Understanding the Social Prescribing Approach: Insights from the Health and Well-Being Community Referral Service in Cork.

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CARL Research Project

in collaboration with

Cork Volunteer Centre

University College Cork, Ireland

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What is Community-Academic Research Links?

Community Academic Research Links (CARL) is a community engagement initiative provided by University College Cork to support the research needs of community and voluntary groups/ Civil Society Organisations (CSOs). These groups can be grass roots groups, single issue temporary groups, but also structured community organisations. Research for the CSO is carried out free of financial cost by student researchers.

CARL seeks to:

- provide civil society with knowledge and skills through research and education;
- provide their services on an affordable basis;
- promote and support public access to and influence on science and technology;
- create equitable and supportive partnerships with civil society organisations;
- enhance understanding among policymakers and education and research institutions of the research and education needs of civil society, and
- enhance the transferrable skills and knowledge of students, community representatives and researchers (www.livingknowledge.org).

What is a CSO?

We define CSOs as groups who are non-governmental, non-profit, not representing commercial interests, and/or pursuing a common purpose in the public interest. These groups include: trade unions, NGOs, professional associations, charities, grass-roots organisations, organisations that involve citizens in local and municipal life, churches and religious committees, and so on.

Why is this report on the UCC website?

The research agreement between the CSO, student and CARL/University states that the results of the study must be made public through the publication of the final research report on the CARL (UCC) website. CARL is committed to open access, and the free and public dissemination of research results.

How do I reference this report?

Author (year) *Dissertation/Project Title*, [online], Community-Academic Research Links/University College Cork, Ireland, Available from: http://www.ucc.ie/en/scishop/completed/ [Accessed on: date].

How can I find out more about the Community-Academic Research Links and the Living Knowledge Network?

The UCC CARL website has further information on the background and operation of Community-Academic Research Links at University College Cork, Ireland. http://carl.ucc.ie. You can follow CARL on Twitter at @UCC_CARL. All of our research reports are accessible free online here: http://www.ucc.ie/en/scishop/rr/.

CARL is part of an international network of Science Shops called the Living Knowledge Network. You can read more about this vibrant community and its activities on this website: http://www.scienceshops.org and on Twitter @ScienceShops. CARL is also a contributor to Campus Engage, which is the Irish Universities Association engagement initiative to promote community-based research, community-based learning and volunteering amongst Higher Education students and staff.

Are you a member of a community project and have an idea for a research project?

We would love to hear from you! Read the background information here http://www.ucc.ie/en/scishop/ap/c&vo/ and contact us by email at carl@ucc.ie.

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Abstract

Purpose: The Irish healthcare system is increasingly struggling to support population health and well-being. Recent Irish health policies are adopting a broader understanding of population health and well-being and an appreciation for the social dimension of health and wellbeing. Social Prescribing is a new approach to supporting population health and wellbeing based on this assumption. The social prescribing approach involves linking healthcare service users with non-clinical sources of support in their local communities through Civil Society Organisations (CSO). To date however, a lack of theorisation, national guidelines or general literature on the approach in the Irish context has existed. Hence, the aim of this study was "To explore understandings of the social prescribing approach in Ireland, amongst stakeholder groups involved in services using a social prescribing approach."

Method: A community-based research approach was taken for this project in collaboration with the Cork Volunteer Centre. Eight consenting participants took part in semi-structured interviews using the online video application Zoom. Participants for this study were from different stakeholder groups involved in providing services using a social prescribing approach Interviews were transcribed verbatim and data were analysed using thematic analysis.

Findings: Participants explained their understandings of the social prescribing approach. Seven Themes were identified during data analysis. These themes are; what is social prescribing?, key components, language, relationship with existing services, service user profile, service provider roles and the referral pathway. Each theme included theoretical understandings and practical understandings as subthemes. These subthemes add to general understanding by differentiating between theoretical and practical considerations relating to these themes.

Implications: The findings of this study offer a fresh insider perspective of the social prescribing approach. Key components of the social prescribing approach were identified. Differences in theoretical understandings of the approach were found to be impacting the practical implementation of services using this approach in different geographical areas. A more rigorous evidence base, particularly from the Irish context including theorisation and national guidelines would significantly benefit this approach going forward to ensure that services can be evaluated to secure adequate and sustainable funding.

Chapter 1: Introduction to the Research

1.1 Background to the Research Project

Many healthcare systems globally are facing multiple challenges (Gmeinder, Morgan & Mueller, 2017). These include adapting to more expansive definitions of the concept of health (World Health Organisation Europe, 2013; 2014), growing and rapidly ageing populations with associated rises in chronic health conditions and increasing expectations regarding quality of healthcare services provided (Gmeinder, Morgan & Mueller, 2017). Cost containment in light of more technologically advanced medical treatments, as well as the above-mentioned factors, is becoming an increasing challenge for the healthcare systems of industrialised nations (Brandling & House, 2009; Stadhousers et al., 2019). These challenges are particularly relevant in an Irish context, as Ireland's healthcare system has historically been characterised by its criterion-based accessibility, inefficient design, low capacity and public-private financing (Dukelow & Considine, 2017; Wren et al., 2017).

In 2017, a cross-party Oireachtas Committee on the future of healthcare in Ireland published 'The Sláintecare Report'. Sláintecare is an ambitious and comprehensive ten-year plan for the future development of the Irish healthcare system, which aims to dramatically reform how healthcare is provided in Ireland into the future (Houses of the Oireachtas, 2017). Priority goals include a universally accessible healthcare system that is free at the point of care, to improve the population health profile, to reform the service funding model and to re-orientate service delivery away from acute settings nationwide using an integrated care model (Houses of the Oireachtas, 2017). Integrated care aims to provide better link up between primary, secondary and tertiary healthcare services, as well as stronger links between health, social care and community-voluntary organisation (Nolte, 2012; O'Connor, 2013), whom in an Irish context have played a pivotal role in providing healthcare services for many generations (Dukelow & Considine, 2017; Harvey, 2012). It is through these reforms that Sláintecare intends to deliver on what has been termed the 'triple aim' for health systems of the twenty first century to improve care, improve health and reduce costs (Berwick, Nolan, & Whittington, 2008; Houses of the Oireachtas, 2017).

Social Prescribing is a new approach to supporting health and well-being that closely aligns with these goals and is moreover, being rolled out in some parts of Ireland under Sláintecare

(Department of Health, 2019a). Social Prescribing is understood as an approach, which involves linking healthcare service users with non-clinical sources of support in their local communities through Civil Society Organisations (CSO) (Bickerdike, et al., 2017; Chatterjee et al., 2018). CSO's are community and voluntary sector organisations who are non-governmental, non-profit, not representing commercial interests, and/or pursuing a common purpose in the public interest (University College Cork, 2020). The social prescribing approach is based on the assumption that not all of people's health needs require treatment with drugs or other medical interventions, and that such needs could be better addressed if their social, emotional and practical needs were met (Kenkre & Howarth, 2018; Pescheny, Pappas, & Randhawa, 2018). To date, services using a social prescribing approach have been piloted with a wide variety of population groups including people with chronic health conditions (Moffatt et al., 2017; Mossabir et al., 2015), psychosocial problems (Grayer et al., 2008), people from disadvantaged socio-economic areas (Hassan et al., 2020) and the elderly (Clements-Cortes & Yip, 2019; Elston et al., 2019). While the literature suggests potential for positive outcomes for both service users and healthcare systems alike (Bickerdike, et al., 2017; Chatterjee et al., 2018), substantial concerns also exist regarding the scope and quality of the current evidence base, as well as the limited guidelines available and under conceptualisation of the social prescribing approach (Bickerdike, et al., 2017; Pescheny, Pappas, & Randhawa, 2018; Pilkington, Loef & Polley, 2017).

1.2 The Cork Volunteer Centre

This research project was carried out as a Community Academic Research Links (CARL) project in collaboration with the Cork Volunteer Centre (CVC). CVC is an organisation in Cork that provides a linking service between prospective volunteers and non-profit organisations. Founded in 2000 as the Cork Volunteer Bureau, the service initially provided a volunteer recruitment and placement service, run by volunteers. In 2005, funding was secured from the Department of Community, Rural and Gaeltacht Affairs which allowed for two paid part-time workers, and in November 2005, CVC registered as a company limited by guarantee with a board of directors. CVC is also a registered charity. In 2020, CVC is one of twenty-two volunteer centres nationwide. Currently located at 13 North Main Street, CVC is staffed by a dedicated team of employees and volunteers and is funded by the Department of Rural and Community Development.

This service was set up to facilitate and promote the benefits of volunteering, for the people of Cork. CVC provides supports for both prospective volunteers and non-profit organisations seeking volunteers. For prospective volunteers, CVC placement officers work with individuals to identify their areas of interest, skills and experience to identify potential volunteer opportunities. Volunteer opportunities are sought by CVC service users for several reasons including but not limited to gaining work experience, improving social outlets, integrating into local community and interest in a particular area. For non-profit organisations, CVC provides a location to advertise for and source willing volunteers, as well as supports around areas including drafting volunteer role descriptions, providing volunteer management training, processing garda vetting applications and assistance with the creation of volunteer policies and procedures. CVC moreover are strong advocates for the overall benefits of volunteering and carry out work to promote volunteering activities such as information sessions, website and strong social media presence, annual Cork volunteer awards and their outreach program to all areas across the county. CVC commissions research projects such as this one to strengthen their policy advocacy role.

1.3 Rationale for the Research Project

CVC advertised an interest in completing a research project into the area of social prescribing through a post on the University College Cork, Community Academic Research Links website. Considering the services they provide, CVC were interested in exploring if there was an increased role that they could play with regards to the concept of social prescribing in Cork. CVC have experience in receiving informal referrals from some non-profit organisations, to link service users with volunteer opportunities in their local communities. However, they were not involved in a formal social prescribing project. Hence, they had an interest in finding out more about the idea of social prescribing and what they could do to get more involved with it in the Cork area.

The student researcher is an occupational therapist working in Cork. His interest in the topic developed as he identified the novelty of this approach in relation to health and well-being, as well as the potential commonalities he identified between it and the occupational therapy profession. The partnership between the student and the CVC was established through the UCC CARL program.

An initial review of current literature identified that the social prescribing approach was beginning to be used across parts of Ireland, however there was limited information published or available about these services in the Irish context. A more in-depth examination of the literature revealed that concerns exist regarding the scope and quality of the current evidence base, the limited guidelines available, the under conceptualisation of the social prescribing approach, as well as the infancy of this approach linking two entirely different sectors (i.e. the healthcare and community/voluntary sectors). Considering this it was decided that this research would focus on exploring understandings of the social prescribing approach amongst those involved in providing services that use a social prescribing approach.

There are positive signs in the literature that services using the social prescribing approach can indeed be of benefit to supporting population health and well-being in the community and there appears to be much optimism and hope in the literature regarding same. It is feared however, that if the social prescribing approach cannot prove its effectiveness in the short to medium term, this approach could be scrapped at substantial cost, or moreover, place a large burden of responsibility for the health needs of individuals on CSO's. Hence it is of utmost importance that a clear understanding exists as to what the social prescribing approach actually is, so that services can be compared like with like, when evaluating services for sustainable long-term funding.

1.4 Research Aim and Questions

The aim of this research project is:

> "*To explore understandings of the social prescribing approach in Ireland, amongst stakeholder groups involved in services using a social prescribing approach.*"

This study used the following research questions to investigate this aim:

- What do individuals from different stakeholder groups, involved in services using a social prescribing approach in Ireland understand the social prescribing approach to be?
- What do individuals from different stakeholder groups, involved in services using a social prescribing approach in Ireland see as the key components to the social prescribing approach?

- What do individuals from different stakeholder groups, involved in services using a social prescribing approach in Ireland see as their role in the social prescribing approach?
- Are there differences in understandings of the social prescribing approach in Ireland, amongst stakeholder groups involved in services using a social prescribing approach?
- Do individuals from different stakeholder groups, involved in services using a social prescribing approach in Ireland, think there is a need for using a social prescribing approach in Ireland?

1.5 Theoretical Framework

As this study aimed to explore understandings of an under-explored area, an inductive approach was taken for this research project. A medicalization – de-medicalization theoretical framework was considered to approach the research, however, it was decided that applying any such over-arching theoretical framework would not be appropriate in the interest of best achieving the research aim and answering the research questions. It was hoped that this research project could make some contribution to the further conceptualizing of the social prescribing approach and considering the sparsity of published literature to date, adopting an inductive approach was hence deemed most appropriate for this research project.

1.6 Methodology

A community-based research approach was taken for this project in collaboration with the CVC. A qualitative method was used, and eight consenting participants engaged in individual semi-structured exploratory interviews using the online video application Zoom. Participants for this study were from different stakeholder groups involved in providing services using a social prescribing approach including three programme link workers, an academic consultant for evaluation of services, a regional head of service for community healthcare programme, a general practitioner, a national programme manager with a community-based stakeholder and a placement officer with a community-based volunteer service. Interviews were transcribed verbatim and data were analysed using thematic analysis.

1.7 Chapters Outline

Chapter 2 of this paper is the literature review which will critically examine the roll out of social prescribing services in Ireland based on current published evidence. It will firstly describe the Irish context by defining the population health profile, the healthcare system, the community and voluntary sector and the policy context. It will then discuss social prescribing as a concept, its background, current implementation, and current evidence base. Finally, it will discuss the contemporary concerns including gaps in evidence and positioning of services.

Chapter 3 of this paper will outline the methodology used for this project. It will open with a section on conducting student research during covid-19 followed by discussing the ontological and epistemological standpoints taken. Next it will outline the community based participatory research and qualitative approaches taken to conducting this research project. It will then describe the participant sampling and recruitment and data collection and finally the data analysis, data validation and outline the ethical considerations for undertaking this project.

Chapter 4 is the findings section which describes the outcomes of the analysis of the data in the form of themes and subthemes. The seven themes identified were; what is social prescribing?, key components, language, relationship with existing services, service user profile, service provider roles and the referral pathway. Each theme included theoretical understandings and practical understandings as subthemes.

Chapter 5 of this paper is the discussion section which will further explain the findings in the context of the literature. This chapter will discuss the findings of this research study in relation to the pre-existing evidence and knowledge available on this subject.

Chapter 6 is the recommendations and conclusion section and will summarise the content of this thesis and provide suggestions around the future design and delivery of services using the social prescribing approach in Ireland going forward.

Chapter 2: Literature Review

"Health is a personal, social and economic good, and the health and wellbeing of individuals, and of the population as a whole, is Ireland's most valuable resource."

(Department of Health, 2013, p.6)

2.1 Introduction

This chapter is a review and analysis of the literature. The first section gives an in-depth description of the Irish context, in terms of the population health profile, the current healthcare system and the recent change in emphasis for health policy, and the role of the community and voluntary sector in terms of health and social care service provision. The second section will analyse and discuss the social prescribing approach, its background, current services, the current evidence base around it and some current debates around its implementation.

2.2 The Irish Context

2.2.1 The Population Health Profile

The overall health status of the Irish population has improved significantly over the past two decades (European Commission, 2017), however there is a growing number of older people and people living, managing chronic conditions with a particularly high prevalence in more deprived socio-economic areas (Dukelow & Considine, 2017). Life expectancy in Ireland has overtaken the European Union (EU) average over the past two decades rising from 76.6 years in 2000 to 82.3 years by 2019 (Eurostat, 2020a) and moreover, there are high levels of positive self-reported health status with 84% of the population reporting to be in good health (Department of Health, 2019b). This has corresponded with an overall population growth from 3.9 million people in 2002 (Central Statistics Office, 2002) to 4.9 million in 2019 (Eurostat, 2020a). Ireland's population however, is becoming disproportionately older. According to the Central Statistics Office, Ireland's population of over sixty-five-year olds in 2002 was 436,001 (11.2% of overall population), however, by 2019 this had risen to 696,800 (14.2% of overall population). This figure is expected to continue to rise to 1,234,500 (21.7% of overall population) by 2039, with 198,300 (3.5% of overall population) over 85 years of age (Department of Health, 2019b). Considering that the healthcare needs of this population group are well-recognised as being higher than that of younger members of society, this emerging trend is anticipated to place significant additional pressure on the Irish Health and Social Care system (Dukelow & Considine, 2017; Wren et al., 2017).

Medical advances are similarly helping people to live longer lives and along with other factors such as increased standards of health care provision, are contributing to Ireland's increased older population (Dukelow & Considine, 2017; Wren et al., 2017). Mortality rates from many conditions including cardiovascular diseases, cancers and respiratory diseases have all decreased significantly, however, this is not to stay that people are living these extended lives impairment free (Department of Health, 2019b). A growing percentage of the population live with a chronic health condition which can cause substantial disruption to how they live their lives. Such conditions include but are not limited to musculoskeletal problems such as back pain, depressive disorders, type two diabetes and hypertension (European Commission, 2017; Wren et al., 2017) and are the primary reason why the healthy life expectation in Ireland is actually only 69.4 years (DALY and HALE Collaborators, 2015; Eurostat, 2020b). The prevalence of mental health illnesses amongst the general population in Ireland is about 18.5%, which is amongst the highest in an EU context (OECD/EU, 2018). Furthermore, findings from The Irish Longitudinal Study on Ageing (TILDA) have demonstrated that significant loneliness exists amongst the Irish population, with strong links between loneliness and older age, loneliness and mental ill health and depression, and loneliness and lower socio-economic status (Ward, Layte & Kenny, 2019). It is similarly important to point out that the prevalence of chronic health conditions are disproportionality high in areas of socio-economic deprivation, where behavioural risk factor for poor health status and general mortality rates are similarly significantly higher than that of the general population and particularly more affluent areas (Dukelow & Considine, 2017; European Commission, 2017; OECD/EU, 2018). This indicates a clear social gradient in the health status of the Irish population, something which the healthcare system in Ireland has struggled to address in the past.

2.2.2 The Healthcare System

Questions over the organisation, management and provision of services have been synonymous with the Irish Healthcare system. Public concerns regarding equal access to services, a hospital-centric design, low capacity with associated long waiting lists and financing of the healthcare service have dominated discourse regarding healthcare (Department of Health, 2019b; Dukelow & Considine, 2017). Currently in Ireland access to healthcare is not universal or based on need, owing to the two-tier system that is currently in place (Burke et al., 2016). Anyone with the means to pay out of pocket, or sufficient private health insurance coverage can choose to access healthcare services privately whereby they can secure more timely access to services at a fee, than those who have to rely on the public health system (Burke et al., 2016; Dukelow

& Considine, 2017). A hospital-centric service design and accompanying under staffing and resourcing of community services has created multi-year long waiting lists for public Primary Care and outpatient appointments (Burke et al., 2014; Department of Health, 2019b; Houses of the Oireachtas, 2017). Ireland continues to have a high rate of hospitalisations for people with chronic conditions which cannot be explained by a higher prevalence of these conditions, meaning that many of these hospitalisations are unnecessary and would be more effectively managed outside of the hospital setting (European Commission, 2017). There is a very low bed capacity within the public hospital system with a ratio of 2.6 beds per 1,000 population, compared with the EU average of 5.1 beds per 1,000 population (European Commission, 2017). A high number of unfilled posts across the system, particularly medical consultants, increase the waiting list backlog and the unmet need across the service (Department of Health, 2019b; European Commission, 2017).

In terms of financing the healthcare service, while Ireland has a very high per capita spend at about 40% above the EU average, the percentage of this provided by the state is disproportionately low compared to the EU average (European Commission, 2017). Instead, out of pocket payments and voluntary health insurance finance about 30% of health spend, a very large percentage in the EU context (Dukelow & Considine, 2017; European Commission, 2017). A series of recent annual health budget overspends has increased the scrutiny under which healthcare is being provided in Ireland as it is placing a growing strain on national finances (Connors, 2018), with a general perception amongst the public that not much in the way of progress is being seen for such investment (Dukelow & Considine, 2017).

2.2.3 Changes in Emphasis for Health Policy

The issues identified in the section above have led to the need for a serious re-think in Irish Health Policy. The establishment of the Health Service Executive in 2005 prioritised the centralisation of authority and decision-making to a national level. The eight previously existing regional health boards were replaced by four substantially larger Primary, Community and Continuing Care Services. The need for national level decision-making on local level issues was eventually seen to be to the detriment of innovation and responsiveness at local level, and moreover was having a negative impact on supporting the health and well-being of the population (Health Service Executive, 2014).

The 'Future Health - A Strategic Framework for Reform of the Health Service 2012-2015', report outlined four pillars for healthcare reform which included structural reform, financial reform, service reform: a new integrated model of care, and health and well-being. As part of these reforms, the *'Community Healthcare Organisations' report was published in 2014, and* set out how health services, outside of acute hospitals, would be organised and managed. Known as community healthcare services, these services include primary care, social care (services for older people and for persons with a disability), mental health and health & wellbeing services. A re-orientation away from the four Primary, Community and Continuing Care Services, lead to the introduction of nine new Community Health Organisations (similar to the old regional health boards) which would deliver services using an integrated care approach (Health Service Executive, 2014), (see image 1).

Image 1: Map of 9 CHO Areas in Ireland

Source: https://www.ncn.ie/index.php/healthy-ireland-smart-start/cho-areas

An integrated care approach aims to provide better link up between primary, secondary and tertiary healthcare services, as well as stronger links between health, social care and community-voluntary organisation (Nolte, 2012; O'Connor, 2013). The integrated care approach is a whole-of-society approach to support community population health and well-being, and when done well, this approach is moreover said to be preventative, enabling, anticipatory, planned, well-coordinated and evaluated (Health Service Executive, 2014). Moves towards utilising integrated care approaches such as the roll out of primary care services

in Ireland have pre-dated the most recent re-alignment of services (O'Connor, 2013), however under the new community health organisations, integrated care has been recognised as being central to the right service, at the right time, in the right place, by the right team. Image 2 below gives a visual explanation of this approach, demonstrating how it has a strong appreciation for the whole-of-society approach as well as the need to support population health and well-being outside of the conventional healthcare system.

Image 2: Overview of Integrated Care Approach

Source: https://www.hse.ie/eng/services/publications/corporate/cho-chapter-5.pdf
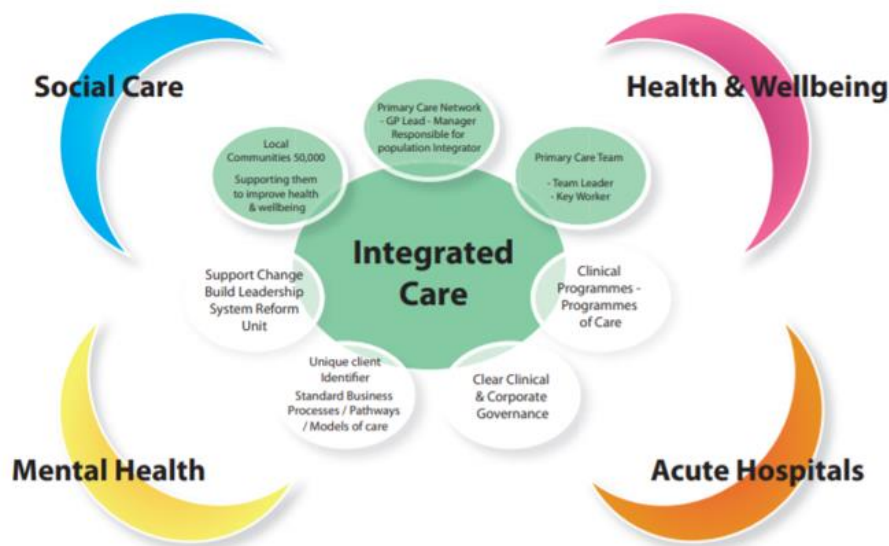
The adoption of an Integrated Care approach has been to the forefront of recent health policy documents which have built on the core pillars of the 'Future Health 2012-2015' document. 'The Sláintecare report' for the future development of the Irish healthcare system has set priority goals including a universally accessible healthcare system that is free at the point of care, improving the population health profile, reforming the service funding model and re-orientating service delivery away from acute settings nationwide using an integrated care model (Houses of the Oireachtas, 2017). 'The Healthy Ireland strategy 2013-2025' is a policy document which aims to promote a whole of society approach for supporting population health and well-being. It aims to bring about real, measurable change and is based on an understanding of the determinants of health including economic status, education, housing, the physical environment in which people live and work. It includes six themes for facilitating action being Governance and Policy, Partnerships and Cross-Sectoral Work, Empowering People and

Communities, Health and Health Reform, Research and Evidence, Monitoring, Reporting and Evaluation, themes that support better integration of the building blocks needed for population health and well-being (Department of Health, 2013).

2.2.4 Civil Society Organisations (The Community and Voluntary Sector)

Civil society organisations (CSO's) have historically played an intrinsic role in the provision of social services in Ireland (Forde, 2009; Powell, 2017), however severe cuts in state funding during the most recent economic recession 2008-2012 caused substantial and enduring harm to the sector's ability to provide adequate services (Harvey, 2012). CSO's have a tradition of providing healthcare, housing, community development and social and family support services to the Irish population whom the state did not provide for (Dukelow & Considine, 2017; Meade, 2012). More recently social partnerships between the state and CSO's have formalised the role of these groups in Irish society as healthcare and social service providers (Dukelow & Considine, 2017; Finnegan & McCrea, 2019).

The state is the key funder of CSO's in Ireland and contributes well over half of not-for profit revenue (Benefacts, 2018; Giving Ireland, 2020). While this increased the funding available to many organisations, it also subjected the sector to increasingly bureaucratic practices of governance and service delivery, promoting a new public management approach (Finnegan & McCrea, 2019). New public management approaches expect organisations to behave as if they were delivering a service within the private money-making sector, with service users seen as consumers (Crouch, 2011).

The sector was moreover badly hit during the austerity period of 2008-2012, whereby the sector saw huge decreases in funding, thousands of job losses and multiple service closures (Harvey, 2012). There is a well-found perception amongst many that the community and voluntary sector was disproportionately highly affected by austerity during this period (Harvey, 2012; Heffernan, McHale, & Moore-Cherry, 2017). Despite such resource shortages, the sector continues to be responsible for a large amount of social service provision, (including healthcare) in Ireland (Harvey, 2015). It is important to clarify here that this section refers to CSO's tradition of being a provider of services, such as healthcare services, for the state and differs from the idea of the social prescribing approach as will be clarified in the following sections.

2.3 The Social Prescribing approach

2.3.1 Background

While social prescribing itself is a relatively new term, the ideas which underscore it have been informally practiced by advocates for social medicine as far back as the mid-nineteenth century in Western Europe (Hobson, 1949). The social prescribing approach assumes that not all of people's health needs require treatment with drugs or other medical interventions, and that such needs could be better addressed if their social, emotional and practical needs were met (Kenkre & Howarth, 2018; Pescheny, Pappas, & Randhawa, 2018). In the United Kingdom, such an approach gained in popularity during the 1980's and 1990's (Black, 1988; Jani et al., 2020), and has been included as part of national health policy since 2006 (Department of Health, 2006). While its purposeful roll-out in Ireland is very much in its infancy, it has become a well-recognised approach to supporting population health and well-being in the United Kingdom. There is promising anecdotal evidence that this approach is improving population health and well-being on a local scale, in the areas in which it has been piloted (Abbasi, 2019; Bickerdike et al., 2017; Drinkwater, Wildman, & Moffatt, 2019), however, concerns also exist regarding the scope and quality of the current evidence base, as well as the limited guidelines available (particularly in an Irish context), and under conceptualisation of the social prescribing approach to date (Bickerdike, et al., 2017; Pescheny, Pappas, & Randhawa, 2018; Pilkington, Loef & Polley, 2017).

2.3.2 Current Services

The social prescribing approach is a mechanism for linking service users with non-medical sources of support within their local communities (Chaterjee et al., 2018). Current services using a social prescribing approach aim to connect service users with locally available community and voluntary opportunities, based on non-clinical 'prescriptions' from primary healthcare professionals (i.e. general practitioners, occupational therapists, physiotherapists, public health nurses, social work, home care support workers, speech and language therapists (McCarthy, 2019; Pescheny, Pappas, & Randhawa, 2018)). To date, a wide range of activities have been used as such 'prescriptions' including but not limited to volunteering activities, gardening and green activities, exercise, creative activities, books for health, community involvement and support, supported employment, time banks, etc. (Health Service Executive, 2015; Keenaghan, Sweeney & McGowan, 2012). There is a growing evidence base to support

the idea that many of these activities can help to improve individual's health and wellbeing, particularly mental well-being (Chaterjee et al., 2018).

The literature reports variations in how this 'link' can occur, varying from simple signposting models whereby service users are directed towards community-based or voluntary activities directly by primary healthcare professionals, to more intensive and individualised long-term supports provided by an appointed community-based link worker (Kimberlee, Ward, Jones, & Powell, 2014; Pescheny, Pappas, & Randhawa, 2018). For many services employing a social prescribing approach, link workers are reported to be a key component. The link work typically works in a non-clinical capacity, receiving referrals from healthcare workers to work with certain service users, whom it is thought of could benefit from having their social needs better met to improve their health and well-being (Bertotti et al., 2017; Elston et al., 2019). The link worker is generally very familiar with community and voluntary based activities in their local area, and it is intended that they would support the service user to identify local groups or activities that they might be interested in getting involved with (Bertotti et al., 2017; Elston et al., 2019). A lack of literature in the Irish context has made it difficult to comment on the layout of services using a social prescribing approach in Ireland, however it has been possible to identify through social media, that some services are operating using this approach.

Currently, services using a social prescribing approach generally target frequent attenders of GP practices, whom it is thought of that their needs could be best met through addressing their social, emotional, or practical needs (Bertotti et al., 2017; Carnes et al., 2017; Moffatt et al., 2017). Particular population groups falling under this category have included older people (Elston et al., 2019), people with chronic conditions (Mossabir et al., 2015) or psychosocial problems (Hassan et al., 2020), and people from socially deprived areas (Moffat et al., 2017). There is a perception that it is regularly individuals from these groups who attend medical services for underlying non-medical issues and thus 'clogging' up the system, as about 20% of GPs' time is reportedly spent dealing with non-medical issues (Husk et al., 2019a; Torjesen, 2016). It is currently thought by many that these people's needs could be best and most efficiently met outside of the mainstream healthcare system (Drinkwater, Wildman, & Moffat, 2019).

2.3.3 Service Variations

Widespread inconsistencies in both the terminology used and the understandings of social prescribing have moreover been reported in literature (Kilgarriff-Foster & O'Cathain, 2015; Pescheny, Pappas, & Randhawa, 2018). The term social prescribing has been used interchangeably with other terms, including, but not limited to 'community referral' (Kilgarriff-Foster & O'Cathain, 2015), 'community health and well-being' (Health Service Executive, 2015), 'social referral' (Rempel, Wilson, Durrant, & Barnett, 2017) and 'linking scheme' (Mossabir et al., 2015). Similarly, several different terms have been used in the literature when identifying the link worker role involved in services using a social prescribing approach including but not limited to 'social prescriber' (Dayson and Bashir, 2014), 'coordinator' (Carnes et al., 2017), 'link worker' (Bickerdike et al., 2017), 'facilitator' (Grant, Goodenough, Harvey and Hine, 2000) and 'navigator' (Pescheny, Pappas and Randhawa, 2018). Such variation in the terms used serves as a strong example of the inconsistencies present across services currently and could be seen as a barrier to developing a stronger understanding of the concept amongst the general public.

Significant variations in the models of practice being used (Kimberlee, Ward, Jones, & Powell, 2014; Pescheny, Pappas, & Randhawa, 2018), and the population groups at which services using a social prescribing approach are targeted at (Drinkwater, Wildman, & Moffat, 2019; Husk et al., 2019a), have similarly created difficulties with the evaluation of services and the generalisability of findings due to this significant variation in services (Bickerdike et al., 2017). While local variation of services is considered somewhat normal when using integrated approaches (Nolte, 2012; O'Connor, 2013), the extent to which current evidence reports variations in language, understandings and service delivery between services reportedly using a social prescribing approach, is potentially limiting its overall benefits for population health (Drinkwater, Wildman, & Moffat, 2019).

2.3.4 Positioning of Services – Nature of Partnership

The lack of a strong theoretical base for the social prescribing approach has prevented literature from clearly identifying where services using this approach should locate their services, between the healthcare and community and voluntary sectors. The key concept of the social prescribing approach is in the fact that it is a "mechanism for linking" between the healthcare and community-voluntary sectors (Chaterjee et al., 2018), however, to date this approach has yet to be conceptually described in theory, nor has the nature of partnership between the two

sectors been explicitly formalised (Husk et al., 2019a; Husk et al., 2019b). This again poses a serious risk to the long-term success and funding of the social prescribing approach, as there would appear to be conflicting opinions as to where social prescribing services should be positioned between the healthcare and community-voluntary sectors (Brandling & House, 2009; Kenkre & Howarth, 2018). This same point was raised by Sir Nick Black (1988), an advocate for formalising the link between the National Health Service in the United Kingdom and community and voluntary organisations, in an article for the British Medical Journal over thirty years ago. In this piece he wrote about the substantial potential that formalising such a link could have for improving population health and reducing pressure on healthcare services, however his enthusiasm came with a stark warning over the need for mutual understanding and a clear definition of the partnership between the two sectors. This warning was given in the context of formalising where services should be provided from, as well as how they should be financed, in order to ensure clarity and mutual understanding between sectors.

Thirty years later, in spite of the fact that the social prescribing approach is claimed to have developed in order to move away from a strictly biomedical model of care, it would appear as if most social prescribing services in the United Kingdom still very much lie within the realm of conventional medicine (Clements-Cortés & Yip, 2019; Conrad, 2005). Many of the studies discussed in literature locate social prescribing schemes within general practitioner surgeries and primary care centres (Farenden, Mitchell, Feast, & Verdinicci, 2015; Friedli, Themessl Huber, & Butchart, 2012; Kimberlee, Ward, Jones, & Powell, 2014). Whether for practical reasons of ease of referral between services or some alternative, it has not yet been made explicit why precisely this trend has emerged. What is notable however is that this positioning of social prescribing schemes within the existing healthcare systems has been linked in some reports with increased service user participation (Kimberlee, Ward, Jones, & Powell, 2014) and moreover has been identified in other studies as being of particular importance to the social prescribing process (Farenden, Mitchell, Feast, & Verdinicci, 2015; Hamilton-West, Gadsby, Zaremba, & Jaswal, 2019).

As well as this locating of services, the term prescribing itself would appear to run at odds with the principals of client centeredness which are suggested to underscore its practice (Kenkre & Howarth, 2018). Pausing for a moment to consider the term 'social prescribing' may leave one wondering if this movement is potentially a façade to expand the clutches of medicine into civil society? Current literature does not entertain such a cynical thought, however the way in which

many social prescribing services (particularly in the United Kingdom) are located within healthcare settings and outreach to the community, instead of the inverse, raises' questions about current practice. The fundamental lack of universal understanding on both a conceptual and practical level significantly restricts the generalisability of findings in this field and hence is potentially limiting the lofty potential of social prescribing services (Bickerdike et al., 2017).

2.3.5 Current Evidence Base

There is undoubtedly a growing evidence base for the social prescribing approach, however limitations still exist. The number of academic papers published on the approach annually has grown from four in the years 2012 and 2013, to about one-hundred and twenty in 2019. A growing number of papers are reporting positive outcomes for individual and group health and well-being when using this approach (Chaterjee et al., 2018; Elston et al., 2019). There appears to be much optimism however, that the social prescribing approach could be a 'silver bullet' or at least some sort of panacea to the difficulties faced by the healthcare systems of developed countries (Drinkwater, Wildman, & Moffatt, 2019; Skivington et al., 2018). Recent systematic reviews have raised serious concerns over the depth of the current evidence base, but moreover report that much of the current evidence available is of poor quality and at high risk of bias (Bickerdike et al., 2017; Chaterjee et al., 2018; Pescheny, Pappas, & Randhawa, 2018). Considering this, it is prudent to first consider the origins of the current evidence base, as published literature appears to exist in three different general formats, (i) evaluative reports from the United Kingdom based social prescribing services, (ii) expert opinion pieces and clinical reviews and (iii) peer-reviewed journal articles. The evaluative reports (i) tend to present findings in a particularly positive light, the expert opinion pieces and clinical reviews (ii) are largely, if not exclusively, written from a medical/general practitioner in the United Kingdom perspective, and while the peer reviewed journal articles (iii) originate from a wider variety of academic sources, they do not currently exist in large quantity. In an Irish context, the literature has been almost silent on the topic.

The social prescribing approach moreover, is yet to be theorised in literature (Elston et al., 2019; Husk et al., 2019b). Considering the newness of this approach as a mooted shift away from the biomedical model of providing healthcare and its complexity in spanning two significantly different sectors, i.e. healthcare and the community and voluntary sector, the social prescribing approach would benefit significantly from knowing its true identity. Literature reports that such under-conceptualisation has created significant barriers to its

universal roll-out, including particularly the level of variation between social prescribing services and the language used when referring to social prescribing services (Bickerdike et al., 2017; Chaterjee et al., 2018; Pescheny, Pappas and Randhawa, 2018).

The primary concern from a population health perspective in light of the dearth of substantial evidence would be whether there is potential for social prescribing to not only not benefit individual's health and well-being, but instead have the potential to harm it (Jani et al., 2019). While this seems unlikely, it has not been ruled out in the current evidence base and should be further explored considering the diversity of population groups that social prescribing is being suggested for. A more real concern currently however, is the potential opportunity costs of investing large amounts of resources in services using a social prescribing approach that potentially have limited population health and well-being benefits, particularly in their current under-investigated form (Jani et al., 2019). While the roll out of any service to improve individual and population health should be grounded in its potential to improve health and not to manage scarce resources, the funding of a service with potentially minimal benefits for improving individual and population health and well-being must be seriously questioned both logically and ethically. A more substantial and rigorously produced evidence base could serve to address many of these concerns (Bickerdike et al., 2017).

While in theory the social prescribing approach does appear well positioned to contribute to meeting the goals set out by Sláintecare (i.e. achieving the 'triple aim' for healthcare systems of improving care, improving health and reducing costs through reforming the funding model and facilitating an integrated care approach) (Houses of the Oireachtas, 2017), evidence gaps and an absence of practical guidelines have a significant possibility of leading to its eventual failure as an approach to support population health. This has been demonstrated by two recently published systematic reviews of social prescribing schemes in the United Kingdom which identified the lack of mutual understanding between healthcare and community-voluntary sector workers as a substantial barrier to the success of social prescribing (Bickerdike et al., 2017; Pescheny, Pappas, & Randhawa, 2018). Another study by White, Cornish and Kerr (2017) in west Scotland explored the working relations of these groups involved in social prescribing services and found that even though both healthcare workers and link workers reported using a social model of health, health care workers still saw themselves very much as the 'experts'. A lack of trust existed between the two groups also, particularly held by the healthcare workers towards link workers and community-voluntary groups, as they feared for

their own liability and accountability. Such mistrust caused by a lack of mutual understanding demonstrates how lack of clarity on a policy level can be detrimental implementation of the social prescribing process on a grass roots level.

A further significant concern regarding social prescribing's long-term practical implementation is the Irish government's track record of scapegoating the community and voluntary sector, particularly in times of economic difficulty (Harvey, 2012; 2014). Not only does the state have a reputation for increasing responsibility and reducing funding for community and voluntary groups (Harvey, 2012), it has similarly used governmentality strategies in the past to silence dissenting groups who criticise government strategies, using funding as leverage (Harvey, 2014). While this has been situation specific, there is a realistic fear amongst the community and voluntary sector that if adequate guidelines for social prescribing are not developed, they may end up shouldering a disproportionately large burden of responsibility (Harvey, 2015; Keenaghan, Sweeney, & McGowan, 2012). Hence formal agreement and understanding of the nature of the partnership between the healthcare and community-voluntary sector will moreover be central to the success of the social prescribing approach (Bickerdike et al., 2017; Keenaghan, Sweeney, & McGowan, 2012).

2.4 Conclusion

While there is a growing evidence base supporting the potential positive benefits of the social prescribing approach, there is a fear that by rolling out this approach without an established theoretical base or national guidelines, services using the social prescribing approach in Ireland could be unintentionally set up to fail, as a means of improving population health status. Considering the lack of conceptualisation, the limited evidence base, the government driven desire for healthcare cost reduction and the Irish state history of placing an unfair burden of responsibility on the community and voluntary sector, it is feared that the security of long-term funding for services using a social prescribing approach could already be in jeopardy. In 2019, the National Health Service in the United Kingdom launched a summary guide for social prescribing and community-based support. A 2012 report by Keenaghan, Sweeney and McGowan for the Health Service Executive in Ireland, highlighted the importance of providing national and local implementation guidance for social prescribing services, to ensure the provision of effective services and the protection of the community and voluntary sector. To date however, no such guidelines have been published in the Irish context.

Chapter 3: Methodology

3.1 Introduction

The emergence of the global pandemic COVID-19 during the research process, was an unanticipated and significant factor during this research project. The COVID-19 pandemic has been an unexpected and unprecedented worldwide health crisis in the contemporary context. It has cause widespread disruption to individuals and societies and has dramatically impacted the ways in people live their daily lives. In Ireland, strict infection control measures have been imposed from the outset of the pandemic, which included a national lockdown closing schools, shops, public spaces and all non-essential services, with all those living on the island instructed to stay at home. Moreover, this period has seen the introduction of strict public health measures including new concepts such as social distancing, cocooning as well as an increased emphasis on personal hygiene such as hand washing, cough and sneeze etiquette and wearing facial coverings in public. Cooperation, humanity, flexibility and creative thinking have been required in abundance by everyone, to ensure the continued delivery of essential services as well as to protect the most vulnerable members of our society. Such characteristics have similarly been required on the part of student researchers, whom have had to demonstrate mature decision-making when proceeding with their ongoing research requirements throughout the pandemic.

In this research project such a response was adopted by the student researcher from the outset of the COVID-19 pandemic. The aforementioned measures implemented as part of the lockdown impacted all aspects of this study. The initial shock of the advent of this crisis caused a delay in coming to a conclusive decision regarding the most appropriate research design to answer the research questions, in light of the new government-imposed measures. The student researcher moreover, as a healthcare professional returned to working full-time as additional COVID-19 covering staff in the acute hospital setting during the crisis. Hence reflection, open communication with academic supervisor and community-based partners and further scholarly investigation were required to inform decisions around progressing with the research project. Due consideration was given to establishing priorities for this research project including contributing to knowledge on social prescribing, producing knowledge for the benefit of the community-based partner, fulfilling the criteria for this master's programme, personal interest and appropriateness in the current context. Thoughtful reflection on the hierarchy of priorities

for this research project as well as practical factors for consideration including social distancing, travel restrictions, service pressures, personal pressures, personal time. While conducting a social research project during the COVID-19 pandemic required significant cooperation, humanity, flexibility and creative-thinking on the part of the student researcher, it moreover proved a unique learning opportunity to come up with innovative ways to conduct research during such unprecedented times.

3.2 Community-Based Research

This study was undertaken using a community-based approach. This approach has been found to be particularly effective in studies that seek to build community group capacity (Letcher & Perlow, 2009; Taylor, Braveman & Hammel, 2004), eliminate health disparities (Culhane-Pera et al., 2010; Horowitz, Robinson & Seifer, 2009), advocate for policy change (Israel et al., 2010) and give a voice to underrepresented groups such as women (Cahill, 2007; Lykes & Scheib, 2016) and minorities (Haaken & O'Neill, 2014; Sutherland & Cheng, 2009). Community-based research (CBR) is an action research approach that is similarly considered as an attitude of enquiry that enables researchers to investigate taken for granted ways of thinking and acting used to improve existing social and personal circumstances (McNiff & Whitehead, 2006, 2009). CBR studies are designed with a specific emphasis on enabling action (Baum, MacDougall, & Smith, 2006; McIntyre, Chatzopoulos, Politi, & Roz, 2007), working collaboratively between communities and academic researchers (Jemigan, 2010; Jemigan, Jacob, & Styne, 2015; Letcher, & Perlow, 2009; Lykes & Scheib, 2016), empowering participants (Datta et al., 2015; Fenge, 2010), and focusing on issues of justice (Branom, 2012), hence differentiating it from conventional research approaches. With its commitment to balancing research and action, CBR is well suited to efforts at the intersections of science, practice, and policy to eliminate health disparities.

For this study, a link with the Cork Volunteer Centre (CVC) was established through the University College Cork (UCC) Community Academic Research Links (CARL) initiative. Considering that the social prescribing approach has been defined as a mechanism for linking people with non-medical sources of support within the community, a CBR approach with the CVC was deemed very appropriate for this study. This approach closely aligns with both the values of the social prescribing approach as a collaborative working between perceived 'experts' and community-based organisations (Chesterman & Bray, 2018) and there is moreover, potential to further explore differences in understanding that may exist between

different stakeholder groups during the social prescribing process. Secondly, considering the healthcare background of the student researcher, a CBR approach in working with the CVC was a means to get a more diverse perspective representative of the different stakeholder groups involved in services using a social prescribing approach currently, and hence better answer the research questions. The student researcher (under the guidance of an academic supervisor and coordinator from the UCC CARL initiative), worked in collaboration with the manager of the CVC to agree upon the research aim and questions, and to set goals around how it may be possible to action and disseminate findings from the research project. This was documented and signed off on in the research agreement at the outset of the project. Regular research meetings and email contact between the student researcher, centre manager and academic supervisor enabled discussions around ethical considerations, participant recruitment and data collection methods and hence facilitated a collaborative research design. The use of such a collaborative approach was particularly beneficial upon the onset of the COVID-19 pandemic as the support, contacts base and expertise in understanding the community-based impacts of this global pandemic were essential to guide decision-making processes around alterations to the research design. Adopting a CBR approach in designing this study was similarly considered very important by the student researcher, to best ensure that the findings of this research could be actioned beyond academic publication to build further capacity for the Cork Volunteer Centre in how they can design their services, lobby for increased funding and advocate for policy change.

3.3 Qualitative Approach

Considering this research seeks to explore the perspectives of a specific population, a qualitative research method was deemed most appropriate. Qualitative research is fundamentally concerned with the way in which people shape the world and has a primary goal to understand social phenomena and give descriptive accounts of those phenomena within a context (Denscombe, 2009). This approach favours inductive enquiry (Bryman, 2012) and generally follows a constructionist interpretivist research paradigm (Denscombe, 2009). Constructionism is an ontological position which regards the social world as a creation of the human mind, a reality that is constructed through people's perceptions and reinforced by their interactions with other people (Denscombe, 2009), while the interpretivist approach is concerned with the understanding (rather than explaining) of human behaviour and focuses on how people make sense of the social world and create it (Bryman, 2012).

The essence of a qualitative approach is to view events through the perspective of the people who are being studied, i.e. how they view the world (Bouma and Athkinson, 1995; Kumar, 1999). The lack of current literature available about the social prescribing approach, as identified by the literature review, influenced the decision to adopt a qualitative approach in this research, as there is a need to generate theories on the conceptual underpinnings of this model. This lack of available literature, moreover, means there is a need to hear from those currently working in this area, as there would appear to be differences in understanding amongst different stakeholder groups involved currently.

3.4 Participant Sampling and Recruitment

The Cork region was targeted for participant recruitment to ensure homogeneity of context, as services using a social prescribing approach in different geographical areas have been shown in the literature review to regularly operate differently (Bryman, 2012). Initially purposive sampling based on an inclusion-criteria was used to recruit participants. The inclusion criteria included that participants would have to be able to communicate verbally in English, be over 18 years of age and be currently and/or have previously been involved in providing services using a social prescribing approach in Ireland in any capacity. A heterogenous sample of people with different roles in the provision of such services was sought including but not limited to link workers, service coordinators, civil society organisation workers, health care workers, steering group members. The community-based partner moreover emphasised the importance of applying a broad and somewhat open-ended interpretation to the term social prescribing in the context of participant recruitment for the study because of the well-documented ambiguity around the term social prescribing in current literature. These would encourage a comprehensive exploration of the concept of social prescribing.

This study was initially advertised by the CVC via email using advertisement poster [Appendix A] and information sheet [Appendix B]. The study advertisement materials were designed in collaboration with the community-based partner and designed using the National adult literacy agency (NALA) plain English guidelines. The student researcher similarly contacted a link worker from a local service using a social prescribing approach, who circulated the study advertisement material via email amongst their network involved with services using a social prescribing approach. Snow-ball sampling methods were used to increase the diversity of the sample of recruited participants and get more participants from different backgrounds. Snow-ball sampling is a sampling technique in which "the researcher samples initially a small group

of people relevant to the research questions, and these sampled participants propose other participants who have had the experience or characteristics relevant to the research. These participants will then suggest others and so on" (Bryman, 2012). In total, 8 participants were recruited for the study. After ensuring all participants received a pre-participation information sheet, the purpose of the study was fully explained again at the start of the interview with an opportunity to ask any further questions. All participants were asked to sign an informed consent sheet [Appendix C], to document non-coercive recruitment.

3.5 Data Collection

Data for this study were collected using individual semi structured exploratory interviews. When conducting a semi structured interview, the researcher has a list of specific topics to be covered, often referred to as an interview guide, but the interviewee has a great deal of leeway in how to reply. Questions that are not included in the guide may be asked as the interviewer picks up on things said by interviewees and questions may not follow on exactly in the way outlined on the schedule (Bryman, 2012). Semi-structured interviews are commonly used in both qualitative and CBR research. For this project, an interview guide [Appendix D] was developed based on the study research questions and piloted before the interviews took place. As previously mentioned, this study aimed to answer the following research questions:

- What do individuals from different stakeholder groups, involved in services using a social prescribing approach in Ireland understand the social prescribing approach to be?
- What do individuals from different stakeholder groups, involved in services using a social prescribing approach in Ireland see as the key components to the social prescribing approach?
- What do individuals from different stakeholder groups, involved in services using a social prescribing approach in Ireland see as their role in the social prescribing approach?
- Are there differences in understandings of the social prescribing approach in Ireland, amongst stakeholder groups involved in services using a social prescribing approach?
- Do individuals from different stakeholder groups, involved in services using a social prescribing approach in Ireland, think there is a need for using a social prescribing approach in Ireland?

Interviews were conducted by the student researcher using the online video application Zoom and ran for approximately forty-five to sixty minutes. Interviews were audio recorded through these platforms, saved onto the student's online university cloud platform and transcribed verbatim. The use of online video applications for conducting interviews in qualitative research studies have been found to have many benefits including removing the need to travel, time and cost saving, relative ease of use, data management features and in the current context maintaining social distancing (Archibald, Ambagtsheer, Casey and Lawless, 2019; Gray, Wong-Wylie, Rempel, and Cook, 2020). Zoom moreover has been identified as particularly proficient in this regard owing to their security features including the ability to securely record and store sessions without recourse to third-party software, user-specific authentication and the real-time encryption of meetings (Archibald, Ambagtsheer, Casey and Lawless, 2019). Other data collection methods such as focus groups were considered for this project however due to the COVID-19 context, these were not appropriate at the time of data collection.

3.6 Data Analysis

Data collected during the semi-structured interviews were analysed using thematic analysis. Thematic analysis is conducted by developing themes that "go beyond such an inventory of domains, to discover the conceptual themes that members of a society use to connect these domains" (Spradley, 1979, p. 185 in Leech & Onwuegbuzie, 2008). Themes are recurrent unifying concepts or statements about the subject of inquiry (Boyatzis, 1998) and are fundamental concepts that characterize specific experiences of individual participants by the more general insights that are apparent from the whole of the data (Ryan & Bernard, 2003). Thematic analysis provides a highly flexible approach that can be modified for the needs of many studies, providing a rich and detailed, yet complex account of data (Braun & Clarke, 2006; King, 2004). Data analysis in qualitative research projects is said to be an ongoing, iterative process that begins in the early stages of data collection and continues throughout the study (Bradley et al., 2007).

For this project, data analysis were carried out by the student researcher and took a four-step approach which included ongoing reading and re-reading of transcripts, reflection, reflexivity and documenting of thoughts and decisions from the outset and throughout. The first step of data analysis involved familiarization with the collected data whereby the student researcher initially read through the interview transcripts to become immersed in the data to fully understand the depth and breadth of the content while documenting any initial impressions

(Bradley et al., 2007; Nowell et al., 2017). The second step involved using an inductive approach to develop initial codes which captured the essence of the interviews, by reading through transcripts line by line (Saldaña, 2016). Next, codes were re-grouped to become categories based on shared characteristics (Saldaña, 2016). The final step involved the use of diagramming to explore connections between categories to define themes and sub-themes (Nowell et al., 2017).

3.7 Data Validation

Considering CBR studies prioritise an emphasis on enabling action (Baum, MacDougall, & Smith, 2006), it is of utmost importance that such studies demonstrate their validity and legitimacy (Nowell et al., 2017). In qualitative research studies such as this, credibility, transferability, dependability, and confirmability are the four evaluative criteria that are used to ensure the trustworthiness (Carpenter & Suto, 2008; Nowell et al., 2017), which is essential for demonstrating such validity and legitimacy. In this study to establish credibility, the student researcher received regular supervision form the study academic supervisor, interviews were transcribed verbatim and interview transcripts were member-checked with study participants before progressing with analysis. Transferability was ensured by providing a detailed description of the research design as well as describing in detail how the data were collected and analysed. An auditing approach was adopted from the outset and throughout the study to promote dependability, with justifications for all decisions made documented and minutes taken at each research meeting and academic supervision session. Confirmability was established through ensuring all the above and furthermore, a reflective journal was utilised throughout the research process to support reflexivity (Finlay, 2002).

3.8 Ethical Considerations

As previously mentioned, the emergence of a global pandemic evoked significant ethical considerations from the outset of this project. Upholding the ethical principles of beneficence and nonmaleficence were of utmost importance in the context of protecting participant welfare and not placing unnecessary pressures on healthcare and community-based services (Ruch, 2014). An application for ethical review was submitted to the UCC Social Research Ethics Committee, however due to increased service demand and the low level of ethical risk associated with this project, it was not accepted for review by the committee. Instead, it was decided to closely follow the guidance of the UCC Code of Research Conduct (2016) and academic supervisor and moreover, the student researcher completed an online certified

Fundamentals of GDPR training module. Regardless of the low level of ethical risk associated with this project ethical considerations impacted decisions made throughout this entire research project.

Literature suggests that when using a CBR approach, concerns can exist around confidentiality, data ownership, as well as potential participants feeling obliged to participate. To avoid this notion, the CARL research agreement was signed by the student researcher, CVC, research supervisor and UCC CARL representative at the outset of the project and informed consent was attained for all participants involved. After careful consideration, it was collaboratively decided to continue to attempt to collect primary data, as with appropriate measures this was deemed possible and a better way to progress with attempting to answer the research questions. It was however, decided to remove the service user perspective from this piece of research, based on observations of the effect of the lockdown on the health and well-being of service users, across all health and community-based services. The service user perspective was, moreover, not seen as crucial to answering this proposed research question. Regarding data collection methods focus groups were replaced by online individual semi-structured interviews in the interest of participant and interviewer safety. Zoom, the online application used for the interviews, was chosen because of its enhanced security and encryption features (Archibald, Ambagtsheer, Casey and Lawless, 2019), as well as the fact that it is widely used amongst the public and was free of charge at the time of data collection. Informed consent forms were completed and signed prior to all interviews and interview transcripts were member checked with participants prior to data analysis. The principles of confidentiality and anonymity were respected throughout the research process and pseudonyms used in the write up of the research project. Data were stored appropriately online on students UCC Drive in accordance with UCC Research Data Management Policy (2016).

3.9 Conclusion

A community-based research approach was taken for this project in collaboration with the CVC. A qualitative method was used, and eight consenting participants engaged in individual semi-structured exploratory interviews using the online video application Zoom. Participants for this study were from different stakeholder groups involved in providing services using a social prescribing approach including three programme link workers, an academic consultant for evaluation of services, a regional head of service for community healthcare programme, a general practitioner, a national programme manager with a community-based stakeholder and

a placement officer with a community-based volunteer service. Interviews were transcribed verbatim and data were analysed using thematic analysis.

Chapter 4: Findings

4.1 Introduction

This chapter presents the findings from the analysis of the research data, generated through thematic analysis which involved inductively examining information within the context of the research aim and questions. The research aim for this project was: *'To explore understandings of the social prescribing approach in Ireland, amongst stakeholder groups involved in services using a social prescribing approach'.* The research questions sought to explore: 1. What do individuals from different stakeholder groups, involved in services using a social prescribing approach in Ireland (i) understand the social prescribing approach to be? (ii) see as the key components to the social prescribing approach? (iii) see as their role in the social prescribing approach? 2. Are there differences in understandings of the social prescribing approach in Ireland, amongst stakeholder groups involved in services using a social prescribing approach? 3. Do individuals from different stakeholder groups, involved in services using a social prescribing approach in Ireland, think there is a need for using a social prescribing approach in Ireland?

Given the dearth of information and clarity regarding services using a social prescribing approach in Ireland, the first section of this chapter will contextualise the findings by providing a service profile of the social prescribing service from which participants were recruited, a policy map documenting the governance structure of this service, and a participant profile, outlining the backgrounds of the recruited participants. This chapter will then proceed to present the findings of this research in the form of themes and subthemes.

4.2 Contextualising the Findings

4.2.1 Service Profile: The Health and Wellbeing Community Referral Service

All participants recruited for this study are currently or have previously been involved in providing services using a social prescribing approach in CHO Area 4, Cork Kerry Community Healthcare. In this area, the formalized service using a social prescribing approach is called 'Health and Well-being Community Referral' (HWCR), a name given to this service after service user engagement and consultation. The HWCR service has been designed and implemented by Cork Kerry Community Healthcare, Health and Wellbeing service, in partnership with the National Family Resource Centre Mental Health Project and funded through funding from Sláintecare. The HWCR service currently operates at eight sites across the region in different healthcare networks (see image 3), most of which launched at the start of 2020, shortly before the onset of COVID-19. It is important to highlight that other formalized services using a social prescribing approach in Ireland outside of CHO Area 4 are currently unrelated to this service so this profile cannot be generalised to the national context.

Image 3: Map of CHO Area 4 Cork Kerry including its 14 healthcare networks

1	North Kerry	4	Midleton / Youghal	11	Douglas / Blackrock / Mahon
2	West Kerry	7	Cobh / Glanmire	12	Ballincollig / Bishopstown / Macroom
3	South Kerry	8	Mayfield / Blackpool	13	Bandon / Kinsale
4	Mallow / Charleville	9	Blarney / Farranree / Churchfield	14	Ballyphehane / Togher
5	Fermoy / Mitchelstown	10	West Cork		

Source: https://www.hse.ie/eng/about/who/healthwellbeing/healthy-ireland/community-healthcare-organisations/compass-healthy-ireland-implementation-plan.pdf

A HWCR steering group for the Cork Kerry Community Healthcare area oversees the development, implementation and evaluation of the service. Membership consists of representation from Cork Kerry Health and Wellbeing, the National Family Resource Centre Mental Health Project, academic consultants and other community-based stakeholders. Each of the eight HWCR service sites in the area have their own part-time link worker and a local area working group to support development and the day to day running of the service. Membership of the working groups generally comprise of the service link worker, community and voluntary group representatives and when possible local healthcare professionals. HWCR services are located in community-based locations and aim to operate by being easily accessible to members of the local community and also through linking back in with healthcare services in the area to promote referrals to the service. Link workers in the HWCR service work by having an in-depth awareness and understanding of community services and resources in their local area so that they can be provide a link for individuals to these community-based services. The policy map below (Graph 1) documents the governance structure of the HWCR service.

Graph 1: Policy Map for HWCR service
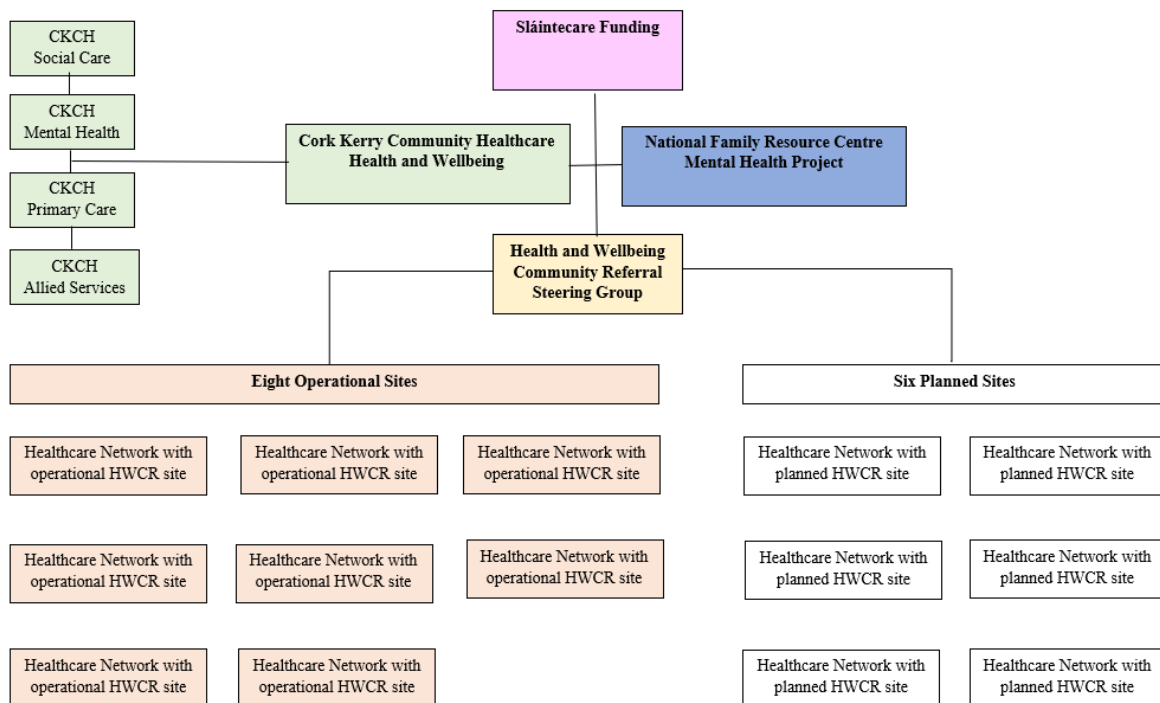
Participants 1 to 7 have a role involving them with the HWCR services in Cork. Participant 8 is not involved with this service, however, is involved with the informal application of the social prescribing approach with her civil society organisation (CSO). As the purpose of this

research project is to explore understandings of the social prescribing approach, it was felt that this additional perspective was both valid and moreover, extremely beneficial to exploring this perspective from an additional perspective. The inclusion of this perspective was further legitimized by the fact that several of the other participants mentioned using a social prescribing approach to providing services, prior to being involved in the formal HWCR service. An overview of the roles held by participants with regards using a social prescribing approach has been included in Table 1 below.

4.2.2 Participant Profile

Table 1: Profile of Research Participants

Participant 1	Programme Link Worker Local area working group member
Participant 2	Academic Consultant for evaluation of services. Health and Wellbeing Community Referral steering group member
Participant 3	Programme Link Worker Local area working group member
Participant 4	Regional Head of service for community healthcare programme. Health and Wellbeing Community Referral steering group member
Participant 5	General Practitioner and GP Educator Local area working group member
Participant 6	Programme Link Worker Local area working group member
Participant 7	National Programme Manager with a community-based stakeholder. Health and Wellbeing Community Referral steering group member
Participant 8	Placement officer with a community-based volunteer service.

4.3 Findings

It is appropriate to acknowledge at the outset, the enthusiasm and passion that was demonstrated by all participants during interviews on social prescribing. Furthermore, there was emphatic agreement amongst participants that a need for SP exists in Ireland. This was evidenced by the most common answer being a straightforward '100%'.

4.4. Overview of Themes

Seven Themes were identified during data analysis. These themes are; what is social prescribing?, key components, language, relationship with existing services, service user profile, service provider roles and the referral pathway. Each theme included theoretical understandings and practical understandings as subthemes. These subthemes add to general understanding by differentiating between theoretical and practical considerations relating to these themes.

Graph 2: Overview of Themes and Subthemes from Findings

Subtheme 1: Theoretical Understandings

Themes:
1. What is the Social Prescribing approach?
2. Key Components
3. Language / Name of Service
4. Relationship with Existing Services
5. Service User Profile
6. Service Provider Roles
7. Referral Pathway

Subtheme 2: Practical Understandings
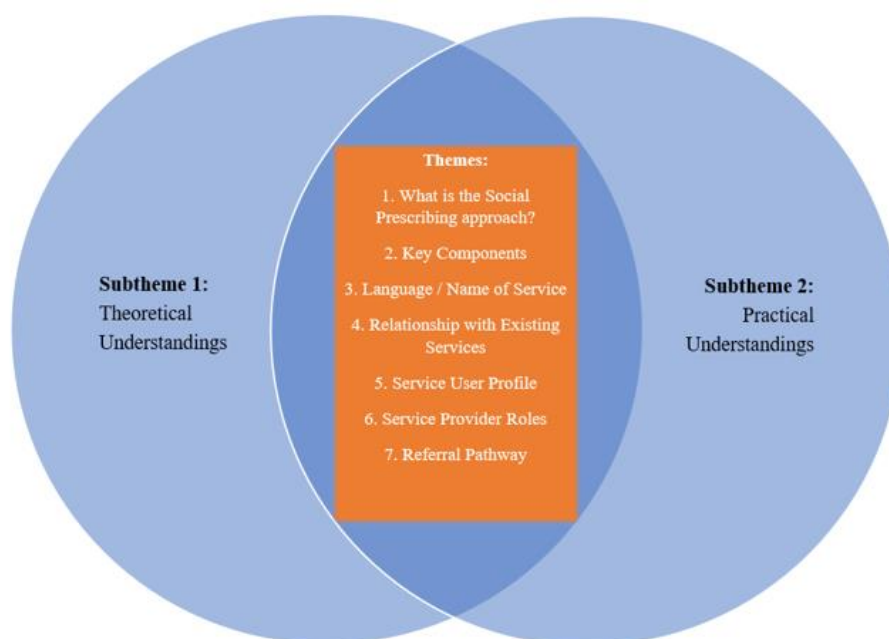
4.5. What is the Social Prescribing approach?

4.5.1 Theoretical Understanding

Overall, agreement existed amongst participants regarding their theoretical understandings of the social prescribing approach. This approach was viewed by participants as a way to support people's health and well-being through supporting community engagement. Participant 2 reported:

"It is really looking at engaging people in a community and looking at their well-being from like a society participation point of view."

The idea that the social prescribing approach does this by providing a link for individuals to groups, services, courses and activities in their local communities, was widely agreed upon by participants, with Participant 1 having this to say:

"You know there's things going on, and there's lonely people, and it's just bridging, it's bringing basically those two things."

The adoption of a society wide perspective when implementing a social prescribing approach was generally viewed as important by participants. A social prescribing approach was seen to have potential roles as both a preventative measure to reduce pressure on healthcare services, as well as a measure to support transitions between the healthcare system and local communities to promote continuity of care. Participants 2, 4 and 7, who are involved at a service implementation level, particularly highlighted this point with Participant 4 reporting:

"I do feel that as a society in order for us all to have good health we do need a whole of society approach."

Participant 7 added to this perspective saying:

"It's that early intervention, prevention work."

With Participant 2 referring to it as:

"It's an adjunct, it's something that can be, support peoples transition out of the medical model."

4.5.2 Practical Understanding

On a practical level, participants suggested that while consensus exists around general understanding of the social prescribing approach, it was likely that differences in understandings could exist amongst service providers from different professional backgrounds, different geographical areas and with different funding sources. Participant 7 reported:

"You know the understandings, they're very broad, and that's probably one of the challenges as well, is you know it's depending on where you are, it varies quite a lot."

With Participant 1 adding:

"I suppose all those external factors impact on maybe, not your understanding, but they do impact on your design and your delivery."

While Participant 5 summarised the general attitude amongst participants that once people had a good general understanding of the concept, that more subtle differences in understanding were not to be worried about.

> *"We're all in this together you know, so I don't think it matters that we have a, it's such a broad subject that it really does, everybody's going to bring their own definition of it really yeah."*

Furthermore, while consensus of understanding existed amongst those interviewed, participants reported a significant lack of general understanding and awareness of the social prescribing approach amongst the general public, community-based organisations and particularly healthcare professionals. Participant 1 reported:

> *"And I mean one thing I have found is that basically nobody has ever heard of it … It's really just because there's a really low level of awareness"*

While Participant 8 who is not involved in a formal social prescribing approach service explained:

> *"It may be a lack of understanding in general. So for some people, [they] are maybe just unclear what it is, but I think if somebody is aware of what it is, the understanding is quite clear."*

4.6 Key Components
4.6.1 Theoretical Understanding

Key components central to the understanding of the social prescribing approach were identified by participants including formal links, a non-clinical process, person-centredness and a holistic perspective including the social dimension. 'Links' refer to how the social prescribing approach aims to connect the healthcare system, individuals and community-based services, to support population and individual health and well-being in the community. The idea of links focuses on the relationship-based nature of this approach between service users, link workers, healthcare professionals, civil society organisations and other involved stakeholders as described by Participant 2:

> *"Ok, social prescribing in my understanding is a non-clinical programme whereby people who don't have good links and engagement with the community can avail of the programme, to support their engagement in, um, basically engaging in the community."*

The idea that a social prescribing approach is a formalized link between these sectors was emphasised by participants. Participants reported that the process of connecting individuals with community-based services to support health and well-being has been done informally for years, however current services being rolled out using the social prescribing approach are creating formal connections between the healthcare system, individuals and their communities to support health and well-being. On this, Participant 5 reported:

> *"I think forever in a day in my 40 years of practice, I would hope that I had been trying to find out about a walking group, trying to find out about a drugs project that had been going on in the area."*

While Participant 1 explained:

> *"Every single post I've done … all of it now involved and element of that, of social prescribing."*

Participant 8 who is not involved with the formal HWCR service but still links people in with community-based groups added to this reporting:

> *"Yeah definitely, we are doing it a little informally, but we do that."*

Interviewees emphasised that social prescribing is a non-clinical approach with a particular focus on the social perspective. Participant 2 explained the non-clinical approach:

> *"When we say non-clinical we're not specifically looking at decreasing anxiety. We're looking at engaging people in a community and basically I would say occupation, so um you know doing the things such as the really important things to people's overall health and well-being like leisure, fun, walking for their health, pain management, knitting, craft, like things that are actually forgotten."*

While Participant 5 explained the importance of the social prescribing approach for meeting the multidimensional needs of an individual's malady:

> *"I mean the social dimensions are not being filled in a lot of their places … I think covid would have exposed that hugely that the social dimension has been a contributing factor so much, because it's so missed."*

4.6.2 Practical Understanding

From a practical perspective, flexibility and fluidity of service delivery were identified as key components, particularly for the HWCR service. While identifying positives of the current HWCR service, Participant 1 reported:

> *"It's very flexible, certainly the way we're doing it in Cork and Kerry."*

Flexibility and fluidity refer to scope being given to local steering groups and link workers, to provide services in their area based on the pre-existing strengths and identified needs of that specific community. As has been mentioned, participants reported significant variations currently exist between services because of factors such as geographic location of services, pre-existing community-based facilities and services, stakeholder groups involved and the sources of service funding. Participant 4 explained:

> *"I think anyone that you speak to will have the key elements of it, but like I said, we have allowed fluidity of the sites, so I would say that everyone that you would speak with will have a different understanding of social prescribing and would describe it slightly differently."*

4.7 Language / Name of Service

4.7.1 Theoretical Understanding

Differences in opinions existed amongst participants with regards to the language used, particularly when naming the service. The primary area of contention was around the use of the word 'prescribing', as many participants felt that this word is inappropriate for the service in question, due to its medical connotations as well as the implication that it disempowers service users. Participant 1 expressed for example:

> *"I don't actually like the phrase social prescribing. I think prescribing is, it's such a medicalized word."*

While Participant 3 added:

> *"People felt the word prescribing itself had medical connotations and so they moved towards the term community referral."*

The name health and well-being community referral has been instead given to this service (based on service-user feedback), with the term community referral seen as being a more

appropriate and service-user empowering term, in particular by Participants 2, 4 and 7. Participant 2 explained:

> "If you're prescribed by a GP, people felt they must go. If you're referred, that gives the person participating more power and that's one of the things that is really interesting in this project," and added "I think referral is much better than prescribing. Yeah it's a power issue."

Some participants, particularly the link workers, felt that even the term 'referral' was too medicalised and disempowering a term to use. Participant 6 discussed this point.

> "They love using the word referral and I think that, I don't think that's very service user friendly actually, because I'd rather people will just ring themselves, self-referral."

There was however a contrasting perspective from participant 5 who felt that the name social prescribing was a clever name for the service. Participant 5 referred to the more "concrete" nature of the word 'prescribe', which may appeal to certain service users and particularly GP's. He also explained the existence of a paradoxical understanding of the word 'prescribe' amongst the public.

> "Yeah, I suppose the adjective prescriptive, yes, it is a negative adjective but, 'will you prescribe something for me doctor?' is seen as a positive."

Participant 5 moreover, suggested that the social prescribing approach should try to take ownership of the word 'prescribe' to help to put it on a level with other forms of healing (such as pharmacological prescribing), which may have better sway with governments and funders.

> "I think they need to concretize what they're doing and if they have to steal a word from another part of the lexicon, so they should, you know."

4.7.2 Practical Understanding

It is important to acknowledge when discussing language that participants perspectives appeared to be universally informed, by a desire to use language that would be of greatest benefit to the overall success of the service going forward. From a practical perspective, link workers particularly felt that the significant differences in the language and names used by social prescribing services in different areas was both a practical inconvenience and a potential

barrier to its sustainability. Participants 1 and 6 mentioned frustration at this particularly, from a service start-up perspective. Participant 1 explained:

> *"All of these groups have been re-inventing the wheel. We're all using different paperwork, we're all using different terminology with different ways of doing things, like there should be one model that works and then we should all work from that model and certainly improve it and give feedback and modify it of course,"* adding *"I think we will be stronger if we use the same terminology."*

It was similarly mentioned that while empowering from a participant perspective, the current name of the service HWCR made it more difficult to form links with other services using a social prescribing approach. Participant 3 gave such a description:

> *"I felt that when I was trying to link in with people at a national level and with people in the UK just to introduce myself and kind of just to make connections, I was putting social prescribing in brackets afterwards then so all of a sudden it's health and well-being community referral link worker brackets social prescriber."*

4.8 Relationship with Existing Services

4.8.1 Theoretical Understanding

Participants provided insights into their perspectives on the relationship between the social prescribing approach and existing healthcare and community-based services. Participant 7 summarised this relationship as being:

> *"It compliments other things so it's not that it's you know, the fix all for everything, but it's going to compliment the GP's, it's going to compliment the occupational therapists you know, so it's kind of, it's part of the puzzle. It's not going to solve everything, but it's part of it."*

Most participants commented on the ever-evolving nature of the social prescribing approach and how it is constantly finding different ways to support pre-existing services. Again, Participant 7 summarised the general sentiment:

> *"It's evolving constantly, and I think that's the beauty of it as well. And we're in a really good time that we get to kind of mould it to be as well. And so yeah, it's exciting."*

There was a strong opinion from Participants 4 and 5, that the social prescribing approach should be seen as on a level with other approaches to supporting people's health and well-

being. When speaking about the different dimensions of ill-health, Participant 5 suggested that the social element should be considered in the same manner that the physical, psychological and spiritual dimensions are considered.

"It's absolutely either a third or fourth friend of the healing … but it could be number one with certain illnesses."

While Participant 4 added:

"One thing that I was very adamant about at the beginning, was that it wouldn't be looked at as this kind of fluffy add-on service that was kind of out there and really, what does it do?"

While widely acknowledged amongst participants to not be a substitute for acute, primary or tertiary healthcare services, participants acknowledged that the social prescribing approach is a low-cost way of supporting people's health, when compared with healthcare services. Participant 1 explained why:

"I mean the government positive is a really cheap way of dealing without trying to reduce mental health issues and health issues in general, I mean extremely cheap. There's no doubt about that because not only is our rate of pay low, but also the things referring them to are basically voluntary."

4.8.2 Practical Understanding

Participants reported that the relationship with existing services has been hampered by the differences that exist between different services using a social prescribing approach currently. Service difference stemming from a lack of general understanding and awareness, from those who are not already directly involved in services, has made it more difficult to gain universal buy-in from the general public, funders and particularly healthcare professionals. Participant 3 said:

"I just feel that the term social prescribing is building an identity and people are starting to notice and so there is for me personally, I suppose there has been an element of confusion or maybe a lack of clarity in some contexts for me am where you have to kind of go all around the villages trying to explain what this is, what it is, but this is what we're calling us so yeah."

While Participant 6 added:

> *"It's been really difficult to connect with the primary care teams and obviously because of covid, they're really busy with other things, and I think anyway it would've been difficult and that just didn't help."*

While the onset of Covid-19 was identified as an additional barrier to forming links with healthcare services, participants spoke of oblivion, lack of buy-in, fear and mistrust on behalf of many healthcare professionals about social prescribing. Participant 4 explained:

> *"The clinical/nonclinical seems to be a real fear, especially from the healthcare professionals and um, the fear of having part of their job taken away from them or possibly losing funding."*

Participant 4 was able to however, present an optimistic future for those who resist embracing the social prescribing approach:

> *"I'd just like to say that the individuals with the greatest resistance have become the champions for social prescribing in our area ... they're the ones banging on my door saying we need this here and we need this there."*

4.9 Service User Profile

4.9.1 Theoretical Understanding

No specific inclusion or exclusion criteria for service users was outlined by participants however, certain characteristics associated with the service users using the service currently were identified. Loneliness and isolation were reported as extremely prevalent amongst users of the current HWCR service, with Participant 1 having this to say about the services users she is engaging with:

> *"I've come across much more people who are ok but lonely, just lonely, where something in their life you know, relationships have broken up or, am a mild learning disability or an immigrant to the country who just never settled in."*

Participant 4 added to this point explaining how in her opinion, services adopting a social prescribing approach should be available for anyone, but always need to remember particularly, the most vulnerable in society:

> *"It [social prescribing approach] should always focus on our most vulnerable and our most isolated and as a mechanism to support those individuals, who for various reasons cannot connect with either you know GP's, Primary or Secondary healthcare services, their wider community."*

The need for some level of personal volition to engage with the link worker was emphasised by most participants, with Participant 3 providing this explanation:

> *"But you need the person to be a willing participant, so you know a lot of that is trying to encourage the referral sources to identify people who are willing, but they don't feel like they're being sent somewhere as a punitive measure."*

Finally, while social prescribing was described as a service for all, participants emphasised that SP is not an alternative or replacement for healthcare service. Participant 1 explained how certain service users may need to be linked in with healthcare services instead of community-based supports if they such supports were more appropriate.

> *"Like we're not trained and not qualified to deal with issues of suicide for example, like we all have done basic and suicide awareness training, but you know, basic so like as far as I'm concerned, if somebody has suicide ideations, then it's my role to link them in with the services and not seeing me as being the services to help with that."*

4.9.2 Practical Understanding

There was general agreement amongst participants regarding the service user profile both in theory and practice. One practical consideration brought up by Participants 1 and 2 related to how the social prescribing approach can expand its supports to meet more multi-dimensional health and well-being needs. Participant 2 explained the following:

> *"Social prescribing and even the health and well-being at the moment is mainly focused towards, um, well people, or people with mental health issues. No one has actually thought about, um, people that might have physical or cognitive issues, or even accessing some of the locations because of their mobility issues could be said, the physical limitations of people, or the sensory limitations of people using a wheelchair, having a stroke, having aphasia, um could all be a barrier for people to access social prescribing, unless we look at how we're going to address that."*

Finally, there appeared to be a contrast of opinions amongst participants as to where service users feel more comfortable linking with services to do with their health. While most participants suggested that community-based non-clinical settings were where service-users felt most comfortable, the legitimacy that people universally have with particularly their local GP was also mentioned. Participant 7 reported:

> *"People also have a lot more trust within I think the community and voluntary sector, than the clinical, and so it's easier to build a relationship."*

While on the contrary, Participant 5 explained:

> *"You know everyone has legitimacy with the GP, you can be going there, and you can go there unjudged by society no matter what your malady is."*

4.10 Service Provider Roles

4.10.1 Theoretical Understanding

All participants were given the opportunity to speak about what they perceive to be as their role in providing services using a social prescribing approach. Participants 1,3,6 spoke about their role as a link worker in linking people with community-based services to promote health and well-being. Participant 3 explained:

> *"The big thing was that I, I wasn't the provider of the services, I was the bridge, hence the link worker and I was linking people to and signposting, they were the main things."*

Participant 6 described the role as having three central components being meeting with and supporting service users to link in with community-based services. The second being to asset map the local services available in the area and the third (which was reportedly emphasised from a funding perspective), was to link in with local primary care services including GP's. While particularly difficult in the context of Covid-19, participants reported they were adapting to achieve the first two components, however Participants 1 and 6 reported difficulties linking in with healthcare professionals. Flexibility was identified as a significant positive of the role, particularly in relation to meeting individual support needs and overcoming the practical barriers of Covid-19 impacting services and difficulties in forming links with healthcare services. Participant 3 added:

> *"I think that's the beauty of the job and that I feel it's still being faithful to social prescribing, but just using it to suit the time that were in"*

Participant 5 spoke about his role in the social prescribing approach as a healthcare professional which included being an access point for the service, being tuned into the fact there's a social dimension to healing and hence legitimizing this social healing.

> *"I suppose our role would be in am making it easy for patients to partake, because we are a funny group [GP's] in that, it's legitimate for everyone to come to us"* and going on to say; *"we can receive the patient and channel them."*

Even though her organization is not involved with a formal social prescribing service currently, Participant 8 spoke about her role as a placement officer in this organization. This role appeared to be quite similar to that described of the link worker, in other services using a formal social prescribing approach.

> *"A Placement Officer is a person who supports both organizations, non-profit organizations and volunteers, and we are kind of a link between both. So when I meet a volunteer wanting to do some volunteer work, we go through their experience, needs, interests, everything, and I try to find the suitable role for the person and organization."*

Particularly, in relation to their informal application of the social prescribing approach, Participant 8 had this to add regarding why some service users are referred to them.

> *"Sometimes it's for well-being and mental health, sometimes for work experience am so there are different reasons."*

Participants 2,4 and 7 who are predominantly involved in service implementation at a regional and national level, reported that their roles primarily include applying for, administering and sustaining funding, overseeing the direction of services and their evaluations, linking with stakeholders and supporting the local services.

4.10.2 Practical understanding

An interesting finding from the interviews was the reported difficulties that link workers can have in sticking to their roles. Factors such as Covid-19 impacting services, difficulties in forming links with healthcare services and feeling an expectation to fill unmet gaps in current services were identified by participants. To overcome this however, Participant 3 explained:

> *"It's about always bringing it back to what's my purpose?"*

Another practical finding was the importance of healthcare professionals as an access point for the service. Healthcare professionals were seen by all participants as important for identifying potential service users and as a way to increase awareness amongst the general public of this approach to support health and well-being. Participant 6 reported:

> *"I think that is actually the true essence of social prescribing and I think it would be brilliant to be actually, ... to be directly linked into the healthcare [services]."*

Participants identified practical ways of supporting their different roles into the future. The link worker's peer support network was identified as an existing facilitator of their role however, other ideas for supports were also suggested. These included the development of a context specific training module for link workers, awareness training for healthcare professionals and community-based services, the appointment of regional coordinators for services and links with

healthcare services and CSO's to be forged at a higher up level rather than at the level of the link worker. The commonality between all of the above suggestions and the key barrier identified to the long-term success of the social prescribing approach was sustainable funding. Participant 2 explained its central importance:

> *"Precarious funding means that people are not as invested in the program, so it might go away, so why would they refer to something that might go away. And that's like the influence of the funding and the system, on the outcomes of the program."*

4.11 Referral Pathway

4.11.1 Theoretical Understanding

Participants reported that in the HWCR service both formal referrals (from healthcare professionals) and informal referrals (including self and family referrals) are accepted by the service. Participant 3 reported to having good buy-in from some local GP's particularly however, she sighted geographic location as an influencing factor in this regard:

> *"Well say somebody working in a more rural area [area name anonymised], you know they don't have the infrastructure on the ground ... like well say, the road I'm based on, there's about 20 doctors on that road."*

As previously mentioned, healthcare professional buy-in was acknowledged by participants as very important as an access point for services using a social prescribing approach. Both Participant 1 and 6 however, while recognising the importance of referrals from healthcare professionals, reported great difficulty forming a link with local GP and primary care services. Due to difficulties establishing links with healthcare professionals, Participants 1 reported that to date, most referrals have been informal.

> *"I've got no GP referrals at all. I think that ive got 38 people either on the books or closed cases and the vast majority of them are either self-referrals or family referrals, like a son for a mother, a mother for a daughter."*

With participant 6 adding that she believes informal referrals are better than formal ones and probably keep closer in line with the person-centred ethos of the service:

> *"I'd prefer people will just ring themselves, self-referral ... most of the time I say [to the potential referrer], why don't you give them my number and ask them to contact me themselves, and I just think that's better again. I think that is really the beginning of the relationship, is the person themselves ringing me and choosing to access my service."*

Again, the flexibility of being able to use both was seen as a significant positive by participants and a point of variation to other approaches. Participant 2 added:

"Here, in Ireland it's technically slightly different, so people can self-refer, people can be referred by a professional therapist, community development workers."

Considering the desire to target the most vulnerable in society, the flexibility of being able to use both formal and informal referral pathways was seen as a positive to link workers.

4.11.2 Practical Understanding

The impact of covid-19 on link workers forming connections with healthcare professionals and to spread understanding and awareness of the service was reported. Participant 1 explained:

"I had just secured a slot to speak at a clinical meeting in a health centre we have here in [area name anonymised] where lots of GP practices are based, and it was literally the week covid broke and that was called off as well."

Several participants identified inappropriate or poor-quality referrals as a barrier to overcome for services using a social prescribing approach. Poor quality referrals were seen to have two potential threats to the service. Firstly, Participant 1 provided an example of healthcare professionals using the service as a dumping ground for 'difficult' service users:

"You could get a referral where somebody says you know this is, this is Dermot. Dermot's, an addict. He's an alcoholic. He has mental health issues, um, can you come up with ways for him to distract himself, to keep him away from drugs and alcohol? You know, going if I knew that I could, like I could change the world, you know you're reading the referral going what like where, how did they even write it you know?"

More worryingly, participant 5 provided an example of where inappropriate referrals could be at the significant detriment of the service user:

"If somebody is sitting in a DIY group or at a crochet group who's actually clinically depressed and is feeling more inadequate, then you know it could be quite disadvantageous and detrimental, so we should, in the same way that we should we get constant reminders about our inappropriate prescribing we should, we should not send the wrong patient, and as I inferred already because we're busy."

In terms of facilitators, the involvement of a diverse range of stakeholders was seen as a particular positive for the overall process, with Participant 4 expressing this point:

"I suppose the multiple key stakeholders is important because everybody can bring something to the table when that needs to be done."

4.12 Conclusion

The interviews conducted generated interesting and thought-provoking findings. Participants explained their understandings of the social prescribing approach and identified key components to the approach, with differences existing between the theoretical understanding and practical application of some of the key components. A good level of common understanding of the approach was found to exist amongst those interviewed, however it was suggested that understandings of the social prescribing approach would likely vary outside of this specific service. A general lack of awareness of the concept was moreover identified as a current barrier to practice. Participants identified that this approach should not be seen as either an add-on or a replacement for healthcare services, but instead should be seen as complimentary. Finally, the importance of relationships was emphasised by participants including relationships with service users, relationships with funders and stakeholders, relationships with healthcare professionals and relationships with civil society organisations, to ensure this linking service can operate to its full potential.

Chapter 5: Discussion

5.1 Introduction

The thesis of this paper was that the lack of a solid theoretical base, clear guidelines and rigorous evidence base for the social prescribing approach, particularly in the Irish context, are currently restricting its potential to be comprehensively evaluated, and that without such evidence it is unlikely to receive sufficient sustainable funding. Ultimately, adequate and sustainable funding are central to the success of any service and considering the current absence of a theoretical foundation or strong evidence base for the social prescribing approach, this study aimed to explore understandings of the social prescribing approach in Ireland, amongst stakeholder groups involved in services using a social prescribing approach. It is however, important to highlight at this stage that the Health and Wellbeing Community Referral (HWCR) service that participants from this study were part of, were newly established at the time of data collection (about six to eight months previous). The onset of the COVID-19 pandemic about two months into their operation, was moreover a monumental obstacle to face so early in the development of a new service and hence was reported to be a significant factor in their services to date.

In this chapter, the findings of this study will be discussed and analysed. The first section will examine the findings in relation to understanding the social prescribing approach, including both the participant reported key components and the current theoretical differences that are impacting practice. The second section will discuss new insights on the social prescribing approach as located in a new space between the healthcare and community sectors while the final section will discuss the importance of working together in order to ensure that the social prescribing approach can be a widespread success.

5.2 Understanding the Social Prescribing approach

The findings of this study offer a fresh insider perspective into understandings of the social prescribing approach amongst those involved in both the formal (HWCR) and informal application of this approach in the Cork Kerry Community Healthcare area. Participants provided an overview both of what they understand the approach to be (both theoretically and practically), as well as the key components that they felt are the true essence of the social prescribing approach. The findings of this study however have demonstrated that differences

in theoretical understandings can impact the implementation of this approach on a practical level.

5.2.1 Defining the Approach and Key Components

The understandings of the social prescribing approach reported by participants in this study, as a non-clinical, formalized linking service to support people's health and well-being through community engagement, has been well documented in literature (Bickerdike, et al., 2017; Chatterjee et al., 2018). While subtle differences in understandings were reported to exist amongst those working in the HWCR service (often based on professional background), it was found that generally, understanding of the social prescribing approach was mutual amongst participants. Key components to the social prescribing approach, particularly in the HWCR service, were reported and included fostering person-centredness, flexibility, a holistic perspective, a community focus, the social dimension of well-being and a relationship-based approach, components that have previously been identified through literature (Bickerdike, et al., 2017; Chatterjee et al., 2018; Elston et al., 2019; Pescheny, Pappas, & Randhawa, 2018). Service link workers were moreover highlighted as being particularly key to the success of the HWCR service, something that has similarly been identified in other studies on services using a social prescribing approach (Elston et al., 2019). Specific models of practice were not identified by participants, however, the social prescribing approach was seen by participants to have a variety of potential applications including as both a preventative measure from ill-health and as a transitional measure to potentially support the continuity of care from the healthcare system to the community. The idea of the social prescribing approach as being a cost saving preventative measure for the healthcare systems has been well frequently suggested in literature (Health Service Executive, 2015), but to date there has been sparse discussion in about the potential for this approach as a transitional service, an area that deserves further exploration going forward.

A key finding from this study was that the participants from the HWCR service viewed the social prescribing approach as a society wide approach to support health and well-being. The adoption of a society wide perspective by the HWCR service is linked to the source of its funding through Healthy Ireland and Sláintecare and the new emphasis on integrated care approaches underscoring Irish health policy (Houses of the Oireachtas, 2017). While examples from the United Kingdom have highlighted the importance of many of the key components listed above, to date many studies have framed the social prescribing approach as more of a

support for GP's and Primary Care professionals to meet the social needs of service users, rather than a completely new approach to how health and well-being is supported in the community (Keenaghan, Sweeney & McGowan, 2012). The perspective amongst those working in the HWCR service is that this service is not a 'fluffy add-on' or an alternative to the healthcare services, but instead should be seen as part of the puzzle to support people's health and well-being in a more appropriate setting, in their local communities. This specific perspective has not yet been widely discussed in literature on the social prescribing approach. Considering the more expansive definitions of the concept of health, societies now hold (World Health Organisation Europe, 2013; 2014), as well as the number of people who are socially isolated due to health limiting conditions or disabilities, but would not consider themselves 'sick', adopting a society-wide approach in social prescribing services would seem particularly appropriate to best meet population health needs.

Participants outlined the profile of the service users whom they are most frequently seeing in the HWCR service, and moreover, reported that the social prescribing approach has potential to be of benefit to anyone who needs increased support for the social dimension of their health and well-being. Participants in this study identified individuals who are lonely and isolated, as particularly appropriate service users for services using a social prescribing approach. There is growing evidence to support the link between loneliness and social isolation with ill-health across all of the dimensions of health (e.g. physical, psychological, social, etc.), (Ward, Layte & Kenny, 2019). A recent publication by The Irish Longitudinal Study on Ageing (TILDA) highlighted that older and more vulnerable cohorts of the population are at particular risk of being at the intersection of these conditions, i.e. being lonely and experience ill-health on some level (Ward et al., 2020). This study, moreover, reported that the COVID-19 pandemic has amplified the pre-existing difficulties encountered by this population group. Both the TILDA study and participants in this research project emphasised that the COVID-19 pandemic has shed new light on the importance of the social dimension of health, which has been so greatly affected for those vulnerable cohorts who engaged in 'cocooning' during the pandemic. While people who are lonely and socially isolated have not always been the specific target population of other services using a social prescribing approach, because of the increased likelihood of an intersectionality of condition between loneliness or social isolation and physical or mental ill-health (particularly for older people and individuals from lower socio-economic backgrounds (Ward, Layte & Kenny, 2019), it is likely that many studies to date have generally targeted services towards the same population group.

The findings of this study have identified some key elements to the roles of those involved in providing services using a social prescribing approach. The link worker role was identified as being central to social prescribing approaches, and was consistently reported by participants to be focused on linking people in with civil society organisations (CSO's), and not to be the provider of groups and services. It was reported that on a practical level this could be quite challenging for the link workers, to avoid the pressure and temptation to fill gaps or provide groups based on service user needs. The healthcare professional's role was identified primarily as being an access point to services using a social prescribing approach, for potential service users. To date the role of the healthcare professional in services using a social prescribing approach has not been widely examined in published literature, and hence would benefit from further exploration in the future. Similarly, while CSO's play a very important role as being the receivers of those availing of the linking service, there is limited evidence available that discusses specifically the role of CSO's as part of formalized social prescribing services. Findings from this study suggest that CSO's are expected to be the providers of these community-based services to support population health and well-being. This study also found that CSO's have potential to be a substantial support for services using a social prescribing approach and moreover link workers, as the area experience, knowledgeable employees, established services and networks which many CSO's have developed over the years are available to be used by potential service users. Finally, participants of this study reported that it is the role of those in positions of management/service implementation to continue to work on and develop supports for services such as training for staff and to increase awareness, organising the governance structure, forge stakeholder links, completed evaluations and secure sustainable funding sources. It was beyond the scope of this study to critically examine the governance structures of the social prescribing approach and should be examined further.

5.2.2 Differences in Theory, Impacting Practice

Participants in this study reported that currently differences in theoretical understandings of the social prescribing approach are impacting implementation on a practical level. While there was general mutual understanding amongst those involved in the HWCR service, participants reported that they are aware that services using the social prescribing approach in the UK and other parts of the Ireland are significantly different to this one, and potentially due to differing theoretical understandings. Service differences in different geographical areas were reported by participants to be linked to their sources of their funding. While it is beyond the scope of

this study to comment on other formalized services using a social prescribing approach beyond the HWCR service, link workers particularly, spoke about how significant differences between the HWCR service and others outside the Cork Kerry Community Healthcare area made it more difficult to link with, network and learn from other longer established services. They moreover mentioned how they felt that these differences had added to the workload in setting up the HWCR services, as owing to the differing theoretical underpinnings they were starting from scratch.

A significant area of contention is around language and the naming of services using a social prescribing approach. The formalized service using a social prescribing approach examined in this study was the HWCR service, which has been named so after service user consultation. This name appears to fit well also with the key components identified by participants for services using a social prescribing approach. The issue identified however is that this is not the most well-established term to describe this approach, social prescribing is. Literature has identified that currently many different names are being given to names adopting this approach, possibly similarly, to move away from the perceived medical connotations of the word prescribing (Kilgarriff-Foster & O'Cathain, 2015; Pescheny, Pappas, & Randhawa, 2018). The issues with this however, is the difficulty it creates for developing a universal awareness of the approach amongst the general public, healthcare professionals and CSO's. There have already been reportedly significant difficulties for link workers in the HWCR service in getting GP and healthcare professional buy-in to the approach, a lot of which they feel is due to a real lack of awareness. While the social prescribing approach is itself not a healthcare service, the importance of close links with existing healthcare services as an access point to avail of it, has been highlighted both in this study and in literature (White, Cornish & Kerr, 2017). From a funding perspective, differences in names of services will create difficulties for evaluation, and reduced universality of understanding could make it less of a priority for funders and governments.

General Practitioners and healthcare professionals have a central role in being an access point for services using a social prescribing approach and because of this, their understandings of approach are key to informing the referral they send. While in the HWCR service informal referrals are also accepted, literature suggests that this is not an option in many other services (Health Service Executive, 2015). Link workers who participated in this study reported that the ability to demonstrate that the HWCR service is reducing the burden on primary healthcare

services was emphasised to them from an evaluative perspective. Hence, receipt of referrals from healthcare professionals was seen as very important. While the area of HCP specific understandings of the SP is yet to be properly examined in literature, a potential issue identified for the formalizing of the link between the healthcare sector and CSO's is the potential for inappropriate or 'poor-quality' referrals. A lack of clear understanding of the purpose of the social prescribing approach and who would benefit from it amongst healthcare professionals could be a risk for the approach. Referrals for individuals who require healthcare services or medical intervention could be a significant challenge for link workers and moreover could be dangerous for service users who may not receive the appropriate supports that they require. Participants suggested that service users could feel fobbed off or invalidated by healthcare professionals who do not properly explain why they are referring them to a local social prescribing service. A component of actual fobbing off of service users was also seen to have potential to happen, a trend which could quickly overburden the social prescribing services, certainly with their current level of resources.

Working to develop an even stronger understanding of the link worker role amongst link workers themselves could be of significant benefit to the service. Ensuring clarity of understanding for service link workers to empower them to identify the limits of their role is important for many reasons including to support them to identify inappropriate referrals for the service as mentioned above and also to ensure that link workers don't get pressured into trying to fill gaps in services that go beyond the realm of their role, i.e. providing services instead of being the link. Participants in this study suggested that considering the differences in theoretical understandings that exist between services in different areas currently that a context specific link worker training module should be developed. They similarly suggested that an awareness and understanding module of the approach for healthcare professionals and CSO's could be developed which would similarly support the link worker role through greater general understanding. If developed such a module could be a beneficial continuous professional development (CPD) activity particularly to healthcare professionals who need to engage with regular CPD activities to maintain their professional registration status. Clear understanding of the approach and the link worker role is essential, particularly to enable to flexible approach to practice.

While adopting a flexible approach was identified by participants as being particularly important to the successful implementation of the social prescribing approach, clear guidelines

around how services using a social prescribing approach in Ireland will operate are required to ensure that the 'just right' challenge is achieved. Implementing a flexible approach against the backdrop of differing theoretical understandings and an absence of clear guidelines, or a framework to outline the parameters of the social prescribing approach makes it likely that quite fundamentally different services claiming to use a social prescribing approach will emerge. While in an ideal world outside of resource limitations this might not be an issue, a certain level of standardisation between services will be required to expand the greater awareness of this approach and to attain adequate sustainable funding for it moving forward. In Ireland, there has been a recent push away from rigid and centralised health policies, towards a more flexible and integrated approach which appears to be a progressive step, however a balance must be struck to ensure that services are serving the purpose for which they are set out to do.

5.3 Forging a New Space

The formalizing of the link between the healthcare system and CSO's, known as the social prescribing approach, is acknowledged to be a new space for supporting people's health and well-being. There are inevitably going to be many discussions regarding where exactly between the healthcare system and civil society, this service should position itself in Ireland. In the United Kingdom where the social prescribing approach was established, it is known to generally locate itself quite close to the healthcare system, often within GP services and outreaching to the community (Kimberlee, Ward, Jones, & Powell, 2014), where it could be viewed as a healthcare outreach modality to address the underlying social causes of ill-health. In the HWCR service in question, a significantly different process has been taken to applying the social prescribing approach, whereby the focus is to locate service link workers in the community and link back to the healthcare services to get referrals. There is now a real challenge for advocates for this approach to provide guidance on where such services should be located moving forward.

The positioning of services is intrinsically linked to the fundamental underpinnings of what the purpose of the social prescribing approach actually is, and what it aims to achieve. If the purpose of this approach is to provide a non-clinical, community-based, person-centred, holistic and flexible service that adopts a society-wide approach to supporting population health and well-being, (key components identified by participants in this study), then the positioning of these services in the community would appear to be the most appropriate option.

If the purpose of this approach however, is to reduce pressure on the healthcare system by redirecting certain service users to CSO's, well then it may be most appropriate to position services within the healthcare setting in order to screen service-users for appropriateness and re-direct to the social prescribing service as appropriate. To be able to establish a true unique identity, the social prescribing approach probably needs to adopt either one of these two options as its number one priority. There may already be a branching of approaches happening in practice, with one model reaching out from the healthcare services, and one model reaching back in to healthcare services from the community. For an approach that is at such an infant stage of its development however, having two models of practice that significantly differ theoretically could be a significant barrier to increasing awareness and lobbying for adequate, sustainable funding for the service.

It is interesting to consider however, that the basing of services using a social prescribing approach within GP practices has already identified benefits for collaborative working and particularly receiving referrals from healthcare professionals (Farenden, Mitchell, Feast, & Verdinicci, 2015; Friedli, Themessl Huber, & Butchart, 2012; Kimberlee, Ward, Jones, & Powell, 2014). While the HWCR service is in a very early stage of its implementation, establishing links with, and receiving referrals from healthcare professionals has reportedly proven particularly challenging for link workers. What is known is that the number of referrals received, (particularly from healthcare professionals), is being linked to the evaluative criteria for service funding. While at the outset of this project, the student researcher had suspicions as to whether the social prescribing approach was a façade to the expansion of the biomedical model into civil society, it is maybe more likely that neoliberal practices such as quantification and professionalisation are driving this link between service usage and funding (Deleuze, 1992). Locating services using a social prescribing within healthcare settings may instead be a means to increase the likelihood of receiving funding, rather than a cynical approach to medicalise society. Further theoretical exploration however, is required to shed further light on this debate.

Participants in this study strongly emphasised that this approach should not be seen as either a fluffy add-on to, or a replacement for healthcare services. They reported that it is a complimentary approach to existing services that exists to add to the puzzle of supporting population health and wellbeing, rather than be a cheap alternative or way of fobbing off 'challenging' service users. If the social prescribing approach is going to be used to manage

scarce resources in healthcare services, it will struggle to improve supports for population health and wellbeing. Approaches such as integrated care or social prescribing are not an alternative to investment in services (World Health Organisation, 2008). A substantial part of the issue with the Irish healthcare system currently is its' under resourced and sparse community and primary care services, hence, the social prescribing approach cannot be seen as a silver bullet for the ails of the healthcare service (Drinkwater, Wildman, & Moffatt, 2019; Skivington et al., 2018).

A recent example worth considering that demonstrates system change is not an alternative to investment in services is the attempted roll out of the Integrated Primary Care services in Ireland since the early 2000's. The roll out of these services followed an integrated care approach that mirrors many of the intentions of the social prescribing approach. While initially (like the social prescribing approach), the roll out of Integrated Primary Care was seen as a panacea for the ails of the Irish healthcare system, it has not yet had its desired impact on improving population health and well-being in their local communities, nor has it made significant progress regarding its roll out. Almost 20 years later, by 2019 only 36% of the intended Primary Care centres had actually been delivered, with significant variations in the quality and scope of the services provided (McCarthy, 2019). The challenges of aligning standards, maintaining adequate resourcing, incentivising care providers to get involved and attaining GP buy-in were significant barriers (O'Connor, 2013) that are relatable to the roll out of the social prescribing approach also. While it was intended to be a free service available to anyone, overtime co-payments developed for certain Primary Care services (O'Connor, 2013). Even with Primary Care services that were properly set up with full engagement from all stakeholders involved, one Irish College of General Practitioners study (2011) found that 64% of GP's felt that the team functioned poorly. Furthermore, even successfully functioning teams eventually began to struggle, as reduced funding and embargos on recruitment started to create long community waiting lists (O'Connor, 2013). The purpose of this example is not lobby against the roll out of such integrated approaches to supporting population health and wellbeing, but instead emphasise that such approaches can only survive with adequate and secure resourcing. The term "dynamic without change", has been used to describe the Irish healthcare system (Dukelow & Considine, p. 226, 2017), with Burke et al. (2016) remarking that constant change in the Irish system means that no plan is given enough time or resources to become successfully embedded in practice. Challenges in adequately supporting population health and wellbeing will not be solved by moving the 'problem' somewhere else.

5.4 Ní neart go cur le chéile (There is no strength without unity)

The enthusiasm and positivity regarding the social prescribing approach demonstrated by all participants was inspirational and moreover, heartening for the approach's future. Participants referred to a feeling of, *'we're all in this together'*, when it came to linking in with other support services, be they healthcare or civil society organisations, particularly during COVID-19. There appears however, to be an element of apprehension and uncertainty between workers from a healthcare background and workers from a community-based background, both of whom are centrally involved in providing services using the social prescribing approach.

In this study, the answers given by participants from different professional backgrounds, did not particularly suggest that difference in understanding was caused by whether someone came from the community and voluntary sector or a healthcare background. There was in fact a good level of mutual understanding between participants, regardless of background. What did appear to exist however, was a level of scepticism between both sides towards each other. It was said of healthcare workers, that a reason for their resistance to embracing the service was fear, a fear losing components of their role or their funding because of new social prescribing services. It also appeared to be implied that services using a social prescribing approach are different to healthcare services as they are person-centred, holistic minded, consider the social approach and not looking for quick fixes. While it may not always appear so in practice, as a healthcare professional I know that in theory most healthcare professions similarly hold these values to their very core, however due to factors such as growing demands on healthcare services, funding and resource shortages, staff shortages, gaps in services and so on, a balance must often be struck between meeting service user and service needs. This reflection mirrors the findings of a study by White, Cornish and Kerr (2017) in their study that explored the working relations of different groups involved in providing a social prescribing service in west Scotland. In this study, a lack of trust existed between the two groups also, particularly held by the healthcare workers towards link workers and community-voluntary groups, as they feared for their own liability and accountability. A similar level of mutual understanding of the approach being taken was reported to exist amongst participants in the Scottish study, demonstrating the importance developing relationships and understandings of each other, as well as the social prescribing approach.

Considering the fantastic intentions of almost of all of those who work in healthcare, the community and voluntary sector and everywhere in between to improve the lives of others, it would be a shame to focus on negatives. The social prescribing approach does appear to have fantastic potential to support population health and well-being and be of significant support to healthcare workers to ensure the continuity of support out of the healthcare service. To further strengthen the idea of a society wide approach, (and since many social services are already provided by CSO's in Ireland instead of the state), the inclusion of more CSO's at steering group level to strengthen the formalizing of the links between different sectors should be considered. While again considering the infancy of the approach, it is likely this is already happening. At the recent launch of the 'Evaluability Assessment for Social Prescribing' (2020), Dr. Micheal Dixon, (chair of the College of Medicine and an NHS champion for social prescribing in England) spoke about creating a tapestry for the social prescribing approach. In his speech, Dr. Dixon described an approach whereby the service link worker is the base unit with a range of supports around them including the healthcare service workers, CSO's, community development workers and even potentially a new role of a volunteer facilitator who would work to identify volunteer opportunities and appropriately place the right volunteers in these roles. This approach creates a vivid image of what the future of the social prescribing approach could hold with a stronger and more trusting link up of the different services involved.

5.5 Conclusion

This chapter has documented the understandings of the social prescribing approach amongst participants in this study, and how their understanding compares with current evidence on the subject. It has moreover contextualised these understandings against the backdrop of some of the challenges that the roll out of the social prescribing approach currently faces including lack of awareness, differences in theoretical understandings, the difficulties of forging a new space between the healthcare service and CSO's and building relationships with existing services.

Chapter 6: Recommendations and Conclusion

6.1 Introduction

This research project used a community-based research approach in collaboration with the Cork Volunteer Centre to explore understandings of the social prescribing approach in Ireland, amongst stakeholder groups involved in services using a social prescribing approach. A qualitative method was used, and eight consenting participants engaged in individual semi-structured exploratory interviews using the online video application Zoom. The findings of this study provided an insight into the Health and Wellbeing Community Referral (HWCR) service that uses a social prescribing approach in the Cork Kerry area. Seven themes which each included two subthemes were identified which have added to the understanding of the social prescribing approach from those who are involved in the HWCR service.

This research has been successful in achieving the aim and answering the research questions it set out examine. It has explored understanding amongst stakeholders involved in providing services using a social prescribing approach in Ireland and highlighted key components of the approach. It has provided a new perspective on the roles of different service providers in services using a social prescribing approach and has suggested that differences in understanding of the social prescribing approach are likely more linked to the funding source of the service, rather than the professional backgrounds of those working in it. An additional finding that this study has shed light on, is the structural organisation and layout of one particular service using a social prescribing approach, the HWCR service. Finally, this study has demonstrated that there is a unanimous perceived need amongst stakeholders providing these services for services using the social prescribing approach in Ireland.

6.2 Recommendations

6.2.1 General Recommendations

There is a real need for the social prescribing approach to be extensively theorised and in the Irish context, for national guidelines for the role out of services and practice to be established. Identifying clearly where this approach is best located on the continuum between the conventional healthcare service and the community and voluntary sector would significantly benefit the universal roll-out of services and clarify who is most appropriate to get involved. Levels of awareness and understanding of the approach amongst the general population must

be increased, however this will likely require national guidelines to be established before any national advertising campaign could be launched.

There is a real need all involved to work together and establish close professional relationships on a service provision level. Considering the purpose of this approach is to provide a 'linking' service, the links between different stakeholder groups providing services, must be stronger to meet this purpose. A diversification of community-based stakeholders with experience in different areas to support the social element of health and wellbeing would benefit the social prescribing approach. The well-established community networks, experience and expertise of such stakeholders could be a valuable resource for this very new approach to providing services. It must not be forgotten moreover that if successful, this approach will significantly increase the demand for community and voluntary services, so they too need to be properly supported and resourced to potentially meet this need. Efforts to create strong links with healthcare professionals and general practitioners must be shifted to a higher, management or service provider level.

No matter what potential there is for any service or approach to make a positive impact, adequate and secure funding is required to provide that service. Services operating using a social prescribing approach, and their link workers, cannot exist on short-term rolling contracts. Longer term commitment is needed to fund services using a social prescribing approach as well as the community and voluntary sector services providing the activities and supports.

6.2.2 Recommendations for Researchers

More rigorous research is needed from different perspectives to really understand what social prescribing is, what it can do, what it can become, who should be involved and who will benefit from this new approach to improving population health and wellbeing. Mechanisms for exploring, understanding and evaluating practice need to be in-built into services using a social prescribing approach and resourced appropriately to develop an appropriate evidence base to prove its effectiveness. Community-based and participatory research approaches could be particularly appropriate for developing such an evidence base in this context as service users and service providers can work together to produce new knowledge on the subject area.

6.2.3 Recommendations for Service Providers of the Social Prescribing Approach

While this piece highlights shortcomings with current theory and practice regarding social prescribing, it has not been written with the intention of criticising this emerging approach to improving health and well-being. Hence, it should not serve to discourage people who are already employed by or engaged with services using a social prescribing approach. This paper instead encourages such workers to continue the good work being undertaken, to maintain accurate and consistent records of work completed, to seek feedback from service users on their experiences of engaging with social prescribing, to take part in research opportunities as they emerge and to engage in reflective practice. It is only those who are utilising and providing social prescribing services on a daily basis who can truly feedback ways in which social prescribing services can develop and be improved for the betterment of societal health and well-being generally.

6.2.4 Recommendations for Policy Makers

While policy-making decisions are complex and multi-faceted, it is of utmost importance that such decisions are made primarily with the intention of improving people's lives, which includes enhancing population health and well-being. The framework and aims defined by the Health Ireland Plan 2013-2025 and the Sláintecare report are ambitious, but attainable, if successive governments commit to the systematic development and adequate resourcing of healthcare services, and adopting a whole-of-society approach to population health and well-being in Ireland in line with the recommendations of the original report. The social prescribing approach undoubtedly has strong potential to contribute to achieving these aims, however its implementation on a policy level has to be informed by rigorous research and defined by clear guidelines that can at least act as a framework as to how local services can best develop. Finally adequate and sustainable funding must be committed to these services to facilitate, firstly, their complete setup and secondly to allow them to fulfil their potential and allow the Irish population and the Irish Healthcare system to experience the full extent of what this approach can offer.

6.2.5 Recommendations for the Cork Volunteer Centre

Volunteer activities have been identified in literature as commonly used by services implementing a social prescribing approach. Further exploration needs to be done into the potential for a volunteer facilitator role working as part of services using this approach to compliment the workings of the service link worker. Given the services they provide and their

experience in the area, CVC appear well-positioned to take on an increased role in the provision of formalized services using a social prescribing approach in the Cork, i.e. the Health and Wellbeing Community Referral service.

6.3 Conclusion

Services using a social prescribing approach have potential to support population health and wellbeing and to reduce the pressure on the healthcare system in Ireland. These services will not succeed however, if adequate and sustainable funding is not committed. It is hence important that clear national guidelines are developed to ensure a level of consistency between services that will allow them to be accurately evaluated, to develop the bank of evidence supporting the efficacy of this approach for population health and well-being.

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Invitation to participate in study on:

Social Prescribing / Community Referral

- Do you work with a community/voluntary group in an area where social prescribing is happening?
- Are you a link worker on a social prescribing scheme?
- Are you a healthcare worker forwarding people to a local social prescribing scheme?
- Were you involved in the design/set up of a social prescribing service?

If one of these applies to you, we would love to hear from you.

If you would like further information on this study, please contact:

Dermot O Callaghan at 114326506@umail.ucc.ie.

Thank you for taking the time to read this poster.

Study Supervisor: Dr. Eluska Fernandez, School of Applied Social Studies, University College Cork.

Appendix B – Study Information Sheet

Information Sheet for Participants

Study Aim: *"To explore the understandings of Social Prescribing in Ireland amongst stakeholder groups involved in social prescribing"*

To whom it may concern,
You are invited to partake in a research study. Before you decide whether or not you wish to take part in the study, it is important for you to understand why and how the research is being done. Please take time to read the following information carefully.

What is the study about?
This study aims to explore understandings of social prescribing from those currently involved in social prescribing/community referral services.

Who can participate?
We are looking to speak to **anyone** who is involved in using and/or providing social prescribing/community referral services, particularly anyone who is a link worker, healthcare professional, community/voluntary service worker, steering group member.

What will the study involve?
Participation in this study will involve participation in one short online video interview (30-45mins) with one the student interviewer via the Zoom application. This interview will be audio recorded and saved on a password protected laptop for data transcribing purposes. All information gathered will be anonymised and stored confidentially.

What time commitment would be involved?
The time commitment involved would primarily include participation in the short online video interview which is envisaged to take 30-45 minutes. Some brief email communication before the interview (to ensure informed consent) and after the interview (to ensure that data is transcribed and analysed accurately) may similarly be required.

Who can I contact for further information?
If you are interested in taking part in this study and would like further information, I would welcome you to contact me, Dermot O Callaghan, at 114326506@umail.ucc.ie.

Thank You for taking the time to read this Information Sheet.

Study Supervisor: Dr. Eluska Fernandez, School of Applied Social Studies, University College Cork.

Appendix C – Study Informed Consent Sheet

Consent Form for Interview

Study Aim: *"To explore the understandings of Social Prescribing in Ireland amongst stakeholder groups involved in social prescribing"*

	Yes	No
I understand what this study is about.		
The study was clearly explained to me and I have read the information sheet.		
I understand the time commitment involved with participation.		
I know that I can leave the study at any time if I want to, prior to completion of the final report.		
I know that my name will not be used in the findings.		
I understand that any record of my interview will be stored in a secure location and kept anonymous.		
I want to participate in this study.		

I _____ want to be a part of this study.

_____   _____

Signature of Participant   Date

For further information please contact Dermot O Callaghan at 114326506@umail.ucc.ie. Thank you.

Study Supervisor: Dr. Eluska Fernandez, School of Applied Social Studies, University College Cork.

Appendix D – Interview Guide

1. Have you completed and returned the informed consent sheet?

2. Could you please briefly outline your role and how it relates to social prescribing?

3. What do you understand social prescribing to be?

4. What do you see as your role in the social prescribing process?

5. Do you think that there are differences in understanding of social prescribing amongst the different groups involved?

6. Do you see a need for social prescribing in Ireland?

7. What do you see as the positives and negatives to social prescribing in Ireland?

What do you see as the barriers and facilitators to social prescribing in Ireland