their readiness to participate, and they often withdraw from participation. **Facilitators:** The availability and accessibility of diverse community groups and services, along with appropriate referrals tailored to the goals, needs, interests, and current state of mental health of service users, facilitate engagement and contribute to the achievement of positive outcomes. While service users can experience an array of benefits, the social aspect of engaging is a

CMO27. If the service user is engaged with community services, **then** their relationships and social connections will increase **because** their community involvement and knowledge of community services will increase.	**CMO27.** ***Accept*** (rem ained unchanged)	foundational element, one which underpins and even enhances other reported benefits.
Complex cases **CMO28. If** service users have very complex health and/or severe mental health needs, **then** it may be more difficult for them to meaningfully engage with community organisations **because** they are not accessible to them based on their needs.	**CMO32.** ***Refine:*** **If** the referral agent carefully assess es the SU with complex needs and their readiness to engage with social prescribing, and makes an appropriate referral, **then** the SU may meaningfully engage with SP and community organisations **because** this meets their goals and complex needs.	**Barriers:** Inappropriate referrals of complex cases to social prescribing pose challenges throughout the entire social prescribing pathway. The lack of set boundaries to service provision, along with the often-complex nature of cases, underscores the necessity for clear referral criteria. **Facilitators:** Depending on the skill set of the SPLW, some may be equipped to deal with a more complex case than others. SPLWs do not exclude service users with complex needs who have been referred to social prescribing, as this could diminish their trust in the services provided. Instead, SPLWs strive to accommodate these individuals' needs to the best of their ability, using available community resources, leveraging other supports (e.g., family), or referring them to suitable specialist services when necessary.

Abbreviations: Social Prescribing (SP) services; Social Prescribing Link Worker (SPLW); Service User (SU); community organisations (COs)

Table 4.2.1 demonstrates the complex factors at individual, community, organisational, and national levels involved in the delivery and implementation of social prescribing in Ireland. An examination of the barriers and facilitators associated with each Context-Mechanism-Outcome configuration provides a comprehensive understanding of how social prescribing operates within the Irish context. This understanding could be instrumental for guiding the future improvements of the Social Prescribing programme.

4.3 Barriers and Facilitators of high-quality implementation of social prescribing in Ireland

The barriers to effective delivery of the social prescribing service and the existing strengths and opportunities that can be leveraged to improve the service were identified at three stages of the social prescribing service. **In the first stage**, the interaction between the service user and the referral agent, the main barriers have been low awareness of social prescribing services among both referrers and potential service users, compounded by a lack of time to explain the potential benefits of social prescribing to patients and assess their readiness to engage with the service. Social prescribing is not integrated into GP software (HealthLink), complicating referrals further, while if integrated, this may significantly increase the number of GPs who refer their patients to social prescribing services, as it would ease making referrals. To address low awareness of social prescribing, effective communication between link workers and referrers is essential, and when link workers take the time to explain the social prescribing service, it leads to more appropriate referrals. In addition, social prescribing champions in health and social care facilitate appropriate referrals. A trusting relationship between a referrer and service user encourages service users to attend initial appointments. When followed by the link worker explaining to the service user how social prescribing can improve their health and address their needs, this greatly increases service users' engagement in the service. A major barrier to a cohesive strategy for promoting social prescribing is the lack of coordination between health and social care services, which leads to inconsistencies in referrals. Currently, the availability of social prescribing services in primary healthcare clinics in Ireland, which facilitates easier communication with general practitioners (GPs), is

limited, indicating that the integration of social prescribing into primary care is still in development. Additionally, host organisations deeply rooted in the community can provide referral agents with valuable information about local resources. Therefore, consistent and effective promotion of social prescribing through various channels to referral agents and the general public enhances awareness and understanding of social prescribing among those who could benefit from it as a viable alternative to medical interventions for improving their mental health and wellbeing.

In the second stage, the interaction between the service user and the social prescribing link worker, appropriate referrals from SPLWs to community organisations are enabled by a person-centred approach by SPLWs, which is a central mechanism of the social prescribing service. SPLWs build trusting relationships with service users and co-produce tailored wellbeing plans based on individual goals and readiness to engage in community activities. However, SPLWs encounter challenges such as insufficient funding, particularly in rural areas, and a lack of administrative and other forms of support. These issues not only increase SPLWs' workload but also limit the in-person time they can devote to service users.

Inadequate funding can also lead to inconsistent service quality, which disrupts trust and continuity in the service provided to users. Additionally, the absence of a cohesive governance structure for social prescribing results in varied service delivery due to different models, funding sources, settings, and available community resources.

To address these challenges, SPLWs exhibit flexibility in their work, allowing them to provide tailored support to service users. This autonomy is crucial for meeting the diverse needs of service users, although it also presents opportunities and challenges in service delivery. For instance, maintaining appropriate boundaries in interactions between SPLWs and service users, such as the number and duration of sessions and the scope of their roles, can be complex. SPLWs have access to many training opportunities to help them develop their skills. Additionally, there are informal, peer-led support networks where they can discuss daily challenges and seek guidance. However, SPLWs operate in an environment characterised by a lack of integration across health and social care services in Ireland, often stemming from poor communication among services and key stakeholders like the HSE, host organisations, and community groups. Therefore, serving as central points of contact, SPLWs facilitate cross-sector collaboration by acting as bridges between health and community

services. This role allows them to establish connections among key stakeholders and break down barriers that prevent service users from engaging with the community.

In the third stage, the interaction between service users and community organisations, the diverse needs of service users necessitate the development of a wide array of community activities, presenting challenges in identifying suitable options for specific population groups, particularly in rural areas where social isolation and loneliness are often more pronounced. Moreover, the motivation and readiness to change in service users significantly influence their willingness to engage in community activities. These factors may vary due to anxiety, complex needs, mild cognitive impairments, mobility limitations, or language barriers. Consequently, the capacity of activity leaders to cultivate an inviting and supportive environment can substantially enhance SU engagement and satisfaction, underscoring the critical importance of social and interpersonal connections within community activities. Activity leaders must exhibit approachability, warmth, and the ability to interpret the social dynamics of the group to foster an inclusive atmosphere. The involvement of SPLWs plays a pivotal role in encouraging and supporting service users to take initial steps towards participation in group activities. However, existing funding models for social prescribing do not adequately cover programme costs, and issues related to accessibility and transportation, especially in rural locations, remain the most significant barriers for many service users, adversely affecting their engagement with social prescribing services. To mitigate this challenge, host organisations often pursue additional funding from external sources. SPLWs are committed to addressing the diverse needs of all service users, including those with complex cases, to the fullest extent possible, by utilising available community resources, leveraging support from family members, or referring them to appropriate specialist services when necessary.

Social prescribing in Ireland - what works for whom, under what circumstances, why, and how?

An analysis of the barriers and facilitators associated with each Context-Mechanism-Outcome configuration provides a comprehensive understanding of how social prescribing operates within the Irish context. The key factors for success in social prescribing include a personalised approach, availability and accessibility of local community services, and a commitment to addressing the social determinants of health, along with appropriate referrals tailored to the goals, needs, interests, and current state of mental health of service users to facilitate engagement and contribute to the achievement of positive outcomes.

In Ireland, social prescribing is particularly effective under specific circumstances, such as when an individual's health is negatively impacted by social, emotional, or practical challenges. It is also relevant when there is a need to bridge the gap between health services and non-medical support, when clinical services alone are insufficient to meet all of a person's health and wellbeing needs, and when suitable local community resources are available for referral. The individuals who benefit the most are those who experience social isolation and loneliness, need support for their mild to moderate mental health conditions, have one or more long-term health conditions, frequently use primary care services, retired and older adults, and individuals who face complex social needs that affect their health. Often, a high level of personal motivation to change from service users is an important prerequisite for success. However, individuals with severe or acute mental health issues, active addiction, or other conditions that require specialist help benefit the least, as they often struggle to engage, while SPLWs may lack training for dealing with very complex cases. In addition, younger service users, due to a lack of suitable community activities, or employed adults, due to scheduling conflicts, benefit least from the social prescribing service.

Effective social prescribing mechanisms that explain what works and why it works successfully involve several key components:

- **Person-centred and flexible support** - this central element focuses on recognising and supporting the individual goals and values of service users. Prioritising what truly matters to them, such as personal goals, interests, and life circumstances, fosters a more holistic sense of wellbeing.

- **Co-production of a wellbeing plan** is a collaborative process between the SPLW and the service user to facilitate the development of a tailored health and wellbeing strategy to address the identified needs, interests, current mental health status, readiness of the SU to engage, and availability of support to engage in community activities. Through open communication and mutual respect, having a dedicated time for building trusting relationships with SUs, and promoting empowerment, motivation, and agency, SPLWs and service users co-create a personalised health and wellbeing strategy that reflects the unique needs, preferences, and strengths of the service user, ensuring that the plan is relevant, realistic, and actionable.

- **Community resources** - central to the effectiveness of social prescribing is the ability of SPLWs to connect service users with suitable and locally available community and voluntary organisations. This involves not just providing information or signposting to available community resources, but also facilitating access to services, activities, and opportunities that can enhance SUs' engagement and provide support tailored to the individual's interests and circumstances. Host organisations, such as Family Resource Centres and Local Development Companies, play a vital role in delivering social prescribing services. They are deeply embedded in the community, connected to local resources, and provide the support necessary for effective SP implementation by link workers. These organisations often serve as a gateway for individuals to engage with social prescribing through a variety of activities.

- **Central role of SPLWs** - the role of knowledgeable and skilled link workers is central and vital in this system. They not only possess the expertise to identify and navigate available resources but also the empathy and interpersonal skills to inspire and motivate service users. By building trusting relationships and offering ongoing assistance, link workers play an essential role in guiding service users through their journey towards improved health and wellbeing. Furthermore, SPLWs act as 'community connectors' and the central point of contact who, through regular engagement with various stakeholders involved in social prescribing, compile an extensive database of community contacts and resources, making them invaluable assets for both service users and organisations.

Social prescribing has been successful in Ireland primarily due to its ability to address the complex web of social factors which can be underlying factors for many health issues. It enhances service users' health outcomes by reducing social isolation, improving mental and physical health, and fostering social connections by connecting individuals with community resources and support networks. Therefore, it reduces the burden on clinical services by diverting individuals from primary care for non-medical issues that can be addressed by social prescribing.

From a health promotion and salutogenesis viewpoint, a significant advantage of social prescribing is that it empowers service users to take an active part in their health and wellbeing by offering them the necessary support to reach their personal goals. Success is significantly influenced by individual motivation and the readiness to change, making forced participation less effective. Additionally, factors such as low confidence and anxiety in unfamiliar social situations can present barriers to participation. Consequently, the provision of one-on-one support by SPLWs and help with service users' initial engagement with community groups is instrumental in overcoming these challenges. Moreover, involvement in social prescribing services enhances health literacy, particularly in understanding the mental health benefits associated with social connectivity, which is vital for encouraging engagement. Social prescribing grants service users access to available resources and fosters a transition towards healthier lifestyles. Service users receive not only support from their link worker but also enhanced opportunities for social interaction and peer support, and these, combined with a sense of community and belonging, help reduce social isolation and loneliness. The context, or environment, in which a supportive community is present and accessible, plays a crucial role in boosting an individual's sense of coherence, which, according to the salutogenesis theory, is essential for enhancing health and wellbeing. Social prescribing helps service users to gain a strong sense of coherence, as it allows individuals to become aware of and utilise available resources and progress towards a more health-promoting and salutogenic lifestyle.

Thus, examining barriers and facilitators at three stages of the social prescribing programme provides valuable insights that can justify and guide future funding and investment. Identifying the factors influencing effective implementation of social prescribing in Ireland may inform better design and implementation of the programme that could lead to enhanced service user engagement, improved outcomes, stronger community-professional partnerships, and more efficient use of resources. This understanding highlights the need for a

national strategy for a coordinated governance model that includes: interdepartmental funding to reflect the cross-sectoral impact of social prescribing;

- better infrastructure with more clarity and integration of social prescribing within the overall HSE service and funding model;
- improved governance consistency in referral pathways, service delivery, external supervision, and outcome evaluation;
- systemic government-level interventions to address the rural challenges, such as limited transport and lack of community infrastructure; and
- a mainstreamed and long-term funding model to mitigate the sustainability risks due to the current subcontracted model that creates inconsistencies and potentially jeopardises the long-term viability of social prescribing.

CHAPTER 5: DISCUSSION AND RECOMMENDATIONS

5.1 Introduction

This realist evaluation sought to identify the key ingredients of social prescribing to inform future training and best practice of social prescribing in the Irish context. This evaluation provides a comprehensive understanding of how social prescribing services operate in Ireland and sheds light on the facilitators and barriers affecting the quality of their implementation, understanding its effectiveness across different population subgroups by identifying the health and well-being outcomes that social prescribing is most likely to impact. It highlights the complexity of social prescribing in Ireland, involving interconnected factors that offer the flexibility and adaptability needed to meet diverse needs and situations. While the principle of providing non-medical support in social prescribing is straightforward, delivering effective local services consistently poses significant challenges. Successful outcomes greatly depend on effective collaboration among key stakeholders.

5.2 Outcomes: The Social, Health, and Well-being Outcomes of Social Prescribing and How it Works for Different Population Subgroups

The interviews with participants have highlighted a wide range of positive benefits associated with social prescribing. Many of the outcomes identified can be seen as proximal outcomes such as gains in feelings of confidence and enhanced social connections that are important first steps toward longer-term, distal outcomes such as improved mental health and overall well-being. Furthermore, outcomes associated with health literacy, including managing health issues and understanding the healthcare system, were also included. Interestingly, while the most common reasons for referral were mental health problems, social isolation and loneliness, and long-term health conditions, the most common outcomes identified from the interviews were improvement in social connections and reduced isolation and loneliness, being a common thread underlying many service users' circumstances. Service users shared that the social prescribing service enhanced their ability to manage challenging situations, as they no longer experienced feelings of isolation regarding their issues. The increased opportunities for socialisation, along with an increased sense of community and belonging, were crucial to the improvement of their well-being. Indeed, the presence and accessibility of a supportive community can significantly enhance an individual's sense of cohesion throughout their life (Koelen et al., 2017).

This effect is further amplified by the person-centred approach employed by SPLWs, which enhances service users' capacity to manage the factors influencing their health and increases their motivation to implement positive changes for improved health and well-being. According to Antonovsky's (1983) theory of salutogenesis, the driving force behind the service user's action may explain the differences in perceived effectiveness of the prescribed activity, and what works best or least for whom. For example, having the ability to understand one's health situation and its causes, as well as the resources available for improvement, fosters 'comprehension'. Additionally, finding purpose in the pursuit of better health and recognising how one's actions contribute to that goal develops 'meaningfulness'. Moreover, having confidence in one's skills and resources to effectively manage their health and achieve positive outcomes ensures 'manageability'. Together, these three components form the sense of coherence in salutogenesis theory (Antonovsky, 1983).

This underscores the importance of understanding the contextual factors that determine the most effective aspects of social prescribing for diverse individuals and circumstances. Conversely, individuals who possess a weaker sense of coherence often face challenges in independently accessing supportive resources. These individuals can also significantly benefit from social prescribing interventions, which offer a connection to community services. It is crucial to assess and identify the most suitable intervention for each person on an individual basis, ensuring that the unique needs and circumstances of the individual remain at the forefront of the approach (Wood, 2021; Woodall et al., 2018).

Our evaluation found that individuals who are socially isolated or experiencing loneliness gained the most from social prescribing. Those who benefited the most also tended to be highly motivated to improve their situations and were ready to engage in the process. Additionally, individuals who needed various practical support or guidance in determining their educational pathways, but lacked the necessary resources, also derived significant benefits from social prescribing.

On the other hand, people in an active addiction state, with severe mental health issues, or individuals who had other, more pressing life or health issues were less likely to benefit from social prescribing due to their inability to maintain the attendance of SPLW consultations or community activities and not being ready to engage with social prescribing. Our findings are in line with a realist review conducted by Husk et al. (2020) that involved 109 studies to examine what approaches to social prescribing work, for whom, and in what circumstances.

The review produced a theory relating to the ways in which the referral process might be implemented for different groups across three organising principles: enrolment, engagement, and adherence. Studies indicated that clients are more likely to enrol if they believe the social prescription will be of benefit, if the referral is presented in an acceptable way that matches their needs and expectations, with concerns elicited and addressed appropriately by the referrer. Service users are more likely to engage if their chosen activity is accessible and they attend the first session with support. Adherence to programmes is impacted through skilled and knowledgeable activity leaders or through changes in conditions or symptoms (Husk et al., 2020). On the other hand, Oster et al. (2023) argue that the sustainability of social prescribing programmes is greatly affected by how the service is designed. It may be more effective to focus on a manageable group of service users rather than trying to serve the entire population. Service users with complex needs might not be adequately supported under the current social prescribing frameworks. Therefore, a careful balance is essential; otherwise, the initiative risks failure if the target demographic is excessively broad, thus undermining its ability to demonstrate tangible benefits, or excessively narrow, limiting its potential impact (Oster eta l., 2023; Polley et al., 2017).

The benefits experienced by service users and reasons behind their health behaviours - comprehending their health status, identifying accessible resources, discovering meaning in enhancing health, and believing in their capabilities - might clarify the variations in how effective the prescribed activity is perceived to be, as well as what approaches work best or least for different individuals. This highlights the significance of recognising the mechanisms and contextual factors that influence the most effective elements of social prescribing for a wide range of individuals and situations.

5.3 Mechanisms: The Active Ingredients of Social Prescribing

The findings from this evaluation highlight the complexity of social prescribing in Ireland, showing that it involves many interconnected factors and mechanisms that can lead to expected or unexpected outcomes. Social prescribing does not happen in isolation; it is shaped and sustained by dynamic interactions within and across different sectors. However, despite the apparent simplicity of these concepts, the effective delivery of suitable services for a sustained period within local communities presents significant challenges. It is essential

not only to develop these services but also to ensure that key stakeholders collaborate efficiently (Oster et al., 2023).

Currently, evidence regarding the practices that contribute to effective social prescribing is limited. Several reviews have examined the implementation of social prescribing in different contexts to define 'good' practice by identifying context-specific enablers and barriers. A realist review by Calderón-Larrañaga et al. (2021) identified meso- and macro-level dimensions, emphasising that social prescribing, and the individuals who deliver and utilise the service, cannot be studied effectively in isolation from the complex organisational, social, and policy contexts in which they operate. Cordis Bright's review (2019), which drew from evaluations of social prescribing interventions and the UK Social Prescribing Network, outlined the key ingredients of social prescribing. These ingredients can serve as the main basis for consensus on what an effective social prescribing service should include, such as funding, buy-in from healthcare professionals, referral process, link worker, patient-centred care, and collaboration and integration between different sectors. The review concluded that there is still no joined-up approach to social prescribing, and most pieces of research point to the need for more evaluations to expand the evidence base. Another review by Sandhu et al. (2022a) examined intervention components of a programme development, implementation, and evaluation. This scoping review stated that it is critical that social prescribing intervention components be defined to ensure the translation to real-world settings is done with attention to the core components that can improve outcomes.

However, the previous reviews also found a wide heterogeneity of existing social prescribing programmes, which creates challenges for commissioners and providers seeking to implement social prescribing programmes, and for evaluators attempting to measure effectiveness. It also makes it challenging for health systems internationally to learn from and adopt the existing social prescribing models. Similar to these reviews, our realist evaluation study found variation in intervention approaches from referral of service users (SUs) to social prescribing services, relationships of various stakeholders with social prescribing link workers (SPLWs), and interactions of SUs and SPLWs with community organisations. The present review found that the success of social prescribing interventions depends significantly on mutual reliance and the establishment of trustful, supportive, and ongoing relationships facilitated by a link worker.

Findings from the present study show that the position of the social prescribing **link worker** is a central and vital component of social prescribing in Ireland. By investing time to understand their service users and adopting a flexible and person-centred approach, the link workers are able to build trusting relationships with service users. The relationship between the link worker and the service user plays a key role in achieving positive outcomes for the service user and is essential for successfully linking service users to various community services relevant to their needs. Improvements in health-related behaviours, management of long-term conditions, and improvement of mental health were supported by setting realistic, user-led, and personalised goals, engaging in problem-solving, receiving regular feedback, and gaining social support. These behaviour change strategies have been proven effective in lifestyle interventions (French et al, 2014; Brand et al., 2014; Cradock et al., 2017; Gilchrist et al., 2024). Importantly, these methods were used while also helping individuals address social and economic challenges. Through the interaction of the SPLW and service user, social prescribing built a sense of purpose, improved self-esteem, reduced social isolation and loneliness, and led to positive physical outcomes such as weight loss, increased physical activity, better management of long-term conditions, and improved mental health (Moffatt et al., 2017a).

Many service users emphasised that **the connection and trust** between them and their link workers is a crucial element of their overall experience with social prescribing. The compassion, non-judgmental attitude, and motivation offered through the person-centred approach of the link worker are fundamental components of the social prescribing service in Ireland. Similarly, the interpersonal qualities of the link worker were raised in other studies as a key factor in service users engaging with the social prescribing service where the approachability, trustworthiness, and communication skills of the link worker were crucial and often resulted in individuals feeling valued and listened to (Woodall et al., 2018; Bertotti et al., 2018; Araki et al., 2022). The collaborative and consultative character of the service was highlighted by both clients and link workers. Instead of being told what to do, service users felt confident that the process involved working together to determine the most effective course of action (Woodall et al., 2018).

The individualised **person-centred approach** undertaken by SPLWs is a central mechanism for the effective implementation of social prescribing services in Ireland. This approach is enhanced by the skills and qualities of the link worker. Previous research showed that the delivery of person-centred care is one of the key pillars of social prescribing for

empowering individuals to improve and manage their health and well-being (Polley et al., 2020; Tierney et al., 2024; Wildman et al., 2019). A person-centred approach to intervention delivery can support SU adherence to services and achievement of personal goals, while the lack of knowledge and skills to deliver person-centred care can act as a barrier to the delivery of high-quality care (Moore et al., 2017). Previous studies found that, regardless of the reasons for referral, personalisation of the support provided by a link worker is one of the most important features in effective social prescribing programmes (Chatterjee et al., 2017; Moffatt et al., 2017b; Pilkington et al., 2017). To be effective in this role, the extensive international evidence base on community health workers and similar roles has emphasised the role of selecting staff based on their membership in the community, knowledge of the local culture, similar life experiences, and similar socioeconomic status (Olaniran et al., 2017).

Furthermore, the current evaluation showed that link workers, because of their deep knowledge of the community and local resources and their connections to health and social care sectors, play a central role as **'community connectors'** in building trusting relationships within their communities. This ultimately helps increase stakeholders' engagement with social prescribing and encourages collaboration in service delivery. Likewise, some researchers have conceptualised social prescribing as a 'system' (Husk et al., 2019, p. 7) that includes two components: the community-based opportunities for improving service users' health and well-being and the processes of connection from health or social care to those community-based opportunities (Cunningham et al., 2021; Husk et al., 2019). In this system, link workers with highly developed skills who personalised the national programme to local needs were central to the intervention's success (Holding et al., 2019). Tierney et al. (2020) described that to establish a successful social prescribing connector scheme, gaining stakeholder buy-in is essential. However, maintaining ongoing relationships is equally important, as the service's success relies on strong connections between link workers and key stakeholders over time. The authors emphasised that link workers play a vital role in bridging healthcare professionals (HCPs) and the voluntary and community sector (VCS). Link workers address scepticism from HCPs about the VCS's ability to assist patients and, equally, help VCS staff communicate with HCPs more effectively. By building relationships and organising joint events, link workers enhance mutual understanding and respect, enabling HCPs to manage patients' non-medical needs more effectively (Tierney et al., 2020). Thus, social prescribing can serve both as a local intervention to enhance individuals' health and

well-being and as a systems intervention to tackle a fragmented and overburdened health and social services system. To achieve these goals, it is important to use a 'learning health system' approach, as suggested by Mulligan (2024), to find effective ways to measure the success of different strategies and address concerns from stakeholders about how the health system can help with social issues. A learning health system (LHS) is a model where organisations systematically utilise data and evidence to enhance healthcare delivery and service user outcomes. It aims to bridge the gap between research and practice by integrating evidence and quality improvement into daily operations (National Academy of Medicine, n.d.). The LHS operates in a continuous cycle: collecting and analysing patient data to identify areas for improvement, applying new evidence to clinical care, and evaluating the impact of changes to restart the cycle (Friedman et al., 2017). Additionally, ensuring that adequate and continuous resources and partnerships support the community sector is vital, as it plays a central role in social prescribing (Mulligan, 2024).

On the other hand, the health care sector is a context that is rich in isolated clusters, such as silos, in need of connectivity. It is a key challenge in health service management to understand, analyse, and leverage the role of key agents, such as social prescribing link workers, who have the capacity to connect disparate groupings in larger systems (Long et al., 2013). Link workers facilitate communication and interactions among individuals and groups that may lack access or trust in each other (Long et al., 2013). In this capacity, they may help mitigate the disconnectedness among health providers, community organisations, and other stakeholders, acting as intermediaries for these varied groups. However, the effectiveness of social prescribing link workers may be hindered by the lack of formal qualifications in their profession and the absence of a well-established professional career structure. Furthermore, uncertainty about their role, coupled with the absence of recognised qualification and a clearly defined career pathway, can add to the stress associated with their demanding and often complex roles (Brown et al., 2021). Over time, as new link workers integrate into an established network, these challenges may lessen. Increasing the number of trained link workers could also help meet community needs (Brown et al., 2021).

5.4 Context: Implementation Barriers and Facilitators

It is imperative for service commissioners and providers to understand the operational facilitators and barriers in relation to existing social prescribing models to inform future

service provision. Research shows that a well-led implementation process is important as it influences the delivery and outcomes of a complex health intervention or programme (Graham Moore et al., 2015), while if a health intervention is not implemented sufficiently due to encountered barriers, the delivery process can be disrupted and negative outcomes can occur (Graham Moore et al., 2015; Durlak & DuPre, 2008). A systematic review conducted by Pescheny et al. (2018) identified a range of factors that facilitate and hinder the implementation and delivery of SP services. Facilitators and barriers identified in eight studies included the implementation approach, legal agreements, leadership and management, staff engagement and turnover, relationships and communication between partners and stakeholders, and local infrastructures. However, the quality of most included studies was poor, and the review identified a lack of published literature on factors that facilitate and hinder the implementation and delivery of Social Prescribing services. Therefore, the review concluded that more high-quality research and transparent reporting of findings are needed in this field.

The current evaluation identified several barriers and facilitators related to the implementation of SP service in the Irish context. The main barriers to the delivery of SP were identified as the lack of awareness and knowledge about Social Prescribing among referral agents and service users, lack of funding for SP programme costs, such as availability of transport and service users' accessibility issues, especially in rural areas, and a lack of integration between social prescribing service and health and social care services and other stakeholders. The key facilitator was identified as social prescribing link workers' role as central points of contact and a reliable knowledge resource for all stakeholders, enabling them to facilitate cross-sector collaboration and serve as a 'bridge' between health and social care and community services. This allows them to build the links between key stakeholders and break down the barriers that exist for SUs to connect with the community. Through regular engagement with various stakeholders, SPLWs build an extensive database of community contacts and resources, becoming valuable assets for both service users and organisations. The key points related to these hindering and enabling factors to social prescribing service delivery are presented in more detail below.

5.4.1 The awareness of social prescribing

The current study identified a need to increase awareness of social prescribing among health and social care professionals and the general public to ensure appropriate referrals into social prescribing service and to manage the expectations of service users. Previous research is

consistent with our findings that there is limited knowledge of social prescribing amongst participants as well as limited involvement in community discussions of the topic (Khan et al, 2022). The social prescribing link worker was considered to be important in supporting engagement with services, and it was preferred that this role be undertaken by people with local knowledge. Many efforts were made to raise public awareness and knowledge about social prescribing. For example, the UK National Academy of Social Prescribing (2022) has delivered multimedia campaigns (videos, social media campaigns, and a podcast) to raise public awareness and knowledge of social prescribing with the work ongoing to establish the effectiveness of this approach (Khan et al, 2022). Overall, there is a need to develop a more robust evidence base for the implementation of services and better training for health and social care professionals to increase knowledge about social prescribing (Cooper et al., 2024), while some studies emphasised the need to raise awareness about social prescribing among service providers and the community, as expansion and sustainability can be achieved through education that fosters a better understanding of social prescribing and its benefits (Esfandiari et al., 2025).

5.4.2 Funding

The current study found that a lack of adequate funding is one of the greatest barriers, as it leads to inconsistencies in social prescribing services delivered. The SP funding models in Ireland do not cover the programme costs as HSE funding usually only covers the expenses for annual contracts for SPLWs, leaving the host organisation to face the challenges of obtaining extra funds for the costs associated with programme delivery. Therefore, a lack of funding or temporary funding can negatively impact both the relationships and the trust in the service, as it can disrupt the continuity of services. Funding and, therefore, availability of community-based resources are particularly challenging in rural areas, and often, the rural areas are left to set up groups themselves, adding to the pressure and the workload of the SPLWs. Furthermore, SPLWs are typically offered year-on-year rolling contracts with unfavourable terms and conditions, which is a barrier to retention, further recruitment, and ultimately the sustainability of the service.

Financing approaches for social prescribing services vary across countries to cover salaries, management, and infrastructure, and depend on the size of the projects and community groups (Sandhu et al., 2022b). These financial mechanisms may include government funding local authority funding, public health money, grants and trusts, and social impact bonds such as in the UK (Polley et al., 2017), research funding in South Korea (Kim et al., 2021), or

more flexible health funding mechanisms such as value-based payments in the USA (Sandhu et al., 2021). In some countries, there was no need for additional funding as health systems repurposed existing staff and infrastructure to social prescribing (Hoffmeister et al., 2021; Heijnders & Meijs, 2018; Naito et al., 2021).

However, with any type of financing mechanism used in social prescribing, it is essential to ensure its continuity (Oster et al., 2023). Social prescribing helps build relationships between stakeholders, and the trust developed from these relationships empowers individuals to take action and improve their circumstances. However, developing these relationships takes time, making stable funding essential for continuity. Link workers may be employed by third-sector organisations, which is the case in Ireland, so securing funding to sustain their roles is crucial. As more social prescribing service users engage with local community organisations and groups, it becomes increasingly important that funding follows the service user. This ensures the organisations receiving referrals can maintain their income and continue providing services (Polley et al., 2017). Similar to our study's findings, a realist review conducted by Calderón-Larrañaga et al. (2021) to identify context-specific enablers and tensions of social prescribing reported that representatives from community organisations frequently express concerns about the budget shortfalls in social care and community services, which impact the sustainability and capability of their services. The typically temporary nature of contracts and the ongoing risk of funding cuts or withdrawals result in a high turnover of staff and the services being provided (Wildman et al., 2019). This creates a negative effect on stakeholders' expectations and commitment towards the service (Calderón-Larrañaga et al., 2021).

5.4.3 Governance

Polley et al. (2017) recommend that it is important to ensure that any social prescribing programme has appropriate governance that includes policies and procedures for each component of the programme. A clear line of accountability is needed at every stage of the social prescribing process and between the organisations and providers involved (Polley et al., 2017; Oster et al., 2023). Our evaluation showed that to support the effective and efficient role of SPLWs, there is a need for a better national governance structure for service delivery, the lack of which results in variations in how services are rolled out in different areas of Ireland. Maintaining a level of flexibility is crucial for addressing emerging local needs; however, having a well-defined framework is key to ensuring a consistent and effective delivery of services nationwide. Therefore, by balancing structured guidelines with

the ability to pivot and respond to specific local demands, a more cohesive and responsive service model can be created that ultimately benefits all stakeholders.

Furthermore, the lack of set boundaries to service provision, in addition to the often-complex nature of cases, highlights the need to ensure that appropriate supports, including training and formal external supervision, are available for all SPLWs. Additionally, the integration of social prescribing within the existing national GP online referral software, Healthlink, has been identified as a critical area for development. This enhancement, if implemented, can increase the number of GPs' referrals to social prescribing.

Findings of this study indicate that many governance issues pertaining to the Irish social prescribing programme are similar to those of other social prescribing schemes. Previous research has indicated that the framework for social prescribing is characterised by a lack of clear guidance and exemplifies a "laissez-faire" attitude towards service standards (South et al., 2008), and ambiguity persists concerning service boundaries (Bickerdike et al., 2017; Wildman et al., 2019). There is a lack of established standards regarding the skillset of link workers, and bespoke training and career progression mechanisms are needed to prepare and retain link workers in their demanding and highly skilled role (Wildman et al., 2019). In some cases, there is an uncertainty regarding whether the management of link workers should fall under the healthcare sector or the third sector (Drinkwater et al., 2019). Furthermore, the key attributes of a 'good' practice and the job descriptions for link workers have yet to be thoroughly assessed (Hutt, 2017). Therefore, enhancing the existing funding and governance structures for social prescribing services emerges as a significant theme that influences the capacity of SPLWs to address the needs of service users, as well as the potential for service expansion and sustainability (Oster et al., 2023). It is essential to acknowledge that various stakeholders may possess differing expectations concerning the levels of governance required in a social prescribing initiative, reflecting the diverse regulations applicable to different sectors. Consequently, it is imperative that all stakeholders and partners are engaged in the design process of the social prescribing programme (Polley et al., 2020).

5.5 Strengths and Limitations

The strengths of this realist evaluation include that it is the first national-level evaluation of the HSE-funded social prescribing services in Ireland. Stakeholders from all components of

the social prescribing service were involved in the evaluation, making it the first large-scale evaluation. This comprehensive approach allowed for gathering feedback from various key stakeholders and provided valuable insights into their perspectives. Both operational and strategic viewpoints were included, which helped to clarify the complexities of the context and mechanisms involved in the service. Moreover, the evaluation yielded important insights for improving the service and guiding future evaluations.

However, there are a number of limitations to this evaluation that should be noted. The limited collection of outcome data meant that no quantitative data were gathered, which could complement the qualitative interview data. Additionally, rural participants, including service users, link workers, and referral agents, were underrepresented in the study due to challenges in recruiting participants from these areas. However, the mechanisms and contextual factors highlighted in this evaluation can contribute to discussions in the delivery of social prescribing in these areas, specifically the central role of the link worker and the relationship between the link worker and the service user are key for the effective implementation of social prescribing. There may also have been potential bias in the selection of service users, attributable to the sensitive nature of the service. It is also important to note that the service users who participated in the study were selected by SPLWs. Consequently, it is likely that link workers did not choose individuals who expressed dissatisfaction with the service, resulting in the exclusion of these perspectives. As a result, the viewpoints of the participating service users may be biased and not fully representative of the wider population. Therefore, to enhance future research in this area, it is important to engage participants who discontinued their use of the service. Understanding the reasons for their departure and identifying aspects of the service that were unsatisfactory will provide a more accurate and comprehensive perspective on the service's effectiveness. In addition, conducting follow-ups with the service users over time would provide valuable insights into the progression of their outcomes.

5.6 Conclusions

This realist evaluation provides valuable insights into social prescribing that extend beyond traditional measures of effectiveness by addressing key questions about how social prescribing works in the Irish context, who benefits from it, and under what circumstances. The evaluation identifies the active ingredients of social prescribing in Ireland and describes

the factors that influence the successful implementation of these services. A key element is the role of SPLWs, who actively engage at all stages: referral, interaction with the service user, and collaboration with community organisations. By fostering supportive relationships, SPLWs enhance community health as trusted intermediaries, promoting collaboration and adapting services to meet needs. The personalised and empathetic approach taken by SPLWs builds trust, which is essential for service users' engagement and progress. Social prescribing enhances service users' social connections, emotional health, and sense of purpose, reducing social isolation and loneliness, and decreasing reliance on healthcare services. Its effectiveness hinges on individuals' motivation and readiness to engage, which SPLWs can help foster.

The evaluation findings point to the challenges in the effective delivery of social prescribing services in Ireland. There is a need for enhanced funding and governance structures, which are crucial elements that affect the ability of SPLWs to meet the needs of service users, as well as the potential to expand the service and ensure its sustainability. Current localised models result in inconsistent service delivery, with varying levels of support, particularly in underserved areas. Without formal structures, support duration and intensity can vary widely, with some SPLWs offering long-term, informal help, especially in areas with limited services. The flexible, person-centred nature of the role can blur boundaries in complex cases. National guidance is needed to ensure consistency and to enhance governance, employment terms, and funding models.

This realist evaluation highlights the complexity of social prescribing, emphasising the interconnected factors that can inform future development and improvement efforts for these services. The study findings offer a range of valuable insights that can help enhance social prescribing in Ireland. Specific recommendations, based on the findings, are outlined below.

5.7 Recommendations

Recommendations for Social Prescribing Practice

Governance

- It is recommended that the HSE adopt a more coordinated and strategic approach to developing social prescribing models of delivery at a national level. This includes

reviewing the framework for the future development of social prescribing within the Irish context.

- At the local level, the coordination and delivery of social prescribing should be embedded within existing Health Promotion and Improvement Manager (HPIM) structures, ensuring alignment with national policy direction, while maintaining responsiveness to local population health needs.
- More robust contracts of employment for SPLWs are needed, together with funding beyond the SPLW position to include programme costs. Short-term, precarious funding of services is perceived as a clear threat to the sustainability of the social prescribing service, as it impacts on continuity and long-term planning. The current funding situation is also viewed as potentially undermining the relationship building between the SPLW and service user, which is the foundation of an effective social prescribing service.
- A national digital plan to facilitate referrals, track outcomes and measure the impact of social prescribing is needed to support effective service delivery and build the evidence base. Currently there is no centralised, digital platform for referrals, data management and tracking. This poses a significant risk to GDPR requirements and the ability to build the evidence base. This would need to be supported by adequate training for all stakeholders (referral agents, SPLWs and community organisation). A pilot/phased approach to implementation should be considered in recognition of the time needed to transition to such a system, giving the limited/non-existent digital infrastructure in some areas.

Improved awareness and understanding of social prescribing

- There is a need to strengthen awareness and understanding of social prescribing within health and social care settings. Greater clarity about the purpose, value, and processes of social prescribing will support more appropriate referrals, consistent engagement, and stronger collaboration between health services, community organisations, and the public.
- Additional resources must be targeted to building awareness for the public on the benefits of social prescribing. This needs to include the creation of a standardised

definition of social prescribing that is shared widely across all social prescribing stakeholders to ensure everyone has a clear understanding and to support effective implementation. Emphasising a focus on community connection is warranted to help address any stigma associated with social prescribing.

- Improving recognition and understanding of social prescribing as a core element of wrap-around, community-based supports for mental health should be prioritised. Greater intersectoral awareness of social prescribing's role in promoting mental health and wellbeing will help to embed it within broader health and social care pathways.
- Efforts to raise awareness and promote social prescribing should be balanced with the capacity of services and community organisations to respond to increased demand. Awareness-building initiatives need to be aligned with available resources and local capacity to ensure that services remain sustainable and equitable.
- The ongoing work of Health Promotion and Improvement Managers (HPIM) and their teams on building awareness of social prescribing services needs to be expanded across all their health and social care networks. Qualitative case studies showcasing the benefits reported by service users and other key stakeholder should be routinely used in this work.

Access to external supervision and improved training opportunities for SPLWs

- All SPLWs should have consistent access to external supervision as a matter of routine. SPLWs routinely engage with service users with complex needs, including traumatic experiences. Providing ongoing supervision and support to all SPLWs is critically important.
- Training and professional development opportunities should be provided for all social prescribing Link Workers to strengthen their skills in key areas related to their work. The following key areas were highlighted in this study; training in suicide prevention, self-harm awareness, solution-focused therapy, understanding migrant and asylum-seeking experiences, and working with people with severe mental health conditions. Additionally, training focused on engaging young people in SP, mapping and interacting with community services, making every contact count, was also highlighted.

- The online social prescribing learning network platform, known as ECHO, was positively regarded by SPLWs and is recommended for continued use as a platform for providing further training for SPLWs.
- Awareness and understanding of service monitoring and evaluation should be strengthened across social prescribing services. Link workers and partner organisations should have clear information on the role of evaluation in demonstrating service impact and informing best practice development. Practitioners' knowledge and confidence concerning the use of service level data, and the selection and use appropriate process and outcome measures from an agreed suite, applied at the right points in the social prescribing journey, is critical in supporting service evaluation efforts. Clear communication is also needed on how collected data will be used, stored, and shared, including reassurance around GDPR compliance and data protection.
- Training should also be provided to SPLWs on the routine collation of case study information that can be used for promotional purposes. The development of a template at national level would be helpful in supporting this process.

Referral Guidelines

- It is important to note that a national referral form has recently been released to support the social prescribing referral process. Guidance on who social prescribing is best suited for is also available.
- A coordinated approach to increase GP involvement in referrals is needed. Integrating social prescribing services into the existing GP referral system known as Health link is recommended to streamline the referral process.
- Identifying who social prescribing is best suited for, and what is required for effective participation with the service, is critical in preventing inappropriate referrals. Having a clear set of referral guidelines would support practitioners' decision-making. These guidelines should be clearly communicated to referral agents.

Recommendations for Social Prescribing Policy

A clear policy and implementation plan is critical to guiding the strategic development of social prescribing at both a national and local level in Ireland. A variety of social prescribing models are in evidence across different countries, including those embedded in primary care, as in the UK, or a mixed model based in the community and voluntary sector, as currently in operation in Ireland. Strategic decisions will need to be made concerning the best model for implementation in the Irish context going forward.

Equitable Provision of Social Prescribing

- The equitable provision of social prescribing services across the country is an important principle underpinning its current and future development. This is especially critical in areas of disadvantage and more rural and isolated geographical areas, where local services and supporting infrastructure may be inadequate to meet local needs. Targeted development in such areas is recommended as part of future service planning.

Community & Voluntary sector

- Community organisations are an integral part of the social prescribing service. Additional resources are required to continue to support the roll out of social prescribing services within the community and voluntary sector. This should include funding and resources to support local infrastructure and to build capacity to meet the needs of service users.

Sustainable Funding Model

- Social prescribing plays a key role in addressing the social determinants of health. Funding sources should reflect this. At a national level there is potential for a cross-sectoral joined-up approach to funding the development and implementation of social prescribing services. Joint funding models could be explored further, similar to the model utilised by Creative Ireland. Showcasing the co-benefits of social prescribing could lead to more sustainable cross-sectoral funding arrangements.

In addition to the Department of Health, the following government departments have remits relevant to the funding and implementation of social prescribing services:

- Department of Culture, Communications and Sport

- Department of Rural and Community Development and the Gaeltacht
- Department of Public Expenditure, Infrastructure, Public Service Reform and Digitalisation
- Department of Social Protection
- Department of Transport
- Department of Justice, Home Affairs and Migration

Education

- Regarding the training of future health and social care professionals, the Department of Further and Higher Education, Research, Innovation and Science is identified as a key actor in ensuring that the social prescribing service, and its relevance for addressing the social determinants of health, are routinely embedded in all undergraduate training for future health and social care professionals.
- In addition, this mandate should be extended to further education and professional training avenues including Continuing Professional Development (CPD) courses and GP training.

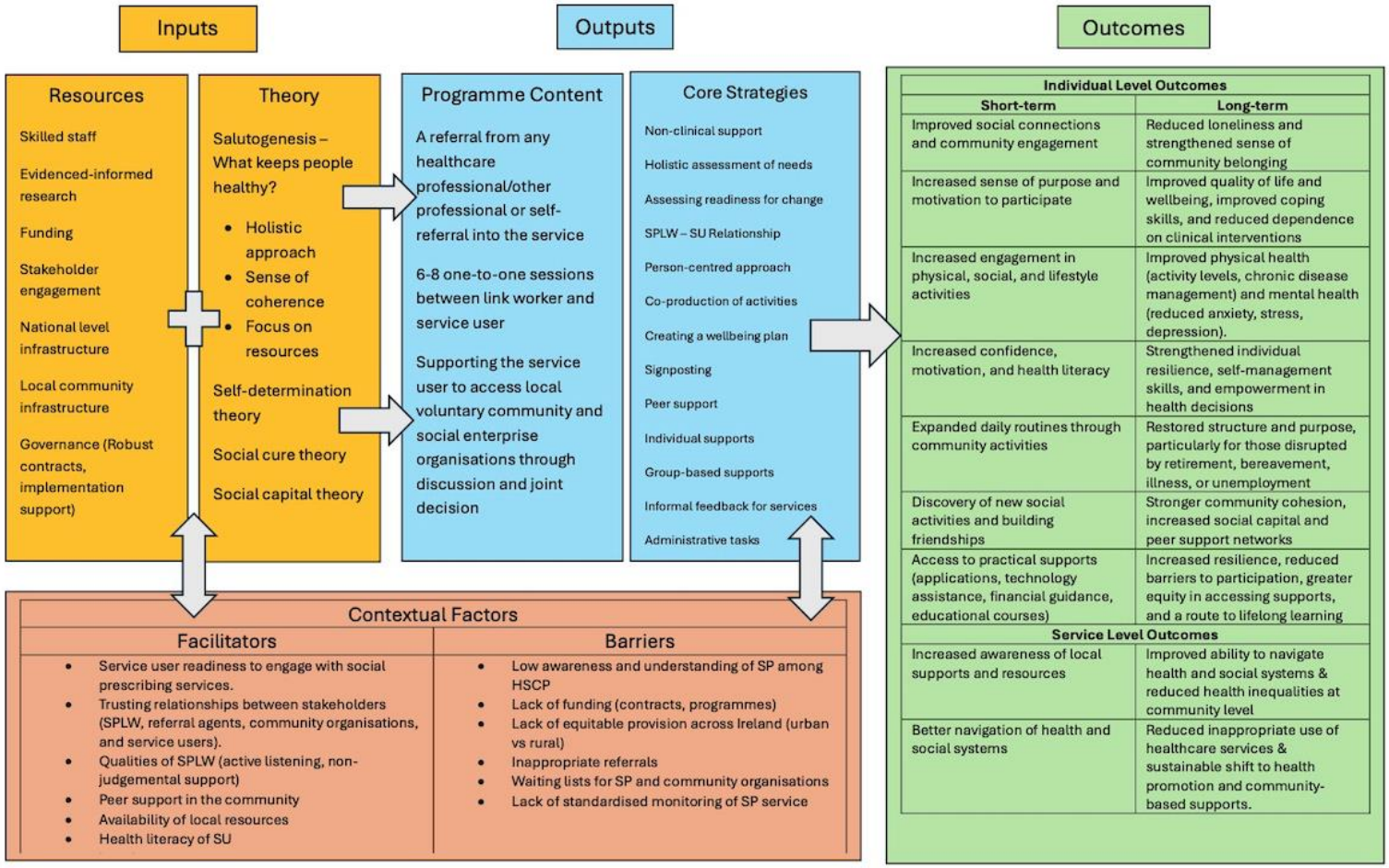
Recommendations for Social Prescribing Research

- Increased investment in research and knowledge translation is crucial to build the evidence base to support the mainstreaming of social prescribing as part of Ireland's healthcare infrastructure.
- More comprehensive robust evaluations of social prescribing services are needed at the national level to inform best practice ad policy concerning its future development. Future evaluations should consider using a mixed method approach, combining qualitative process evaluation methods with quantitative outcome measures, addressing both proximal and distal outcomes at individual and service level. Based on the findings from this realist evaluation study, the evaluation logic model set out below is proposed to guide evaluation planning.
- In view of the significant variability in how social prescribing is implemented across different settings, it is recommended that evaluations complement outcome-based

studies with implementation research on the process of implementation in order to capture the contextual level factors that impact on service delivery.

- Outcome evaluations should seek to capture not only the medium- and long-term health and wellbeing impacts of social prescribing, but also the proximal outcomes, such as increased service user motivation, confidence, sense of purpose, agency, and empowerment, as these often serve as key pathways to broader improvements.
- A robust evaluation framework is recommended, one that recognises and respects the complexity of social prescribing service in Ireland, such as, for example, the Consolidated Framework for Implementation Research (CFIR) (Damschroder et al., 2022).
- Understanding the economic impact of social prescribing is of particular importance. A cost-benefit analysis study is recommended to evaluate the costs of delivery and the economic and social returns on social prescribing within the Irish context.

Figure 5.7.1 Logic Model for Social Prescribing Service in Ireland



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Appendices

Appendix A

Table 3.2.3. ***CMOs by stages***

Stage 1 **Referral of Service User to SP service**	**Stage 2** **Interaction of Service User with SPLW**	**Stage 3** **Interaction of Service User with Community Organisation**
CMO1. If the referrer (HCPs, etc.) clearly communicates to service users what the social prescribing service can offer them and why this may benefit them , **then** service users will feel confident in their interactions with SPLWs **because** they are equipped with the appropriate expectations of the service	**CMO9. If** the SPLW has a knowledge of context for referral, and a wide range of coaching skills, **then** they are able to refer the service user to appropriate community/statutory organisations and activities **because** they can provide personalised support.	**CMO20. If** there is a variety of activities available at community services, **then** the service user is likely to engage **because** they are more likely to find an activity suitable to their needs and interests.
CMO2. If the referrers clearly communicate to service users what the social prescribing service can offer them and why this may benefit them, **then** service users will feel confident in their interactions with SPLWs **because** they are equipped with the appropriate expectations of the service.	**CMO10. If** SPLW provides personalised support to SU, **then** SU will gain a greater benefit from the SP **because** this will facilitate better SU engagement. provided with individualised support.	**CMO21. If** community activities are relevant and meaningful to SU and SU receives support to engage in these activities, **then** the service user will engage and experience positive outcomes **because** the service is meeting the SU's needs and they can fully engage in the activities.
CMO3. If the endorsement of SP referrals is provided by credible sources, **then** acceptance of SP by patients may be enhanced (e.g., GPs, other HCPs). **CMO4. If** GPs engagement with SP service is increased, **then** the number of referrals will increase **because** GPs are seen as a credible source by SUs.	**CMO11. If** the SP plan is service user-led and SP goals are set by the SU, not staff, **then** the service user will get greater benefits **because** the activities are based on the service user's needs.	**CMO22. If** the activity leader is skilled in facilitating the activities effectively and creates supportive atmosphere, **then** the service users may be more likely to attend **because** the activity is of good quality and benefits SUs.
CMO5. If the GP has skills limited to clinical training, **then** this will influence referral numbers **because**	**CMO12. If** appropriate supports for non-direct work (admin, promotion)	**CMO23. If** community organisations receive appropriate training on

the GP will have an overly clinical outlook on the patient's condition.	are provided to the SPLW, allowing them to provide more one-to-one meetings with service users, **then** the service users feel empowered to make changes **because** they are provided with individualised support.	addressing SUs' needs, **then** the SU is more likely to maintain attendance/be engaged **because** their needs are understood.
CMO6. If SPLW maintains persistent communication with referrers to 'remind' them of the availability of the service and highlight SUs' positive experiences, **then** the number of referrals will increase **because** referrers will be aware of SP service and its benefits.	**CMO13. If** the SPLW receives appropriate training and support, **then** they will be able to effectively manage the interaction with SUs **because** they have a good skill mix necessary for the effective implementation of SP service activities.	**CMO24. If** the activity is accessible to the SU, **then** they are more likely to attend **because** it is easy to do so.
CMO7. If host organisations engage in the promotion of SP services, **then** HCPs are more likely to make appropriate referrals **because** they are aware of the service.	**CMO14. If** the SPLW acts as a 'community connector' by linking service users with community resources, while also building and maintaining connections with key stakeholders, **then** it will lead to better outcomes for SUs **because** it enhances trust in SP service and promotes collaboration among all stakeholders.	**CMO25. If** the service user is engaged in the SP service, **then** they take better care of their health and wellbeing **because** they improve their coping skills and self-confidence to take control over their lives, health, and circumstances.
CMO8. If the SPLW is based in a primary healthcare clinic, **then** more service users will engage with SP service who would not otherwise self-refer to the service **because** a strong reputation of GPs ensures greater compliance from service users and improved attendance to SP consultations.	**CMO15. If** SPLWs are able to 'negotiate the communication' across sectors, **then** different stakeholders can be brought closer **because** SPLWs' negotiation will foster understanding and acknowledgment of the	**CMO26. If** the service user attends community activities with other service users with similar contexts, **then** their social networks will increase, and they may get peer support **because** they have meaningful interactions with other service users.

	specific contexts and challenges they face.	
	CMO16. If there are no appropriate community-based services to refer SU into due to a lack of funding**, then** the SPLW becomes the intervention **because** she/he will act as the ongoing support for the SU.	**CMO27. If** the service user is engaged with community services, **then** their relationships and social connections will increase **because** their community involvement and knowledge of community services will increase.
	CMO17. If the SPLW becomes the intervention, **then** the overall resources may become exhausted **because** this is time-consuming and takes away from other activities of the link worker.	**CMO28. If** service users have very complex health and/or severe mental health needs, **then** it may be more difficult for them to meaningfully engage with community organisations **because** they are not accessible to them based on their needs.
	CMO18. If SPLW is allowed flexibility and authority to develop their own micro-solutions to problems as they emerge, **then** SUs will benefit most **because** the service will be more personalised for them.	
	CMO19. If an appropriate referral to CO is made by SPLW based on the co-production of a wellbeing plan, **then** SU will get the greatest benefit **because** the activity will meet SU's goals, needs, and interests.	

Appendix B

Interview Guide for Social Prescriber Link Worker (SPLW)

☐ Sláintecare

☐ Non Sláintecare

☐ Urban

☐ Rural

☐ Rural Town

Thank you for agreeing to take part in this interview. We are interested in finding out how the Social Prescribing service works.

General Questions about Social Prescribing (SP)

- Can you tell me about your involvement in Social Prescribing? (e.g., how long have you worked as a SPLW?)
- Do you work full- or part-time?

1. **We are very curious about how the SP programme impacts service users' lives. How do you think the programme has caused or helped to cause the outcomes you have seen with your service users? Can you give me examples?** (physical, emotional, mental health & well-being, social, other?)
2. **Can you provide any examples, based on your experience, where service users have not engaged well with Social Prescribing overall?**

3. **We've seen that social prescribing works differently in different places. Can you describe your service and how it operates?**

A. **Referral to the social prescribing service**

4. **Can you tell me about your experience with different referral pathways into the service?**

5. **Based on your experiences, how informed are service users about the service when you meet with them?**

6. **<u>Based on your experiences, how informed are referrers about the service?</u>**

7. **What ideas do you have to enhance the understanding of what the service is about a) for service users; and b) for health and social care referrers?**

8. **What factors do you think can influence the service users in following up on the initial meeting with the link workers?**

9. **What ideas do you have on how such issues can be addressed?**

10. **Can you tell me about the questionnaires or outcome measures that you use with service users?**

11. **Can you tell me who do you think the Social Prescribing service works best for and least for?** Who gets the greatest benefit from SP services? Why do you think so?

B. Interactions between link workers and service users.

There are lots of ideas about how social prescribing programmes work, and we think it probably works differently in different places and/or for different people. I'd like to go through some of those ideas with you. We are very curious about how the interactions between the SPLW, and the service user can impact how outcomes are met.

12. **What support do you provide to a service user?**

13. **Do you develop a plan with the Service User and, if so, how do you do that? (if not, why not?)**

14. **In terms of your overall interactions with service users, can you tell me about the types of skills you have brought to your role?**

15. **What opportunities for training have you had to develop these skills?**

16. **What other areas do you think need to be addressed to help you to be more effective in your role?**

17. **Can you tell me about any experiences you have had where a service user with very complex needs (such as severe mental health challenges) has been referred to you?**

C. Referrals to community-based organisations

18. **Can you tell me about your overall experience of referring to community-based organisations. What works well, what challenges have you experienced?**

19. **Can you tell me about the types of supports you have provided for different service users when referring them to a community activity?**

20. **Can you tell me about situations where it is not possible to match the needs and/or interests of the service users with the community-based activities that are available?**

21. **How do you ensure that the group/activity that you are referring a service user into is of good quality?**

22. **Can you tell me about any work that you do to build connections with local voluntary and statutory community assets in your locality? What factors have challenged/facilitated this work?**

23. **Can you provide any examples, where service users have not engaged well with community activities and have not experienced positive outcomes? What do you think are the reasons for this?**

24. **If you could change something about this programme, what things would you change about SP to make it work more effectively here?**

25. **Are you familiar with the Social Prescription Framework? Can you tell me if you have any thoughts or ideas on what changes could be made to enhance it?**

26. **Is there anything else that you think we need to know, to really understand how this service works here?**

Thank you for your time today

Appendix C

Interview Guide for Established Social Prescribing Service Users

☐ Sláintecare

☐ Non Sláintecare

☐ Urban

☐ Rural

☐ Rural Town

Thank you for agreeing to take part in this interview. We are interested in finding out how the Social Prescribing service has worked for you and your ideas on why it has worked the way it has for you.

General Questions about Social Prescribing (SP)

1. **Can you tell me about how long you have been involved with this Social Prescribing Service?**
2. **Overall, thinking back to when you first started with the service, how would you describe the overall experience? What worked particularly well for you? What has been challenging?**
3. **improve your health and well-being in any way? Can you give me examples?**
4. **If you have seen any improvements, do you have any ideas on the reasons for these improvements?**

A. Referral into the service

5. **Did you know much about social prescribing before you met the link worker?**
6. **Can you tell me how you first heard about this social prescribing service in your area?**
7. **Can you tell me what was your understanding of the SP service at that time?**
8. **Can you tell me what brought you to the service?** (for example, did your GP/another HCP make a referral or perhaps you had heard about the service yourself and made contact?)

9. **If you did self-refer, can you tell me about what motivated you to do this?**

10. **If you did self-refer, can you tell me how easy or difficult you found the referral process to be?**

11. **About how much time did you have to wait before your first contact with the link worker?**

B: Meetings with your link worker

12. **Can you tell me what you liked about your engagement/meetings with your link worker?**

13. **Is there anything that you didn't like/that made it challenging?**
14. **Do you use other health and social care services**
15. **How do you think Social prescribing service is different from other services that you use?**

16. **Do you feel supported by the link worker to engage with community groups and supports in your area? Can you give me an example, please? If not, how do you think you could be more supported?**

17. **Thinking about your meetings with your link worker, what did you like about your engagement with the link worker. Is there anything that you didn't like / that made it challenging?**

C. Community activities

18. **What kinds of activities did you do?**

19. **Was the activity you were interested in available for you in your community?**

20. **Did you enjoy these? Did they meet your interests?**

21. **What did you not like or enjoy about the activities?**

22. **What could have made the experience better for you?**

23. If you have not experienced any positive changes (e.g. in your health and wellbeing), why do you think that might be?

24. Is there anything about SP that you would change to make it better? and why?

25. Who do you think would really benefit from social prescribing?

26. If you were to explain Social Prescribing to a friend who had never heard about it before, how would you describe it?

27. Would you recommend SP to a friend? Why/why not?

D: Demographic information

Before we finish, I'd like to note some information about you, such as your age, employment status, etc.

Your age: _____

Do you live alone? Yes ☐ No ☐

What is your sex? Male ☐ Female ☐

What gender do you identify as?

Man (including trans man) ☐ Woman (including trans woman) ☐

Non-binary/gender non-conforming ☐

Another gender (please specify)

What is your ethnic group/background?

White: Irish ☐ Irish Traveller ☐ Roma ☐ Any other White background ☐

Black / Black Irish: African ☐ Any other Black background ☐

Asian / Asian Irish: Chinese ☐ Indian / Pakistani / Bangladeshi ☐ Arabic ☐

Any other Asian background ☐

Mixed (provide description)

Other (provide description)

What is your employment status?

Employed ☐

Unemployed ☐

Student ☐

Engaged in home duties ☐

Full time/ part time carer ☐

Retired from employment☐

Unable to work due to sickness or disability ☐

Other ☐

What is the highest level of education you have completed to date?

No Formal education ☐

Primary education ☐

Lower Secondary (junior certificate) ☐

Upper Secondary (leaving certificate) ☐

Technical or Vocational (NFQ Levels 4/5) ☐

3rd Level non-degree (NFQ Level 6) ☐

3rd Level Degree or Higher (NFQ Levels 7/8/9/10) ☐

Thank you very much for your time today

Appendix D
Interview Guide for New Service Users

☐ Sláintecare
☐ Non Sláintecare

☐ Urban
☐ Rural
☐ Rural Town

Thank you for taking the time to meet with me today. I know that you have recently started with the social prescribing service here and I'd like to chat with you today about your experience so far. And about your ideas about how this service might be of use to you.

1. **Can I start by asking you about how long you have been in contact with this social prescribing service? (number of weeks)**
2. **Can you tell me about your overall experience of SP so far?**

A: Referral into the service

3. **Can you tell me <u>how</u> you first heard about this social prescribing service in your area?**

Prompts:

- Poster/flyer/social media/newspaper/other source?
- Where did you hear about it?
- Did a doctor or social care worker or another type of health service tell you about it/refer you to it?
- Which service was this, if you know?
- Did you self-refer?

4. **Can you tell me <u>what</u> you heard about the social prescribing service?**

Prompts

- How was it explained to you?
- Did the information you received make sense? Was it easy to understand?
- Were you given any written information on it to read through or directed to a website for more information on it?

4. **Can you tell me what has brought you to the service? (for example, did your GP/another HCP make a referral or perhaps you had heard about the service yourself and made contact?)**

Prompts:

- If a HCP made a referral, did you understand why it was been made?
- Can you tell me what type of HCP made the referral?
- Dd you have the opportunity to ask the HCP any questions about social prescribing?

5. **If you did self-refer, can you tell me about what motivated you to do this?**

6. **If you did self-refer, can you tell me how easy or difficult you found the referral process to be?**

Prompt:

Is there anything you would like to change about how the referral process works?

7. **About how much time did you have to wait before your first contact with the link worker?**

Prompt:
Were you put on a waiting list? (if yes, how long did you wait?)

8. **Can you tell me about your first contact with your link worker?**

Prompts:

- Was this first contact by phone or in person?
- What did you like about this first contact with your link worker?
- How useful did you find this first meeting? **(**What made it useful or not? (can you give me an example?)
- What could have been done differently?

9. **Based on your experience so far, do you feel supported by the link worker to engage with community groups and/or supports in your area? Can you give me an example, please? If not, how do you think you could be more supported?**

Prompts:

- Do you feel listened to?
- Do you feel understood?
- Is it easy to use the service?
- Is it easy to ask questions?

10. **Can you tell me about what types of supports you hope to get from the social prescribing service?**

Prompts: **(ask for examples for each)**

- Physical health and wellbeing
- Mental health
- Emotional health
- Social connections/meet new people
- Bereavement support
- Educational supports
- Financial supports
- Literacy supports
- Self -confidence
- Stress management
- Anything else?

11. **Can you tell me about any other health and social services you currently engage with on a long-term basis or have in the past:**

Prompts:
-Management of a chronic health condition
-Physiotherapy
-Social work
-Social Care
-Occupational therapy
-Mental health services
-Any other services?

12. Before we finish up, is there anything else that you would like to tell me about your experience with this service so far?

Prompts:

- What has worked well for you?
- What challenges, if any, have you experienced? (location, public transport, mobility issues, others?)

Finally, I'd like to note some information about you, such as your age, employment status, etc.

Your age: _____

Do you live alone? Yes ☐ No ☐

What is your sex? Male ☐ Female ☐

What gender do you identify as?

Man (including trans man) ☐ Woman (including trans woman) ☐

Non-binary/gender non-conforming ☐

Another gender (please specify) _____

Prefer not to say ☐

What is your ethnic group/background?

White: Irish ☐ Irish Traveller ☐ Roma ☐ Any other White background ☐

Black / Black Irish: African ☐ Any other Black background ☐

Asian / Asian Irish: Chinese ☐ Indian / Pakistani / Bangladeshi ☐ Arabic ☐

Any other Asian background ☐ Mixed (provide description)

Other (provide description)

What is your employment status?

Employed ☐ Unemployed ☐ Student ☐

Engaged in home duties ☐ Full time/ part time carer ☐ Retired from employment☐

Unable to work due to sickness or disability ☐

Other ☐

What is the highest level of education you have completed to date?

No formal education ☐

Primary education ☐

Lower Secondary (junior certificate) ☐

Upper Secondary (leaving certificate) ☐ Technical or Vocational (NFQ Levels 4/5) ☐ 3rd Level non-degree (NFQ Level 6) ☐

3rd Level Degree or Higher (NFQ Levels 7/8/9/10) ☐

Appendix E

Interview Guide for Health and Social Care Professionals (HSCPs)

☐ Urban

☐ Rural

☐ Rural Town

Thank you for agreeing to take part in this interview. We are interested in finding out your experience with social prescribing.

General Questions about Social Prescribing (SP)

- Can you tell me about your overall experience of the social prescribing service to date?
- How long have you been engaged in referring service users to SP services?
- Can you tell me how you heard about the SP service?
- Can you tell me what you know about the SP service?

1. **Based on your experiences, what do you see as the greatest benefit of the SP service for the service user?**
2. **Which service users do you think are likely to benefit most from using SP service and why?**
3. **For whom do you think social prescribing is most effective? Why do you think so?**
4. **Which service users do you think are likely to benefit least from using SP service and why?**

A. Referral process

Organisational factors

5. **Can you describe the referral process?**
6. **Does this referral process work for you?**

7. **How does this referral process work for you? Could it be improved? How so?**
8. **Is the social prescribing service a support to you in your work with service users?**
9. **Do you think the endorsement of social prescribing by GPs and other healthcare professionals encourages service users to engage with the SP service? Can you explain why?**

Communication of the benefits of Social Prescribing to the patient

10. **How do you explain the social prescribing service to your patients?**

11. Do you have enough time to talk about SP with the patient?

12. Could you share your experience or thoughts on how well the SP service is promoted among HCP?

13. What are the challenges to integrating SP referrals into your work/referring people to SP?
14. **What factors influence your decision to refer someone to SP?**
15. **Which service users do you think are likely to benefit <u>most</u> from using SP service and why?**
16. **Which service users do you think are likely to benefit <u>least</u> from using SP service and why?**

Thank you for your time

Appendix F

Interview Guide for Community Organisations (CO) representatives

Thank you for agreeing to take part in this interview. We are interested in finding out how the social prescribing service has worked for you and your ideas on why it has worked the way it has for you.

☐ Sláintecare

☐ Non Sláintecare

☐ Urban

☐ Rural

☐ Rural Town

General Questions about Social Prescribing (SP)

1. **Can you tell me what you know about social prescribing services in your locality?**
2. **What kinds of activities does this organisation offer for social prescribing service users?**
3. **What potential health and well-being benefits have you seen for SP service users who have engaged with your organisation activities?**
4. **How do you think these benefits have come about?**
5. **Which SP service users do you think are likely to benefit the *most* from the activities provided by your organisation?**
6. **Which SP service users do you think are likely to benefit the *least* from the activities provided by your organisation?**
7. **Can you share an example where a service user did not benefit from the activities?**

Interacting with Social Prescribing Link Worker (SPLW)

Communication with SPLW and other community organisations

8. **What type of communication or interactions do you have with the SP link worker?**
9. **Can you tell me about your collaborations, if any, with other community organisations for Social Prescribing?**
10. **What is the role of the SPLW in connecting different community organisations?**

11. How do you think the SPLW can improve communication between different organisations in your community?

B. Interacting with Service User (SU)

Factors influencing the delivery of community service/activities

12. What factors are necessary for the successful participation of SP Service users in your activities?

Another important challenge that COs encounter is funding issues.

13. Can you describe any funding issues you have encountered while providing community services and activities to SP Service Users?

Research shows that the quality of activities and activity leaders' skills and understanding of Service Users' needs influence the engagement and participation of SP Service Users.

14. Can you tell me about your ideas on how the skills or experience of activity leaders might influence the quality of the community activity? better engagement of SU with the activity? (if applicable)

15. Can you share your experience of working with a Service User who has complex needs and how it influenced the activity/service delivery which your organisation provides?

16. How do these social activities impact service users?

17. Can you describe any example of peer support among your service users?

18. Are there any challenges you would like to highlight regarding your connection with social prescribing in your area?

19. What ideas do you have to enhance the experience for the service user?

Thank you for your time

Appendix G

Interview Guide for Health Promotion and Improvement Managers/ HP& Improvement Team

☐ Sláintecare

☐ Non Sláintecare

☐ Urban

☐ Rural

☐ Rural Town

Thank you for agreeing to take part in this interview. We are interested in finding out how the Social Prescribing service works.

General Questions:

How long have you been in your current role?

For how long have you been involved with SP services?

1. **Can you tell me about your overall experience of the social prescribing service to date?**
2. **Can you tell me about your work/ work of your HP & Imp team in relation to the SP service?**
3. **Based on your experiences, what do you see as the greatest benefit of the SP service for the service user?**
1. **For whom do you think social prescribing is most effective? Why do you think so?**
2. **Which service users do you think are likely to benefit least from using SP service and why?**
3. **What do you see as the greatest challenges for the successful delivery of the service?**
4. **Can you tell me about any work you and your team do in raising awareness of the SPs service among**:
5. **What challenges have you experienced in this work?**

6. **What ideas do you have to address these challenges?**

7. **Can you tell me about any governance structures in place for the SP services in your area (e.g.is there a steering committee, who sits on it; who does it report to)?**
8. **If there are specific governance structures in place, how well do these work?**

9. **If not, what are your thoughts on this? Do you think this kind of governance structure would be useful?**

10. **Overall, what recommendation do you have to enhance the provision of the SP service offered here?**

11. **Are you familiar with the HSE 's Social Prescription Framework? Can you tell me if you have any thoughts or ideas on what changes could be made to enhance it?**

12. **Is there anything else that we have not covered that you feel is important to know for this evaluation?**

Thank you for your time

Appendix H

Realist Interview Guide for Host Organisation Managers

☐ Sláintecare

☐ Non Sláintecare

☐ Urban

☐ Rural

☐ Rural Town

Thank you for agreeing to take part in this interview. We are interested in finding out how the social prescribing service works in your organisation.

General Questions about Social Prescribing (SP)

1. **What potential health and well-being benefits have you seen for SP service users who have engaged with your organisation activities? (Prompts: outcomes in relation to physical/mental/social/ other areas of wellbeing.**

3. **How do you think these benefits have come about? For whom do you think social prescribing is most effective? Why do you think so? Prompts: Who gets the greatest benefit from SP services?**

4. **What circumstances might have hindered the achievement of benefits? (provide example)**
5. **Can you tell me about your organisation and its role in the provision of social prescribing service**
6. **Can you tell me about how social prescribing services are organised here?**
7. **How has the service grown over the last number of years?**
8. **What impact has the growth had on the service delivery?**
9. **Can you tell me about your specific role regarding the social prescribing service?**
10. **How long have you been in this role?**

A: The referral process

11. **Can you tell me how referral into the social prescribing service happens here?**

12. **Can you give me an idea of the number of referrals to the service on a weekly and monthly basis?**

13. **What challenges exist?**

14. What ideas do you have to address such challenges?

15. **Can you tell me about the number of referrals who follow through on using the SP service?**

16. Do you have a role in advocating for the SP service with different health and social care professionals? What facilitates or hinders this?

B: Interactions with link workers

17. Can you tell me how this host organisation supports meetings between service users and link worker?

18. Does this organisation also provide activities for community members and service users to engage in? (If yes, **what impact does this have for service users?)**

19. Can you tell me about any supports this organisation provides for link workers

20. Can you tell me about the reasons why you believe some service users do not continue to engage with the link workers?

21. Do you have any ideas on how this might change?

22. **What factors unique to your organisation facilitate or hinder the SP service users' adherence/participation in the SP service offered here?**

23. Can you share your experiences of receiving referrals for service users who may have complex mental health needs 25. How did your service/activities benefit them, or did they benefit from them (if yes – how; if not - why)?

24. Are there any challenges you wish to highlight regarding such cases?

C: Links with the community sector

25. Can you tell me about the extent of the links this organisation has with community organisations in the area that service users might use?

26. How could these be enhanced?

27. Can you tell me about what challenges and what facilitates building connections with other community organisations?

Overall

28. Can you tell me about any governance structures in place for the SP service here (e.g.is there a steering committee, who sits on it; who does it report to)
29. If there are specific governance structures in place, how well do these work?
30. If not, what are your thoughts on this? Do you think this kind of governance structure would be useful?
31. Overall, what recommendation do you have to enhance the provision of the SP service offered here?

32. **Are you familiar with the HSE 's Social Prescription Framework? Can you tell me if you have any thoughts or ideas on what changes could be made to enhance it?**

33. **Is there anything else that we have not covered that you feel is important to know for this evaluation?**

Thank you for your time

Appendix I

Participant Profile Data

Table 1 *Individual service user data*

Service User ID	Age	Gender	Living Alone	Location	Employment	Education
SUNew 1	35	Woman	Yes	Rural town	Part-time	3rd Level non-degree (NFQ level 6)
SUNew 2	31	Woman	No	Urban	Sick leave	Technical/Vocational (NFQ Levels 4/5)
SUNew 3	60	Woman	Yes	Rural town	Semi-retired	3rd Level Degree or Higher (NFQ Levels 7/8/9/10
SUNew 4	54	Woman	No	Rural town	Full Time Carer	3rd Level Degree or Higher (NFQ Levels 7/8/9/10
SUNew 5	32	Man	No	Urban	Full-time	3rd Level non-degree (NFQ level 6)
SUNew 6	29	Woman	No	Rural town	Part-time	Lower secondary (JC)
SUEst1	75	Woman	No	Urban	Retired	3rd Level Degree or Higher (NFQ Levels 7/8/9/10)
SUEst2	68	Man	Yes	Urban	Retired	Secondary school (LC)
SUEst3	24	Woman	Yes	Urban	Student	Technical/Vocational (NFQ Levels 4/5)
SUEst4	45	Non-Binary	No	Urban	Unemployed	Secondary school (LC)
SUEst5	53	Man	No	Urban	Retired	Secondary school (LC)
SUEst6	47	Man	No	Urban	Retired	Technical/Vocational (NFQ Levels 4/5)
SUEst7	56	Man	Yes	Rural town	Retired	Lower secondary (JC)
SUEst9	47	Woman	Yes	Urban	Part-time	3rd Level Degree or Higher (NFQ Levels 7/8/9/10
SUEst11	19	Woman	No	Urban	Student	Lower secondary (JC)
SUest13	64	Woman	Yes	Rural town	Retired	3rd Level Degree or Higher (NFQ Levels 7/8/9/10
SUEst15	67	Man	No	Urban	Semi-retired	Secondary school (LC)

SUEst17	44	Woman	No	Urban	Unemployed	3rd Level non-degree (NFQ Level 6)
SUEst22	44	Man	No	Urban	Unemployed	3rd Level non-degree (NFQ Level 6)
SUEst23	78	Man	Yes	Urban	Retired	Primary education
SUEst25	69	Woman	Yes	Urban	Retired	Secondary school (LC)
SUEst26	42	Woman	No	Urban	Full Time Carer	3rd Level Degree or Higher (NFQ Levels 7/8/9/10
SUEst27	55	Woman	Yes	Urban	Semi-retired	3rd Level non-degree (NFQ Level 6)
SUEst28	21	Woman	No	Urban	Student	3rd Level non-degree (NFQ Level 6)
SUEst29	67	Woman	Yes	Urban	Semi-retired	Primary education
SUEst30	54	Woman	Yes	Urban	Full-time	Secondary school (LC)
SUEst31	31	Man	No	Urban	Unable to work due to illness or disability	Primary education
SUEst33	52	Woman	No	Rural town	Full Time Carer	Secondary school (LC)
SUEst34	64	Man	No	Rural town	Retired	3rd Level Degree or Higher (NFQ Levels 7/8/9/10
SUEst35	66	Woman	No	Rural town	Retired	3rd Level Degree or Higher (NFQ Levels 7/8/9/10
SUEst36	54	Woman	No	Rural town	Part-time	Secondary school (LC)
SUEst37	35	Man	No	Rural town	Full-time	Technical/Vocational (NFQ Levels 4/5)
SUEst38	62	Woman	Yes	Rural town	Unable to work due to illness or disability	3rd Level non-degree (NFQ Level 6)
SUEst39	33	Woman	No	Urban	Unable to work due to illness or disability	Secondary school (LC)
SUEst40	72	Man	Yes	Urban	Retired	3rd Level non-degree (NFQ Level 6)
SUest41	56	Woman	Yes	Rural	Unemployed	Lower secondary (JC)

SUest42	72	Woman	Yes	Rural town	Retired	Lower secondary (JC)
SUest44	46	Woman	No	Rural town	Part-time	Lower secondary (JC)
SUest45	26	Woman	No	Rural town	Full-time	3rd Level non-degree (NFQ Level 6)
SUEst47	60	Woman	No	Rural town	Part-time	3rd Level Degree or Higher (NFQ Levels 7/8/9/10
SUEst48	38	Woman	No	Rural town	Part-time	Technical/Vocational (NFQ Levels 4/5)
SUEst50	78	Woman	No	Urban	Retired	Lower secondary (JC)
SUEst51	55	Woman	No	Urban	Unable to work due to illness or disability	Technical/Vocational (NFQ Levels 4/5)
SUEst52	69	Woman	Yes	Urban	Retired	Technical/Vocational (NFQ Levels 4/5)
SUEst53	26	Woman	No	Urban	Full-time	3rd Level Degree or Higher (NFQ Levels 7/8/9/10
SUEst54	67	Man	Yes	Urban	Retired	Lower secondary (JC)
SUEst56	67	Man	Yes	Urban	Retired	3rd Level Degree or Higher (NFQ Levels 7/8/9/10
SUEst58	54	Man	Yes	Urban	Unable to work due to illness or disability	Lower secondary (JC)
SUEst59	68	Woman	Yes	Urban	Retired	3rd Level Degree or Higher (NFQ Levels 7/8/9/10
SUEst60	50	Man	No	Urban	Unable to work due to illness or disability	3rd Level non-degree (NFQ Level 6)
SUEst61	56	Woman	No	Urban	Unable to work due to illness or disability	Lower secondary (JC)
SUEst63	54	Man	Yes	Urban	Unable to work due to illness or disability	Secondary school (LC)
SUEst64	66	Woman	Yes	Urban	Retired	Lower secondary (JC)
SUEst65	67	Woman	No	Urban	Retired	3rd Level non-degree (NFQ Level 6)
SUEst66	73	Man	Yes	Urban	Retired	Technical/Vocational (NFQ Levels 4/5)

Table 2

Location of social prescribing service for SU

Location of social prescribing service for SU	Frequency (%)
Dublin	20 (36)
Cork	9 (16)
Galway	6 (11)
Laois	5 (9)
Westmeath	5 (9)
Limerick	4 (7)
Mayo	4 (7)
Donegal	1 (2)
Sligo	1 (2)
Total	55 (100)

Table 3

Geographic location of SPLW

Geographic Location of SPLW	Frequency (%)
Urban	17 (57)
Rural town	12 (40)
Rural	1 (3)
Total	30 (100)

Table 4

Host organisation of SPLW

SPLW ID	Host Organisation
SPLW1	Local Community Development Partnership
SPLW2	Local Community Development Partnership
SPLW3	Family Resource Centre
SPLW4	Family Resource Centre
SPLW5	Community Development Project*
SPLW6	Family Resource Centre
SPLW7	Local Community Development Partnership
SPLW8	Local Community Development Partnership
SPLW9	Family Resource Centre
SPLW10	Community Development Project
SPLW11	Family Resource Centre*

SPLW12	Local Community Development Partnership
SPLW13	Local Community Development Partnership
SPLW14	Local Community Development Partnership
SPLW15	Local Community Development Partnership
SPLW16	Family Resource Centre*
SPLW17	Family Resource Centre
SPLW18	Family Resource Centre*
SPLW19	Family Resource Centre
SPLW20	Local Community Development Partnership
SPLW21	Family Resource Centre*
SPLW22	Family Resource Centre
SPLW23	Local Community Development Partnership
SPLW24	Community Development Project
SPLW25	Local Community Development Partnership
SPLW26	Community Development Project
SPLW27	Community Development Project
SPLW28	Community Development Project
SPLW29	Local Community Development Partnership
SPLW30	Family Resource Centre

* SPLW works part-time in primary care

Table 5

Referral agent information

Referral Agent ID	**Role/Title**
Ref01	Homelessness Support Worker
Ref02	Clinical Specialist Dietician Mental Health Unit
Ref03	General Practitioner
Ref04	General Practitioner
Ref05	General Practitioner
Ref06	Domestic Abuse Support Worker
Ref07	General Practitioner
Ref08	Clinical Nurse Specialist (Mental Health)
Ref09	Clinical Nurse Manager
Ref10	Assistant Psychologist
Ref11	Diabetes Consultant
Ref12	Occupational Therapist
Ref13	Clinical Nurse Specialist (Mental Health)
Ref14	Occupational Therapist

Appendix J

Figure 1

Activities available to service users

1. Education, Learning & Personal Development

- Adult education centres
- GRETB Guidance Service
- Galway Recovery College
- SP Creative Ireland Art courses
- Library / Local libraries
- FRC organised classes
- Youth organisations & centres
- Healthy Food Made Easy
- Art classes

2. Health, Fitness & Wellbeing

- Chair yoga
- Yoga
- Community wellness class
- Dublin City Council exercise programs
- HSE Living Well / Living Well programme
- HSE “5 Ways to Well-being”
- Walking club
- Running groups
- Local sports activities
- Mindfulness classes
- Meditation classes
- Tai chi

3. Older Adult & Age-Friendly Supports

- Age Action
- Age Friendly Homes
- Alone
- Golden Years & Conexus Daycare Centres
- Handy Helpers
- Men’s Shed

4. Community & Social Connection

- Local coffee morning
- Community wellness class
- Men’s Shed
- Women’s shed
- Local resource centres

- FRCs (Family Resource Centres)

5. Employment, Recovery & Work Supports

- Employability services
- Local employment services
- Workability Programme
- DNP group (if community employment or recovery-focused)
- We Can Quit