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HEALTHY COMMUNITIES PROJECT: IMPACT EVALUATION REPORT

OCTOBER 2021 - JANUARY 2023

HSE | hi Healthy Ireland | Rialtas Áitiúil Éireann Local Government Ireland | Dublin North East Inner City | Sláintecare. Healthy Communities | An Roinn Sláinte Department of Health | Dublin City Community Co-op

Final Report

Healthy Communities Programme:

Impact Evaluation Report

October 2021 - January 2023

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Acknowledgements

This report details the implementation of the Healthy Communities Programme in the Dublin North East Inner City (NEIC) from the conception of the project to its current status. The project was developed by the Health and Wellbeing division of the Health and Social Executive (HSE) Dublin North City and County and has been led and implemented by the Dublin City Community Cooperative ("the Co-op"), with guidance and funding from partners. These partners include the North East Inner City Initiative, the Health Service Executive (HSE), Healthy Ireland, Local Government and the Sláintecare Healthy Communities. Research support and project evaluation have been provided by the Think-Tank for Action on Social Change (TASC).

The authors would like to thank everyone who has contributed to this evaluation, in particular the clients and staff of the Co-op for generously giving their time and telling their stories.

At TASC, thanks are due to Dr. Adeelia Goffe, Dr. Gerry Mitchell, Dr. Shana Cohen, Faizan Ali, Maria Pachowicz, John White, Sally Brophy, Louisa Mackenzie and Sylvia Byrne. Dr. Emily Murphy is thanked for her early work on this project.

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Abstract

The North East Inner City (NEIC) has a population of 46,123 and experiences higher levels of need than the wider Dublin city area and the country nationally. Almost 16% of people living in the NEIC experience high levels of socioeconomic deprivation (NEIC, 2021), with pockets of poverty and social exclusion. In 2017, the Mulvey report focused on the social and economic challenges faced by the NEIC. It also outlined potential strategies for regeneration and brought together key stakeholders (statutory, community & voluntary sector) from the area.

In 2020, the HSE Health and Wellbeing division in Dublin North City and County were asked to develop a proposal that would improve the health and wellbeing of the population in the NEIC. The project proposed was based on learning from a number of well-established projects with a focus on community health work and social prescribing. It also incorporated existing evidence-based initiatives. The programme represented a new multifaceted place-based way of working to reduce health inequalities in a community experiencing disadvantage.

The Dublin Inner City Community Co-operative Society Limited (the Co-op) was successful in the tender process in August 2020 to set up and deliver the agreed programme of work.

The NEIC Healthy Communities Programme delivered by the Co-op then became aligned to the National Sláintecare Healthy Communities model in 2021. The goal of the Healthy Communities Programme in the NEIC is to tackle health inequalities. This is achieved through the delivery of targeted evidence-based initiatives such as social prescribing, Healthy Food Made Easy, We Can Quit, stress management programmes, Health Literacy and Smoke Free Homes.

Research was commissioned by the HSE and completed by TASC in 2021 and the NEIC Programme Implementation Board agreed to fund continuous research into 2022. This research focuses on two parts:

1. Evaluate the impact of the Healthy Communities Team on the effectiveness of the delivery of the programme.
2. Continued evaluation of the overall Healthy Communities Programme on participants.

The research involves a mixed methods approach including qualitative interviews, focus groups and self-reflections from stakeholders and quantitative data from programme management software and pre- and post- course questionnaires.

The findings from this report demonstrate a strong sense of teamwork and partnership both internally (e.g. within the Healthy Communities Programme team) and externally (between the Co-op, HSE and Department of Health). They also highlight the positive impact of the local community health team in supporting the implementation of and participation in the suite of programmes delivered.

This evaluation both validates the approach that has been taken in the NEIC Healthy Communities Programme and provides a framework to build on the progress to date in tackling health inequalities in the NEIC.

Foreword

We are delighted to present the Evaluation of the Sláintecare Healthy Communities Programme for the North East Inner City (NEIC). This evaluation assesses the implementation of the Healthy Communities programme in NEIC, examining the impact of the Healthy Communities Team on programme delivery and the influence of programmes (Social Prescribing, Healthy Food Made Easy, Wellbeing & Stress Management and Health Literacy) on participants.

The Healthy Communities project has an explicit goal to help the NEIC community to live longer, healthier and more fulfilling lives. It works towards this goal by addressing inequalities in health status for people experiencing poverty and social exclusion in the NEIC. These health inequalities derive from the social determinants of health, which include the conditions in which people are born, grow, live and work.

Health and Wellbeing CHO DNCC were tasked in 2020 to develop a proposal that would improve the health and wellbeing of the population in the NEIC. The project proposed was based on learning from a number of well-established projects with a focus on Community Health Work and Social Prescribing. It also incorporated existing evidence based healthy eating, smoking cessation, health literacy and positive mental health programmes and initiatives. The project was in line with the NEIC strategic plan 2020-2022 which has an objective to promote inclusion health for socially excluded groups experiencing severe health inequalities. For the first year, the project was co-funded by the NEIC and the Department of Health as representing a multifaceted, place-based and community- led way of working to reduce health inequalities and to promote social regeneration.

In 2021, the Department of Health, working with the HSE and local authorities and community agencies, established the Sláintecare Healthy Communities Programme to provide health and wellbeing services in 19 disadvantaged areas across Ireland. The NEIC Healthy Communities project was subsequently aligned with and funded under the Sláintecare Healthy Communities programme. The mainstreaming of this pilot project is in keeping with the strategic approach of the NEIC initiative.

Improving community health requires collaborative, intersectoral work and community capacity building. A key strength of this model lies in the commitment of the Healthy

Communities team, ensuring the project's vision and aims are actively pursued. One of the unique features of the NEIC programme is the role of the community health workers where local people are employed and trained to provide health and wellbeing peer support, signposting and deliver programmes in their community. Through their hard work and local insight they have started to address the needs of those in the NEIC community.

The developments, achievements, and positive outcomes detailed herein result from the collective efforts of the dedicated Healthy Communities team, working in collaboration with partners across the community, HSE staff, and the local authority to address health inequalities. We recognise the work of TASC in completing this extensive piece of research. The insights gained from this evaluation will guide the ongoing development of the project and will be shared with other Sláintecare Healthy Communities initiatives.

We wish to thank all those who have contributed to the delivery of the successful outcomes outlined within this report including the HSE Health Promotion and Improvement team and who have provided local on the ground support at every stage of the project. We would like to acknowledge the support of the NEIC Programme Office (in particular the former coordinator Michael O'Riordan), the Oversight Group and the NEIC programme implementation board in co-funding the project in year one and funding the research in year two.

A special thank you to the dedicated and hardworking Healthy Communities team and the Dublin City Community Co-Op without whom the successful implementation outlined in this report would not have been possible.

Ellen O'Dea
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Health Service Executive

Jim Walsh
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Member NEIC Programme
Implementation Board

Foreword

During summer 2020, the Co-op responded to a call for tenders for a Healthy Communities Programme in the NEIC of Dublin. At the time, we felt such a project would complement our existing portfolio of work, in particular our community development and social inclusion activities funded under the national Social Inclusion and Community Activation Programme (SICAP).

As a cooperative structure with 13-member community development organisations all deeply embedded in their local communities and neighbourhoods, we know and understand first-hand the health, social, economic, environmental and cultural inequalities that exist across Dublin's inner city.

Discussions and conversations on health inequalities and the social determinants of health are commonplace within the Co-op. So, when an opportunity to apply for funding to tackle health inequality arose it was one we couldn't let pass.

It is nearly three years since we drafted our proposal and hit the 'submit' button. It is difficult to imagine life before the Healthy Communities Programme, such has been the impact of the funding, the activities and the Healthy Communities staff on the Co-op and, more importantly, on the people of the NEIC.

This comprehensive and detailed independent evaluation of the Healthy Communities Programme, jointly commissioned by the Co-op and the HSE and funded by the NEIC Initiative, validates the decision to invest in community health and wellbeing in Dublin's inner city.

The evaluation, carried out by TASC, provides evidence that well thought out investments, properly resourced, appropriately staffed and correctly targeted, where the need is the greatest, will have the desired impact.

The Healthy Communities Programme in the NEIC has been a success and this independent evaluation testifies to that fact. For its success to continue the project's funding must continue. Confirmed multi-annual funding would go a long way in this regard.

I wish to thank TASC for the work, time and effort it has put into the evaluation as well as their collegiality and professionalism throughout the process.

One of the defining features of the Healthy Communities Programme has been the incredible partnership between the Co-op's Healthy Communities Programme and HSE staff. I do not hesitate in saying that the way in which the Co-op and HSE staff interact and support each other on this project has been a critical factor in its success. It is a way of working that should be replicated.

And finally, as CEO, I wish to acknowledge the wonderful, dedicated and committed staff of the Healthy Communities Programme, without whom none of this would ever have been possible. The Programme started in the depths of a COVID-19 lockdown, but the team, all newly hired, never let such matters distract them. Sleeves were rolled up and they simply got on with it. We are very proud and honoured to have them as colleagues.

Noel Wardick
Chief Executive Officer (CEO)
Dublin City Community Co-operative

List of Abbreviations

CEO	Chief Executive Officer
Co-op	Dublin City Community Co-operative
CSO	Central Statistics Office
DOH	Department of Health
GDPR	General Data Protection Regulation
HSE	Health Service Executive
MYCaW	Measure Yourself Concerns and Wellbeing
NEIC	North East Inner City
NHS	National Health Service
Smoke Free Homes	Smoke Free Homes
SICAP	Social Inclusion and Community Activation Programme
SWEMWBS	Short Warwick- Edinburgh Mental Wellbeing Scale
TASC	Think-tank for Action on Social Change
We Can Quit	We Can Quit
WHO	World Health Organisation
WHO-5	5-item World Health Organisation Wellbeing Index

Programme Partners

Table 1. List and details of project partners

Partner	Relationship
Dublin City Community Co-operative (Co-op)	Delivery partner for Sláintecare Healthy Communities Programme.
Think-tank for Action on Social Change (TASC)	TASC is an independent think-tank whose mission is to address inequality and sustain democracy by translating analysis into action. A research partner for the Co-op Healthy Communities Programme, TASC is increasingly expanding its work in health inequalities, creating a new stream in 2023.
North East Inner City (NEIC) Initiative	Working to implement the 2020-2022 North East Inner City Strategic Action Plan and the actions of the Mulvey Report (2017) to help make the area a safe, attractive and vibrant living and working environment for the community and its families with opportunities for all to lead full lives.
Health Service Executive (HSE)	Provides public health and social services within the area. Developed the original proposal for the Healthy Communities Programme. Focused on meeting the needs of the population in order to reduce health inequalities.
Department of Health (DOH) & Healthy Ireland	Provided funding through NEIC Sub Group 5 to implement a sustainable healthy communities model.
Local Government Ireland	Provided seed funding through NEIC Subgroup 5 to implement a sustainable healthy communities model.

Sláintecare Healthy Communities	The Sláintecare Healthy Communities Programme was launched in 2021. It provides health and wellbeing services and community development initiatives in community areas across Ireland where health inequalities are most evident. Sláintecare Healthy Communities is designed to bring about real, measurable change and is based on an understanding of the determinants of health and evidenced-based health and wellbeing programmes. Whilst the local authority's role in Sláintecare Healthy Communities is to examine the wider determinants of health, for the HSE, the investment in health service initiatives is focused on the implementation of an enhanced health and wellbeing programme to improve the health outcomes of people living within the 20 Sláintecare Healthy Communities Areas. These initiatives will be delivered through partnership working with a range of partners (HSE, local authorities and community groups) to provide dedicated services to build lasting improvements in health and wellbeing.

Key findings

Please find below a summary of the strengths and challenges identified during the evaluation of the Healthy Communities Programme:

1) Programme strengths

a) *A positive impact on the NEIC community:*

- Providing a constant presence in the community and strengthening community action.
    - The community health workers (CHWs) are accessible to NEIC residents. For example, they carry out home visits. During COVID-19, they delivered ingredient packs to participants on the Healthy Food Made Easy course, which enabled them to share information on the doorstep about the wider support available from the Healthy Communities Programme.
    - They engage residents by delivering leaflets on the streets several times a year.

- Enabling and empowering community members with information and resources to make informed decisions to improve their health.
    - Promotion of primary health interventions (e.g. screening, prevention and vaccination programmes).
    - Facilitating community coffee mornings, using them as opportunities to build relationships with residents and become the point of contact for further information.
    - Developing the local community through peer-led programmes, such as facilitating the Healthy Food Made Easy course.
    - Offering a wide range of courses to 527 participants, including harder to reach groups (see Appendix 14)
    - Increasing social connectedness of community members and organisations to work on shared goals.
    - Individual roles complement each other in a team that is able to provide appropriate support for clients.

- Community health workers can be an effective means of reaching out to disadvantaged communities and improving health outcomes.
- Encouraging participation by listening to and responding to the needs of the community and innovating.
- Developing partnerships and the value of intersectoral work, creating strong relationships with all stakeholders, which form the foundations for successful implementation for the overall Healthy Communities Programme in the NEIC.

b) *Building supportive relationships with participants*

- Creating supportive environments that encourage sustainable behaviour changes.
  - Supporting residents to access programmes and services that result in reduced numbers living in isolation, and increasing confidence, for example, the social prescribing course.
  - Delivering services bespoke to each participant, making and maintaining contact with potential participants on the courses.
  - Engagement can be life changing for participants.
  - Developing positive working relationships with healthcare providers who make referrals to the Social Prescribing programme.
  - Increasing community presence between 2021 and 2022.

c) *Contributing to participants increased wellbeing by:*

- Reducing isolation and expanding social networks.
- Developing personal skills and improving self-confidence.
  - Developing healthier habits: (e.g. Healthy Food Made Easy course reported outcomes included eating more fruits and vegetables, spending less on food and increased energy.)
  - Improving physical and mental health By introducing self-help techniques, which are then transferred to the community.
  - Supporting access to improved housing.

d) *Recruiting and managing an effective team*

- Carefully recruited, people with lived experience and appropriate skills.
  - Training is ongoing and builds capacity.

- Active care and support of staff, as in the Co-op's Employee Assist Programme, adopted in 2021 based on staff suggestions and supported by management.

e) *Externally collaborating with a wide network of organisations*

- Regular and timely communication among all stakeholders fosters positive and productive relationships.
- Developing and disseminating good practice with partners and stakeholders.

2) Healthy Communities Programme challenges:

a) *Challenging client groups*

- Barriers to participation, including knowledge of opportunities, legal status, concerns about stigma, health related and mobility issues.
- Wide ranging age distribution (social prescribing participants range from 19 to 95 years old).
- 44% of enrolled social prescribing participants with a registered disability had completed the programme as of December 2022.
- 12.8% of those who completed the social prescribing programme were carers (compared to 4.8% of those enrolled).
- 17.9% of those who completed the social prescribing programme live with their partner/spouse, compared to 9.7% of those enrolled. 22.1% of those enrolled and 25.6% of those who completed the programme live alone.
- Large number of referrals, but a relatively small number of people who have completed the social prescribing programme.
- Delivering services is time intensive, skilled and challenging:
    - Between 2021 and 2022, the Healthy Communities Programme entered 1200 conversations with participants into the Elemental database
    - 145 participants were registered, of which 39 completed the programme.
- Social prescribing link workers mark participants as 'completed' in the Elemental software when they have either 1) engaged in meaningful activity 2) have had their needs met 3) have been referred on or 4) are no longer participants 5) other. There is no specific end date. Completing can therefore look different for different participants. Please see Table 2 for more detail.

- It is important to emphasise the value of the Healthy Communities Social Prescribing programme for residents. This means if the interaction within the course are brief and are not always completed they have often developed relationships and built trust, through multiple interactions whereby they may be receiving supports from another provider as a result of these interactions.

b) *Staff challenges include:*

- Heavy workloads.
- Constraints working with clients due to sharing premises with other staff.

c) *Data challenges include:*

- Elemental software underestimates the number of contacts (or attempts) that the Healthy Communities Programme staff has with their clients.
- Data are automatically calculated so it is not possible to see the number of contacts per individual participant.

d) Physical environment challenges

- Constraints on creating safe and welcoming spaces for residents.
- Lack of dedicated office space.
- Lack of private space in the office to meet with social prescribing participants, local community stakeholders or guests.

1.0 Introduction

1.1 Report aims

This report aims to build on research and findings from 2021 and action research during 2022 to:

1. Evaluate the impact of the Healthy Communities team on the effectiveness of the delivery of the programme.
2. Continue evaluation of the overall Healthy Communities Programme (and it's programmes: social prescribing, Healthy Food Made Easy, Healthy Food Made Easy Cool Dudes, Wellbeing & Stress Management, Health Literacy suite of three courses (i.e. Health and Community Professionals, Well Now and Mind Yourself! Men's Health, We Can Quit and Smoke Free Homes) on participants.

The research itself involved a mixed methods approach including qualitative interviews, focus groups and self-reflections from stakeholders, quantitative data from programme management software and pre- and post- course questionnaires.

1.2 Background

1.2.1 The social determinants of health

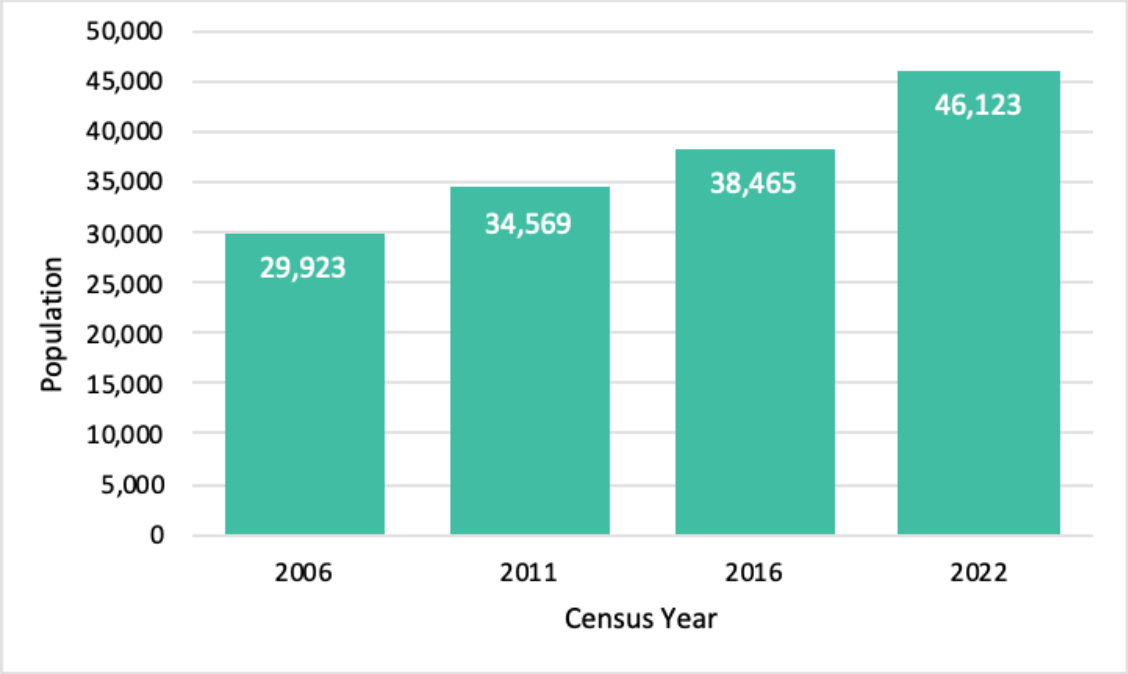
The social determinants of health are the non-medical factors that influence health outcomes. These are the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life. Good physical and mental health are key to an individual's wellbeing and quality of life. A variety of factors influence such health conditions. The World Health Organisation (WHO) notes that:

> *The social conditions in which people live powerfully influence their chances to be healthy. Indeed, factors such as poverty, food insecurity, social exclusion and discrimination, poor housing, unhealthy early childhood conditions and low*

occupational status are important determinants of most diseases, deaths, and health inequalities between and within countries (WHO, 2004).

The Healthy Ireland Strategic Action Plan 2021-2025 (Department of Health [DOH], 2021) placed a greater emphasis on promoting a healthy Ireland amongst disadvantaged and harder to reach communities. The NEIC population is 46,123 (City Population, 2022) and has been increasing steadily over the past few years (Figure 1).

Figure 1. Population increase in North-East Inner City Dublin



Source: City Population, 2006-2022.

Both the Trutz Haase (2009) and the Mulvey (2017) reports highlight the heterogeneity and shifting demographics of the NEIC region. In particular, the mosaic nature of the landscape, with intermixing of highly deprived and affluent areas.

The Mulvey (2017) report focuses on the social and economic challenges faced by the NEIC and outlines potential strategies for its regeneration. This is the most recently published description of NEIC residents providing information on the resident population as of the 2011 Central Statistics Office (CSO) census. Information from this report is cited as the basis for many initiatives in the NEIC. Mulvey (2017) highlights the following characteristics:

- A higher than average density compared to other areas in Dublin, with 14,000 people.

- A relatively young population, with a higher proportion of people under the age of 25 compared to the national average.
- A diverse ethnic and national composition with increasing numbers of EU and non-EU nationals arriving to the area, settling alongside white Irish nationals.
- High levels of socioeconomic deprivation, with pockets of poverty and social exclusion; one third of the small areas in the NEIC are classified as disadvantaged/very disadvantaged; male unemployment levels at two to three times the national average. Unemployment, educational attainment and housing conditions are some of the issues that need to be addressed.
- A mix of housing types, including social housing, private rented accommodation, and some owner-occupied houses. Issues include inadequate housing, substandard conditions, and a lack of affordable options.
- Some areas with 80% single parent households, where ~50% of the population have a primary education and less than 5% with third level education; other areas with very low levels of single parent households, with tertiary education over double the national average of 31%.

1.2.2 Sláintecare Healthy Communities

Sláintecare Healthy Communities is a cross-government initiative to deliver increased health and wellbeing services to 19 community areas across Ireland—of which, the NEIC is the 20th. A partnership approach is taken, engaging local authorities and local community groups to support the reduction of health inequalities in their areas through empowering individuals and communities to make healthier lifestyle choices to improve their overall physical and mental health and wellbeing.

As in other countries, there is a strong link between poverty, socioeconomic status and health in Ireland. Data on demographics and health status indicate that 22.5% of the population is exposed to disadvantage and the prevalence of chronic illness (e.g. stroke, coronary heart disease and diabetes) is nearly two times higher in more deprived areas (Health Service Executive [HSE], 2019).

Since this programme started, the DOH has commissioned healthy communities in 20 Social Inclusion and Community Activation Programme (SICAP) areas.[1] In 2021, three Sláintecare Healthy Communities areas were identified for CHO Dublin North City and County: Ballymun, Finglas South/Cabra North and Darndale, which are aligned to two SICAP areas. In 2023, the NEIC has aligned with these Sláintecare Healthy Communities. The aim of the Sláintecare Healthy Communities Programme was to identify specific areas in which high risk factors to the health and wellbeing of the population were particularly prevalent due to deprivation, with a view to implementing targeted initiatives to tackle these challenges from within these communities.

The NEIC Healthy Communities Programme was initiated prior to the model for area based initiatives being developed. While there are commonalities, differences between the programmes may have implications for the sustainability and future development of an area-based Healthy Communities Programme within the NEIC.

It must be noted that there are individual differences in the approaches used among the different Sláintecare Healthy Communities areas. The majority use an individualised approach, with social prescribing link workers serving community members and courses provided through outsourcing facilitators. In contrast, the Healthy Communities Programme based at the Co-op uses a team-based model consisting of a project coordinator, Social Prescribing Link Workers, and Community health workers. The team is embedded within the community and includes peers with lived experience.

Funding for the project is provided under Sláintecare with the HSE. Regular governance and oversight meetings are chaired by the Head of Service for Health & Wellbeing. Attendance at these meetings includes Dublin City Coop, representatives from the DOH, NEIC Primary Care, and HSE's Health & Wellbeing division. Initially meetings were held monthly, but in 2023 as the project became more established this was changed to quarterly, during which key performance indicators are reviewed. As the project became aligned to Sláintecare Healthy Communities, they now also attend Sláintecare Healthy Communities local implementation team meetings for CHO Dublin North City and County.

1.2.3 The North East Inner City, Dublin

The NEIC is affected by a complex interplay of factors including an increasing population and pockets of affluence alongside areas of continued deprivation, and challenges around housing and employment. In addition, it has been and continues to be the site of large-

[1] In 2023, the Co-op HCP became the 20th.

scale accommodation and commercial developments, primarily around the eastern part of the area.

The NEIC covers the area just north of the River Liffey and is bordered by Drumcondra to the north, East Wall to the east, the River Liffey to the south, and Phibsborough to the west (Figure 2).

Figure 2. North-East Inner City map

Source: Dublin NEIC Maps, ESRI

The Mulvey Report (2017) set out a range of actions to tackle the long-term social and economic regeneration of the area, with the following priorities:

1. Crime and drugs
2. Education, training and employment opportunities
3. Services for families and young people
4. Physical improvements.

The NEIC Strategic Action Plan 2020-2022 (NEIC, 2019) was developed to ensure the recommendations contained in the Mulvey report (2017) were delivered in a planned, monitored and evaluated fashion, ensuring sustainability. Priority actions include:

1. Enhancing policing services and promoting engagement between An Garda Síochána and the local community,
2. Maximising educational, training and employment opportunities,
3. Improving family youth wellbeing,
4. Enhancing community wellbeing and the physical environment,
5. Reducing substance use, misuse and promoting inclusion health,
6. Integrating and aligning delivery of cross-agency services to better serve the needs of the community

Lastly, the Healthy Ireland Framework (2019-2025) underpins much of the inter-sectoral and interdisciplinary approach used by the Co-op. It is the national cross-governmental and cross-sectoral structured approach to improved health and wellbeing and has four main goals:

1. Increase the proportion of people who are healthy at all stages of life.
2. Reduce health inequalities.
3. Protect the public from threats to health and wellbeing.
4. Create an environment where every individual and sector of society can play their part in achieving a healthy Ireland.

1.2.4 Dublin City Co-op

The Co-op was established in 2014. An alliance of thirteen community development organisations throughout Dublin's inner city that have grouped together to develop and deliver social, economic and cultural services to the communities in which they are based.

The Co-op delivers the Healthy Communities Programme in the NEIC of Dublin, its geographic boundaries extend from Drumcondra Road/Dorset Street/Bolton Street and Arran Street East to Dublin Bay and the Liffey. By 2019, an estimated 46,000 people lived in NEIC. Over twenty years, its population has increased by 78% (Inner City Organisations Network, 2019). The Mulvey Report (2017) describes it as extremely diverse, including individuals with varying socioeconomic status, and from various backgrounds, nationalities, cultures and communities.

Dublin City Council (DCC) has recently described the NEIC as having "a history of socio-economic deprivation" (DCC, 2023, chapter 13, para. 1). Approximately 16% of the population is identified as being disadvantaged or very disadvantaged[2], with some parts of the NEIC having comparatively high levels of single parent households and low proportions of third-level education (NEIC, 2021). Historically, the area has been a draw for new communities with large numbers of migrants moving into the centrally located neighbourhood (Mulvey, 2017).

This trend has continued with recent increases in the numbers of International Protection Applicants[3] and Beneficiaries of Temporary Protection[4] being placed in temporary accommodation by the Department of Children, Equality, Disability, Integration, and Youth (Grennan, 2023). In addition to refugee accommodation, the NEIC also hosts a number of services providing temporary accommodation to those experiencing homelessness (e.g. Depaul) and those in need of substance abuse support (e.g. Ana Liffey Drug Project).

A recent Healthy Ireland Survey shows the prevalence of high risk behaviours, including smoking. In the general population, 18% or respondents identified themselves as smokers, with 14% of the population reporting smoking on a daily basis. More in-depth studies indicate that smoking as well as other high risk activities (e.g. substance abuse) is more prevalent in disadvantaged groups (South et al., 2022).

The Healthy Communities Programme has selected staff to work with the diverse backgrounds and perspectives of NEIC. The number has varied over the last few years. Currently, there is one project coordinator, one full-time community health worker, two part-time CHWs and one full-time Social Prescribing Link Worker. All of whom are supported by the CEO and programme development, monitoring & evaluation coordinator.

[2] Deprivation is based on age, education level, household composition and employment status and other variables.

[3] International Protection Accommodation Service data available at: https://www.gov.ie/en/collection/90641-statistics/#2023.

[4] https://www.gov.ie/en/press-release/602b5-minister-for-justice-announces-extension-of-the-temporary-protection-permissions-granted-to-persons-fleeing-the-war-in-ukraine/#:~:text=To%20date%20some%2075%2C000%20people,renewed%2Fextended%20from%20March%202023.

1.3 The Community Health Programme in the NEIC

1.3.1 Funding and key project deliverables

Funding of €98,500 was provided by the DOH and an additional €98,500 was provided by the NEIC Initiative, Subgroup 5 - Substance Use, Misuse and Inclusion Health[5] to implement a sustainable healthy communities model. The project goal has been to support the NEIC community to develop and promote more positive health behaviours, improve Health Literacy, develop social supports and increase uptake of screening and immunisation services. These goals were chosen to have a long-term impact, to improve the health and reduce health inequalities experienced by the NEIC community.

The Co-op was successful in the tender process in August 2020 and chosen to set up and deliver the agreed programme of work. The programme was initiated on 1st December 2020 with initial funding for one year. It aims to tackle health inequalities in the NEIC by building the capacity of the community to address their health issues. This is achieved through integrating, collaborating and engaging with existing services, facilities and programmes in the area, as well as learning from well-established and researched projects around the country, including those where Community health workers are already in post and social prescribing activities taking place.

The following were specified in the 2021 Grant Aid Agreement between the Co-op and the HSE:

- employment of 1 x 1.0 Whole-Time Equivalent, Healthy Communities Programme Coordinator and 4 x 0.5 Whole-Time Equivalent (18.5 hrs per week), Social Prescribing Link Workers and Community health workers.
- providing training to local people so they can promote primary healthcare interventions

The Healthy Communities Programme works alongside the HSE to:

- develop and implement a model of social prescribing within the area with health and wellbeing, mental health and community stakeholders
- develop a training and capacity building plan for the Healthy Communities Programme staff

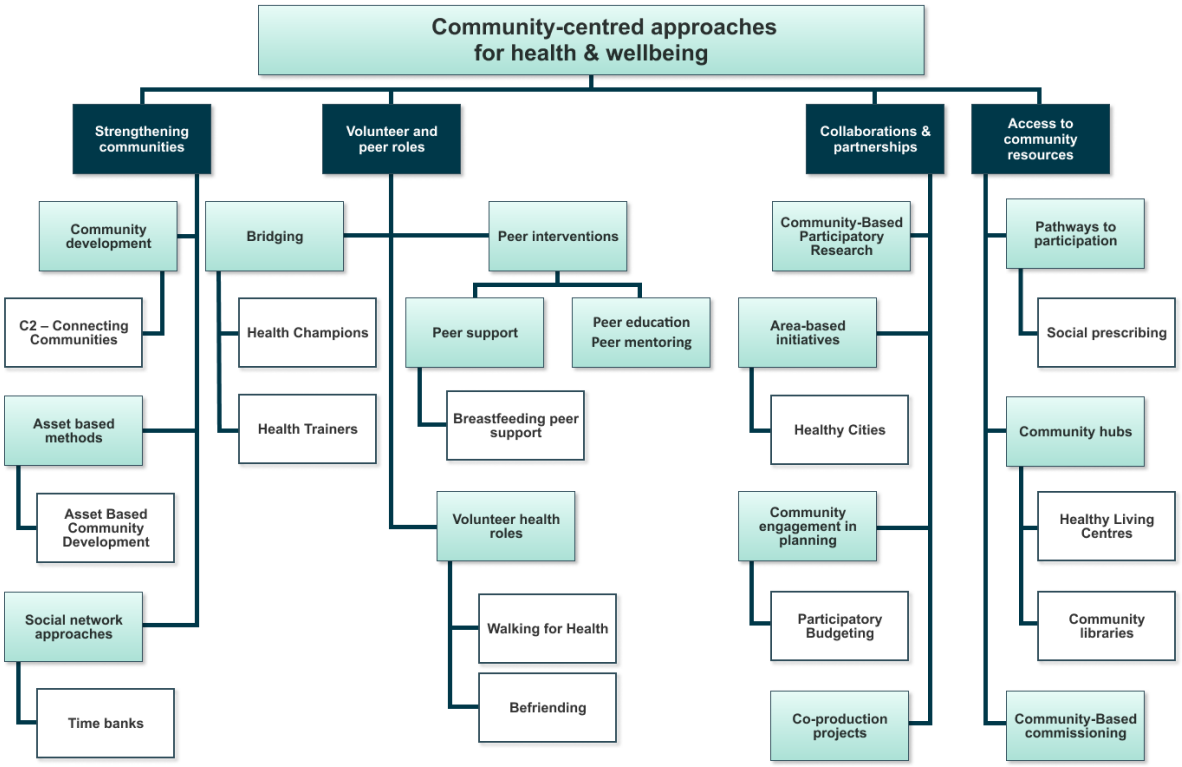
[5] NEIC Sub Group 5: Improve health outcomes for people who use and misuse drugs and alcohol; and promote inclusion health for socially excluded groups experiencing severe health inequalities.

- deliver specific programmes annually: 3 x stress management programmes, 8 x Healthy Food Made Easy courses and 4 x We Can Quit courses
- together with the National Adult Literacy Agency, provide Health Literacy training for health and social care workers in the community and community members and support toolkit implementation
- to support service uptake of the National Screening Programme and National Immunisation Programme
- apply an action research approach to project evaluation and outcome measurement, from which a full evaluation report will be submitted

A diverse range of community interventions, models and methods can be used to improve health and wellbeing or address the social determinants of health. The NEIC community health practice is rich and diverse, encompassing national programmes through to small local projects such as We Can Quit and Healthy Food Made Easy. This section introduces a 'family of community-centred approaches'.

An illustration from *A guide to community-centred approaches for health and wellbeing* (National Health Service [NHS], 2015) demonstrates some common options and identifies the mechanisms of change based on the core concepts of equity, control and social connectedness (Figure 3). The term 'community-centred' has been used rather than 'community-based' because these approaches draw on community assets, are non-clinical and go beyond using a community as a setting for health improvement. Community-centred approaches complement other types of interventions that focus more on individual care and behaviour change or on developing sustainable environments. The family analogy is used because there are many interconnections and relationships between the different approaches.

Figure 3. A UK NHS example of a family of community-centred approaches



Source: NHS (2015)

In late 2020, the Co-op secured funding from the HSE and the NEIC Sub Group 5 to deliver the Healthy Communities Programme, with staff starting in January 2021. Necessary staff included a project coordinator, Social Prescribing Link Worker, and Community health workers. Services provided to the community included the social prescribing programme, delivered from October 2021 to the present and included the following courses: Healthy Food Made Easy, We Can Quit, Wellbeing & Stress Management and Cool Dudes.

Under the development and successful implementation of the NEIC Healthy Communities Programme, Health Promotion and Improvement Officers support the partner's organisations through activities such as organising governance meetings, drafting the grant aid agreements and supporting Healthy Communities Programme staff. These officers build the capacity of the team through supporting initiatives with marketing and branding, developing sustainable partnerships for programme implementation, maintaining relationships with relevant statutory, non-governmental, community and voluntary organisations. The Health Promotion and Improvement Officers also assist with

any challenges that arise and ensure issues are dealt with in a timely manner. Evaluation of the programmes and reporting on the lessons from the interventions is also a key part of the role.

1.3.2 Implementation challenges

COVID-19 restrictions (2020-2022) and the HSE cyber-attack (2021) have posed challenges for implementation. In spite of this and to its credit, the Co-op has delivered the following:

- 1 x 1 Whole-Time Equivalent Healthy Communities Programme coordinator and 3 x 0.5 Whole-Time Equivalent Community health workers were recruited from the local community
- Induction and training has been delivered to community health workers so they can promote primary healthcare interventions such as access to vaccinations, screening services and prevention programmes
- Social prescribing has been set up and is currently being delivered through Summerhill Primary Care Centre
- Health Literacy for Lung Cancer, Women's cancer and general cancer in the form of three videos featuring Healthy Communities Programme Coordinator and two community health worker's worked with the HSE's Cancer Control Programme
- Health Literacy workshop for health professionals
- Vaccination hesitancy webinar – set up but had to be postponed due to cyber attack
- Due to upskilling of Healthy Communities Programme staff, in-house facilitation of programmes has been possible, allowing the Healthy Communities Programme to deliver more courses than anticipated as well as enhancing the capacity of the project to meet the needs of the community
- Action research conducted through healthcare staff, community organisations and interviews and focus groups with local residents
- Key performance indicators include programme delivery and attendance at programmes.

A strong partnership model underpins the work. Both mental health and primary care services support and refer to the Social Prescribing Link Worker and a social prescribing clinic was held twice weekly in Summerhill Primary Care Centre in 2022. Strong links have been made with local GPs and pharmacists. Please see Appendix 15 for a flow chart detailing the wide range of organisations that receive and make referrals onto the Healthy Communities Programme.

The foundation work in the induction programme has enabled the Programme Coordinator, the Social Prescribing Link Worker and community health workers to capacity build and connect local residents to the programmes and activities available.

2.0 Healthy Community Staffing

The advantages of including community health workers and using a community development approach as part of an area-based community model include:

- Capacity building by supporting local people who have an interest in health issues to become a resource within their local community.
- Developing capacity in the local community to reach out to individuals and families most at risk from health inequalities.
- Promoting participation in the community in activities which improve the health and wellbeing of the local community and supporting them to access services that address their health needs.
- Promoting primary healthcare interventions such as access to vaccinations, access to screening services and prevention programmes.

The learning to date is that the community health workers have needed very intensive induction and training but are developing broad skills and having increasing influence in promoting healthier lifestyles within their community.

2.1 Staff roles

There are three roles held by members of the Healthy Communities Programme team and some individuals have overlapping roles, which allow for staff resources to cover shifting workloads. The roles are as follows:

2.1.1 Programme Coordinator

They oversee the work conducted by the Healthy Communities Programme team, manage the project staff and also provide support and supervision to the health team, as well as sourcing training opportunities to further support the work of the project.

They also promote the work of the project at various events and conferences as well as sitting on health-related groups and committees.

2.1.2 Social Prescribing Link Worker

This role is outlined in the National Model of Social Prescribing.

They are responsible for working with individuals on a one-to-one basis to improve health and wellbeing by linking them with groups, organisations and activities in their community to support their mental and physical health and wellbeing and work as part of the Co-op's Healthy Communities Programme team. They also work in partnership with health professionals and the community and voluntary sector to create pathways for service users.

2.1.3 Community Health Worker

Their role is twofold: capacity building and health promotion. Capacity building in the local community is achieved by supporting local people who have an interest in health issues to become a resource within their local community and to reach out to those most at risk from health inequalities.

They also work to promote health for all residents through health awareness and education, training, and information sharing, including social prescribing. Part of this remit includes promotion of primary healthcare interventions (e.g. screening, prevention and vaccination programmes).

They work closely with members of the NEIC community and support individuals to access health and wellbeing services, thus promoting participation in the community in activities. This has a compound effect of improving the health and wellbeing of individuals in tandem with that of the local community.

They are also trained in facilitating courses which are offered to NEIC community members through the Healthy Communities Programme and deliver this programme to groups in the community (e.g. Healthy Food Made Easy).

They also facilitate the Healthy Communities Programme community coffee mornings and work to build relationships with residents of the area, so as to become a point of contact for further information where appropriate.

2.1.4 HSE Health Promotion & Improvement Officers

Under the development and successful implementation of the NEIC Healthy Communities Programme, HSE Health Promotion and Improvement Officers support the partner organisations through activities such as organising governance meetings, drafting the

grant aid agreements and supporting Healthy Communities Programme staff. The HSE Health Promotion and Improvement Officers aim to build capacity of the Healthy Communities Programme team through supporting initiatives with marketing and branding, developing sustainable partnerships for programme implementation, maintaining relationships with relevant statutory, non-governmental and community and voluntary organisations. The HSE Health Promotion and Improvement Officers also assist with any challenges that arise and ensure issues are dealt with in a timely manner. Evaluation of the programmes and reporting on the lessons from the interventions is also a key piece of the role.

2.1 Staff Profiles

Senior Manager and CEO

Noel Wardick is a senior manager and CEO with over 20 years' not-for-profit/civil society experience both in Ireland and overseas. He spent many years working in the international aid sector including seven years in the East and Horn of Africa. An experienced director, Noel has served on the board of Ireland's independent statutory agency, the Charities Regulator, as well as serving terms on the boards of Comhlámh and Transparency International Ireland, the anti-corruption organisation. Noel joined the Co-op as CEO in July 2015. Much of Noel's spare time is spent coaching hurling with his local GAA club in Clontarf.

Programme Development, Monitoring & Evaluation Coordinator

Siobhan Larkin works for the Co-op in the role of Programme Development, Monitoring, and Evaluation Coordinator. A significant focus of her work is on supporting the Co-op's portfolio of programmes and also overseeing the Integrated Reporting Information System, the reporting tool for SICAP.[6] Siobhan has worked in various adult education and community development settings for over 25 years both as a project coordinator and as a facilitator/trainer. She is interested in

[6] SICAP is a programme targeted at disadvantaged communities, aiming to improve their quality of life, reduce poverty, and promote social inclusion and equality.

the difference that wellbeing and creativity can make in empowering people and communities. Siobhan has previously won an AONTAS STAR[7] award for a creative personal development project she co-designed, developed and delivered.

Healthy Community Programme Coordinator

Catherine Heaney has been involved in community development for over 25 years, with 12 years before joining the Co-op specifically focused on community health as a Healthy Communities Programme Coordinator in South Dublin. Catherine has a BA Degree in Leadership and Community Development and trained in the Stanford University Patient Research Centre as a Master Trainer in Chronic Disease Self-Management as well as training in complementary approaches to trauma management. Catherine has also been a regular guest lecturer on the M.Sc. in Community Health in Trinity College Dublin on the role of community in chronic disease self-management.

> *I have been involved in the community sector for over 25 years and started as a young parent accessing courses at a local primary school's parents room. My personal journey has given me a real understanding of how difficult it can be to get involved in activities and the support someone might need to help them to do that. Also, as a result of coordinating and facilitating a chronic disease self-management programme, as well as my own personal experience, I have a deep understanding of the challenges someone has while living with a long-term chronic health condition.*

Social Prescribing Link Workers

Lorraine Tuohy has over 15 years' experience working in the voluntary and community sector in both day and residential services and is a qualified Community Reinforcement Approach Therapist. She has a diploma in Community Drugs and Alcohol Work with UCD and has worked supporting people in the area of addiction and recovery, and those

[7] AONTAS STAR Awards are awarded to education providers working in adult, community, and further education, for initiatives that support: Health and Wellbeing; Third-Level Access and Engagement; Social Inclusion; Global Citizenship Education; and the Learner Voice.

experiencing homelessness. Lorraine also worked as a Research Assistant and Social Prescribing Link Worker with the Royal College of Surgeons in Ireland.

> *My own personal journey and life experience is what brought me to the decision to work in an area that provides support and encouragement to people. This is something that I am extremely passionate about—self-efficacy and empowerment: a person realising that they are more than and can achieve more than they have been led to believe by others or their own self-talk has convinced them they can. I grew up in the area of NEIC where I now work, a disadvantaged area with lack of services, lack of solid education routes, addiction, unemployment, illness and loss. Having a lived understanding of how this disadvantage can impact on your life journey fuels my enthusiasm to support people to make positive changes however big or small they may appear and always the answer to my 'why' on difficult days in work. Even though 'team player' seems like a cliché it is a word I will use, although my role requires a huge amount of independent responsibility, I want to work with and contribute as much as I can to the Healthy Communities Programme team to be successful in providing real support to the community, the ongoing support provided by the Co-op and be a support to my colleagues in the work that we achieve together.*

Lewis Byrne is both a Social Prescribing Link Worker and community health worker. He received a Royal Life Saving Award as a trained lifeguard and is a recipient of a coveted Gaisce Award. As well as being a fluent Irish speaker, Lewis has represented Ireland at an International Mixed Martial Arts Federation competition and is involved in coaching young people at his sports club. Lewis has a deep understanding of the importance of community services that cater for our youth and is an avid advocate for the role of physical activity as a way to engage with people of all ages and abilities.

> *I also like to think an openness and conversational skill to a certain degree is important for this role and is something I believe helps me interact with service users more effectively.*

Community Health Workers

As a member of the new communities, **Maimuna Adams** is passionate about advocating for the health of the people in her community. Maimuna has a BSocSc in Social Policy and Sociology with University College Dublin and aims to use this knowledge as well as her personal experiences, to better support her community by promoting inclusion in community health activities and services.

I have learnt about the perspectives of locals on their disadvantages and diversities, and it got me thinking about having projects that meet the actual needs of the people rather than assuming what they need.

Charlene Dolan is a qualified Special Needs Assistant as well as holding a qualification in office administration and has volunteered for Barnardo's in their funding department on the donor marketing team. Charlene has also volunteered with the Big Scream Halloween Festival both assisting in coordinating activities and facilitating workshops with children and young people and volunteers in her own community organising events for families. Charlene is passionate about supporting people in the community to become engaged again in their area post-pandemic as well as encouraging residents to participate in activities that support their mental and physical health and wellbeing.

My personal attributes I bring to the health team would be how good I am at talking with and understanding people living in my community and I think living in the community all my life has helped me with that as I see the struggles people have and going on in their lives and can really relate to them.

2.2 Staff training

The Healthy Communities Programme staff have received a variety of certified, uncertified and in-house training since starting their roles. The induction training and the ongoing professional development training has brought the health team to a high standard. A significant amount of the training received by the community health workers in their first year was facilitated by the Healthy Communities Programme project

coordinator. This training included in-clinic shadowing and mentoring, with the aim for the community health workers to be able to work with clients. These courses are essential to their respective roles and complement qualifications received prior to joining the Co-op (a list of those is available in Appendix 11.)

One staff member suggested that they could not pick a training course which has most impacted their work because they felt that every training course they had attended was valuable and "will be used at some stage if not already". Another staff member stated that additional training opportunities would be the way to further support them.

Due to the nature of their work, training is an on-going process which is valued by the staff. As one staff member remarked:

> *Ongoing training is very important, however the training needs to be responsive to any situations which might arise. For example, we are conducting training in de-escalation techniques in aggressive situations as a result of a number of minor incidents which occurred this year.*
>
> *Also, more opportunities for newly trained members of the health team to put their new skills to practice while being supported by other experienced facilitators.*

Another staff member commented that their favourite training course was the Wellbeing & Recovery Action Plan, which they had completed for their personal development rather than their work. They felt that it related directly to their work and would benefit a wide range of people. In their reflection, they wrote that the training benefited their "own personal wellbeing in relation to [their] work boundaries, [and] personal life". They could see how the course would also benefit most people that they support.

Staff were directed in the reflection instructions to discuss the training that was important to them. Here, staff highlighted a number of different courses as being "impactful" or "of high importance": Applied Suicide Intervention Skills Training (ASIST), Engage Men in Health, Healthy Food Made Easy facilitator training and the two Making Every Contact Count courses (see Appendix 11 for the full list of available courses). These sessions were immediately relevant to their work, filled a gap in their knowledge or gave them confidence when carrying out their responsibilities.

3.0 Methodology

3.1 Research objectives

The purpose of this study was to evaluate the delivery of the Healthy Communities Programme and several related courses between October 2021 and December 2022.

The evaluation included:

- An investigation of how the Healthy Communities Programme is embedded in the services available within the NEIC by comparing existing services with:
    - referrals into the programme[8]
    - social prescriptions received from it[9]
- Four qualitative interviews with participants (see Appendix 7 for sample schedule)
- Three focus groups with 28 participants and NEIC residents (see Appendix 8 for sample schedule)
- 11 qualitative interviews with Healthy Communities Programme staff and Co-op management
- Five written reflections by Healthy Communities Programme staff
- Three qualitative interviews with healthcare workers referring people onto the social prescribing programme
- analysis of pre- and post- course questionnaire data

The following section details the methods used in each aspect of the data collection and analyses in this report. Quantitative data were analysed to create an overview of client profiles using demographic and questionnaire data acquired during the referral and registration processes. Qualitative data from interviews and focus groups with clients, staff from referring agencies, Healthy Communities Programme staff and Co-op management were thematically analysed to gain insight into various aspects of Healthy Communities Programme processes. Lastly, Healthy Communities Programme presence in the community was also assessed using readily available public data.

[8] A list of organisations referring clients to the social prescribing programme are available in Appendix 1.
[9] The HCP team has provided a list of organisations which have provided social prescriptions - see Appendix 2.

3.2 Elemental[10] quantitative data analysis[11]

The Co-op uses purpose-built software (Elemental) designed to facilitate and manage the provision of SP.[12] Elemental brings together information from a variety of sources.[13] Staff enter information on each participant at different points in their journey through the programme. Individual cases are then aggregated in a series of reports for viewing.[14] In addition, some client data are made available in a table format which can be used for statistical analyses.

This evaluation uses data on 150 participants entered between 1 October 2021 and 31 December 2022 (N=150). Data extracted from Elemental were combined with information available on the Co-op's registration forms[15] in order to disaggregate some of the data which were not readily available from the Elemental data extraction. Once available data could be disaggregated using the registration data and duplicate entries were removed, the total sample size was 145 and included:

- demographic information including ethnicity, disability, health condition, whether they have a carer, caring responsibilities, living situation, employment status, substance abuse, relationship status and gender
- an overview of the number of referrals
- type of referrals
- participant status
- contacts with Healthy Communities Programme staff and
- Participant wellbeing.

[10] Elemental is the programme management software used by the project.

[11] All data were collected and processed in accordance with TASC's General Data Protection Regulation (GDPR) and the Data Protection Act 1998-2003 protocols. You can find more information about TASC's GDPR Privacy Policy statement here.

[12] Some referring organisations use a paper-based referral form provided by the HCP, a copy of which is located in Appendix 3.

[13] Please see Appendix 4 for sources of Elemental data.

[14] According to Elemental's privacy policy not all data fields or options for viewing the data were available to the research team (e.g. case notes, individual demographic data).

[15] An example of the HCP participant information/registration form is available in Appendix 5.

As part of a wellbeing assessment on the social prescribing programme, participants were given the following questionnaires to complete at the start of the programme and on completion:

- The Measure Yourself Concerns and Wellbeing (MYCaW) questionnaire
- The 5-item World Health Organisation Wellbeing Index (WHO-5)
- The Short Warwick-Edinburgh Mental Wellbeing Scale (SWEMWBS). Scores were uploaded into the programme software and then analysed as part of this evaluation. The average change in scores for each assessment were then compared to look at social prescribing participant outcomes.

Please note that not all participants answered all questions in the three wellbeing assessments. Therefore, the number of participant's responses to each question varies.

For details of each questionnaire, see Appendix 6. Please note that not all participants answered all questions in the three wellbeing assessments. Therefore, the number of participant responses to each question varies.

3.3 Qualitative interviews, focus groups and other sources

Interviews and focus groups were conducted with social prescribing participants, and NEIC residents, health care staff working in the NEIC and Healthy Communities Programme staff, including senior Co-op management. Focus groups were organised with the support of the Co-op Healthy Communities Programme staff. In all cases, participants expressed an interest in conducting an interview with TASC staff. Contact details for the participants were then provided to TASC staff. Interview questions focused on individual journeys, reasons for referral, community membership, and contacts with social prescribing staff, courses and future goals. Examples of interview and focus group topic guides are available in Appendices 7 and 8.

All interviews and focus groups were recorded and transcribed by TASC staff. Themes were identified based on ideas expressed within each setting, grouped across different datasets, and the perspectives of service users, residents, the Co-op Healthy Communities Programme staff, and health care workers were compared.

- Four qualitative interviews with participants
- 11 qualitative interviews with Healthy Communities Programme staff
- Five written reflections by Healthy Communities Programme staff
- Three qualitative interviews with Healthcare workers referring people onto the social prescribing programme

- Three focus groups with 28 participants and NEIC residents

More detailed information about qualitative data collection is provided below.

3.3.1 Interviews with participants

Social prescribing participant opinions were gathered via telephone interviews (N=4) between October and December 2022, in order to allow individuals the freedom to speak about their own journeys. Some participants were currently enrolled in the programme while others had already completed.

Focus groups were held with the theme of community membership and community needs. Three were conducted, two at the Co-op and one at a Direct Provision Centre (DPC) in the NEIC. Respondents in the latter group had been resident in the NEIC between six months to two years and were from a variety of different regions including Asia, Africa and Eastern Europe.

Two were held with community members, some of which had engaged with the social prescribing programme, courses run by the Healthy Communities Programme staff, or both. The focus groups held at the Co-op were mixed by gender and migrant background, but the majority of participants had been in the NEIC for their entire lives. The dominant demographic group represented were White-Irish females, between 50-60 years old. Focus group questions were centred on the individuals' journeys, community membership, community needs, contacts with Social Prescribing Link Workers, contacts with community health workers, and courses.

Three focus groups were conducted with NEIC residents, who were not necessarily involved directly in the social prescribing programme. Three were held at two locations between August and December 2022: the Co-op meeting room (FG 1 (N=12) & FG 3 (N=10)) and a Direct Provision Centre in the NEIC (FG 2 (N=6)).

3.3.2 Interviews with staff

Health care workers who were referring participants on to the social prescribing programme were initially approached by the Co-op and expressed an interest in conducting an interview with TASC staff. Contact details for the Healthcare workers were then provided to TASC staff. Three referrers participated in interviews: a general practitioner, an occupational therapist and a social worker. Two additional Healthcare

workers expressed an interest in the project, but were unavailable for interview. Interview questions focused on the patient/client journeys, reasons for referral, community membership, contacts with social prescribing staff, courses and future goals.

Seven Co-op staff working on the Healthy Communities Programme were invited to interviews. Staff were those with teaching responsibilities, social prescribing and project management. Currently, members of the Healthy Communities Programme staff include a project coordinator, three community health workers, one Social Prescribing Link Worker, supported by the CEO and a programme development and monitoring coordinator. Two former community health workers left the project, but were either replaced or additional hours added to existing staff to make up for the staff departure. Interviews focused on the role of the interviewee in the Healthy Communities Programme, the challenges faced by programme participants and the role of social prescribing and Healthy Communities Programme in the NEIC.

3.4 Other qualitative data

3.4.1 Staff reflections

The five staff engaged in the Healthy Communities Programme were additionally asked to provide a written reflection on their roles to date. Some questions/topics were provided as guidance: personal/professional skills, positive incident on the job, training acquired since starting and supports needed to fulfil job expectations.

3.4.2 Course questionnaire feedback

As part of action research in 2021 and 2022, Healthy Food Made Easy and We Can Quit courses incorporated pre- and post-course assessment online questionnaires. However, in order to encourage participation, a member of staff, who was not involved in facilitating the courses, supported survey completion and entered responses manually into the online platform (Jotform).

Healthy Food Made Easy

Pre- and post-course questionnaires were developed by TASC in order to understand the perspective of the participants. Demographic, GP contact, health needs, and other information were sought in order to understand the needs of the participants taking the course (see Appendix 9).

Wellbeing & Stress Management

Wellbeing & Stress Management courses incorporate Capacitar techniques.[16] Capacitar is an organisation that delivers wellness education programmes using multicultural approaches to addressing stress and trauma globally. Pre- and post-course questionnaires were designed by Capacitar and cover similar topics as those focused on during their six week course. The first few questions focus on how individuals view their lives (e.g. emotional and physical wellbeing). In part two of the questionnaire, individuals are asked about how they deal with their emotions. The third part of the questionnaire covers physical and emotional difficulties (see Appendix 6).

In addition, comments by course participants were noted down by the Healthy Communities Programme during some sessions. These were then used to provide more in-depth feedback to supplement the questionnaire data.

Lastly, a written comment from the facilitator of the first course in 2021 was provided to TASC for review.

We Can Quit

We Can Quit questionnaires were designed by TASC to look at pre- and post-courses opinions, as well as gather basic demographic information and smoking habits. The list of questions is available in Appendix 10.

Other courses

The Smoke Free Homes and Well Now courses did not have raw data available for use as part of this Healthy Communities Programme evaluation. However, as they were offered in partnership with other community organisations that had either published online material (e.g. blog) or provided a draft report (e.g. the Well Now course used quotes from a focus group), it was possible to include some of that information here. Where needed, these supplementary materials are included in the footnotes.

[16] Capacitar International: https://capacitar.org/our-impact/.

3.5 Public and community presence

An assessment of the public-facing presence of the Healthy Communities Programme, including website, social media (e.g. Facebook and Twitter), community canvassing and conference presentations (e.g. talks and posters).

3.6 Methodological limitations

3.6.1 Challenges accessing participants

Conducting the research and implementing the programme has been challenging. They both require dedicated time, expertise and patience. It is often not easy to encourage clients to participate in interviews or focus groups. It has proven difficult to get in touch with some respondents by phone and text message. Some people were particularly difficult to reach. For example, an attempt to meet with one participant with speech and language difficulties in person was unsuccessful. After initially agreeing to a face-to-face interview during a phone call, the participant did not attend the in-person meeting which was organised.

Due to difficulties in accessing the participants independently, this evaluation remained dependent on inputs from the Co-op Healthy Communities Programme at various key stages: recruitment for interviews, focus groups and course questionnaire completion/entry. Therefore, there is the potential for positive selection bias to have influenced the qualitative data.

3.6.2 Limits of Elemental data

Elemental allows for tracking participant information from the point of referral to completion of the programme. However, it has the following limitations:

- Much of the data are displayed in an aggregated format (e.g. demographics, contacts, etc.), rather at the level of the individual participant.
- Additionally, data are pooled for all types of contact. No distinction is made between contacts directly with the participants themselves or contacts with Healthcare workers about a participant. However, having data aggregated by who/what organisation the contact is with would be useful to improving our understanding of the types of inputs necessary to support social prescribing participants.

- It is not possible to conduct a temporal assessment (to look at participants' journeys and duration on the programme) because of the way the data are displayed.
- For the research component, it is not possible to identify the number of contacts with each participant, only an aggregated total (of all contacts, regardless of who they are with) for all participants. However these data are available to the Healthy Communities Programme team, via individualised case notes.
- It is not possible to link inputs with participant case information and wellbeing scores.
- As not all referring organisations use the electronic platform for referring participants into the Co-op, it is not possible to obtain the full list of referring organisations from Elemental data.[17]

The complexity of participant lives can't be reflected in the way that the data from Elemental are currently displayed. Instead, it provides an overview, making it difficult to see participant experiences in depth; and there are a fixed set of criteria to select from in recording interactions. Additionally, not all participants were entered initially into the system as there is a waiting list and it may take some time to speak with individuals who are referred on to the programme as they might not answer the initial attempts at contacting them.

Results also indicate that participants are referred to the programme for various reasons, but that the underlying causes are not always readily identified in the referral documentation by Healthcare workers. Elemental tends to aggregate data by group limiting the ability to identify individualised outcomes. In order to examine the underlying cause(s) of referral, work has been done to modify Elemental and enter data associated with social prescribing participant cohort groups/reasons for referral which will allow for enhanced tracking of participant needs.

In addition, when viewing the ethnicity data, it is important to note that there are a few challenges with interpreting the results. Firstly, at times, ethnic group is confounded with nationality, making ethnic group identification unclear. Secondly, the ethnicity categories provided by Elemental are based on the United Kingdom's categories (as used by the

[17] For the purposes of this evaluation, we requested this information directly from the social prescribing team.

Office for National Statistics) and are not directly comparable to the CSO categories, which are used in Ireland. Therefore, making a direct comparison to CSO categories based on 2016 or 2022 census data has not been pursued as a part of this research.

4.0 Results

4.1 Introduction

The programme officially started on 1st Dec 2020 and staff started in January 2021, at the very beginning of the most severe lockdown period. As widely documented, the COVID-19 pandemic and lockdown restrictions resulted in increased mental health issues (Kelleher et al., 2022; Kelly, 2020). At the time of its implementation, one in five people nationally had experienced increased psychological stress due to COVID-19. There were high levels of reported anxiety, depression, and greater use of alcohol and drugs, with long waiting lists for primary care psychology appointments. There was particularly acute demand for child and adolescent mental health services linked to financial stress, isolation, and health fears. At the same time, waiting lists for public mental health services are very long.

A previous TASC report (December 2021) highlighted the challenges faced in implementing and delivering a community-based project during this period. The rollout of the social prescribing programme and health-related classes has had to respond to long-standing health issues - such as the prevalence of chronic conditions related to smoking, combined with financial pressures and mental health conditions provoked or exacerbated by the pandemic and economic fallout. The demand for mental health support, combined with pressure on the HSE and charities, has made the delivery of the social prescribing programme and assessing its impact more difficult.

As detailed in two previous TASC reports,[18] Sláintecare provides a clear roadmap of how Ireland's health system will promote health and social care through community-led initiatives and engagement (DOH, 2022). Sláintecare Healthy Communities Programme have been rolled out at various locations around the country, including in Dublin's NEIC by Co-op staff who deliver a social prescribing programme as well as a number of courses to provide individuals with the skills and confidence to be proactive/autonomous in

[18] TASC has completed two previous reports as a part of the Co-op HCP internal evaluation: *Action Research as part of Dublin City Community Co-op social prescribing and Community Health Programmes NEIC Submitted to Dublin City Community Co-op & HSE* (December 2021) and *Evaluation of HCP Course Facilitators Report* (February 2022).

managing their own health. As an intervention, the community health workers have succeeded in giving participants greater confidence in their ability to interact effectively with public services and benefit from community-based activities that help improve their mental and physical health.

The Healthy Communities Programme has had four specific, interconnected impacts:

1) Enhancing skills in healthy eating, stress management, and health management amongst course participants and social prescribing referees, and also in IT (how to use zoom, for example), helping participants to become less isolated and more confident in engaging with activities, health services, and family and social networks;

2) Giving social prescribing participants greater self-confidence in managing their physical health and improving their mental health, as well as understanding the connection between the two;

3) Promoting the courses and social prescribing programme to family members and the wider local population; and

4) Indicating gaps in community-based activities, public health information, and even patient understanding of their own health issues. Addressing these gaps can lead to more effective use of health services and greater participation in local activities, as well as a sense of belonging to the area.

A detailed discussion of the quantitative and qualitative data analyses under specific themes follows, but a summary of key findings is as follows:

- **The Healthy Communities Programme has a positive impact on the NEIC community**
    - By providing a supportive presence in the area
    - Reaching out through various means (e.g. leafleting and home visits)
    - Developing partnerships with other local stakeholders
    - Encouraging participation in the community (e.g. coffee mornings)
    - Building relationships with participants
    - Empowering participants with information, resources and peer lead programmes to make informed decisions to improve their health.

- **Engagement with the project is associated with improvements in participants' wellbeing by**:
    - Through reducing isolation
    - Providing support to access improved housing
    - Expanding social networks
    - Encouraging sustainable behaviour
    - Developing personal skills and improving confidence
    - Developing healthier habits
    - Improving physical and mental health

- **Delivery is strengthened by the**:
    - Leadership of the project co-ordinator
    - Quality of the Healthy Communities Programme staff who are carefully Recruited, some with lived experience and appropriate skills
    - Fostering positive and productive relationships with a wide network of organisations, including sharing best practice.

- **Challenges in Healthy Communities Programme delivery include:**
    - Diverse client group in terms of age, legal status, employment status, housing status, marital status and disability
    - Barriers to participation, including social isolation, lack of knowledge of opportunities, legal status, concerns about stigma, health related and mobility issues
    - Large number of referrals, but a relatively small number of people who have completed the programme
    - Heavy staff workloads, software limitations and constraints on creating safe and welcoming spaces for residents, due to a lack of private space

4.2 Social Prescribing Participant Profiles

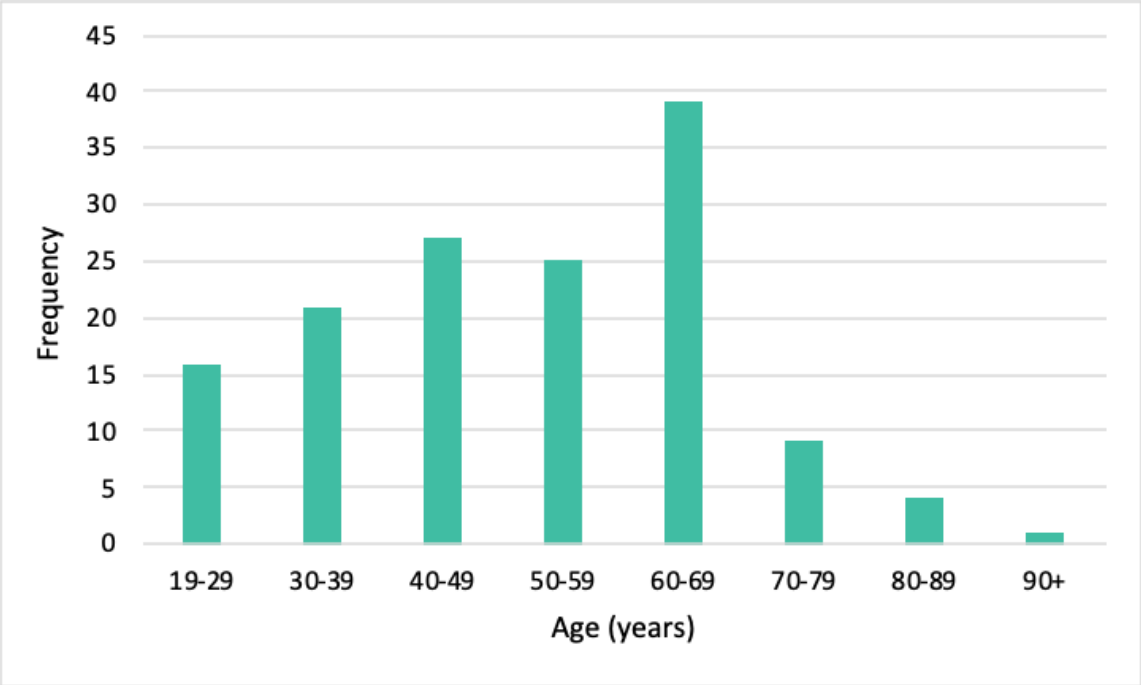
Records of the temporal distribution of participants' registrations and the number of days enrolled are located in Appendix 12. Below is a summary of the demographic trends in social prescribing participants.

The small total sample size (N=145), diversity of categories and incomplete demographic information on participants precludes statistical analyses of demographic trends in programme completion. Nonetheless, it is possible to look at the general patterns across demographic groups and make a number of observations about the demographic composition of all participants enrolled in the programme, compared to the subset of participants who have completed the programme. Highlights of the demographic breakdown are available below. A full breakdown of participant demographics is available in the summary table located in Appendix 13.

4.2.1 Age

The age distribution for social prescribing participants was quite wide; the youngest was 19 years of age and the eldest was 95 years of age. On average, participants were 51.3 years of age (N=145). The age for three participants was excluded from these data as the date of birth entered was improbable, based on the age requirements of the programme. The majority of participants were in the age group 51-61 (N=39). The next largest categories were individuals from 40-49 (N=27) and 50-59 years of age (N=25) (Figure 4).

Figure 4. Age distribution of participants (N=145)

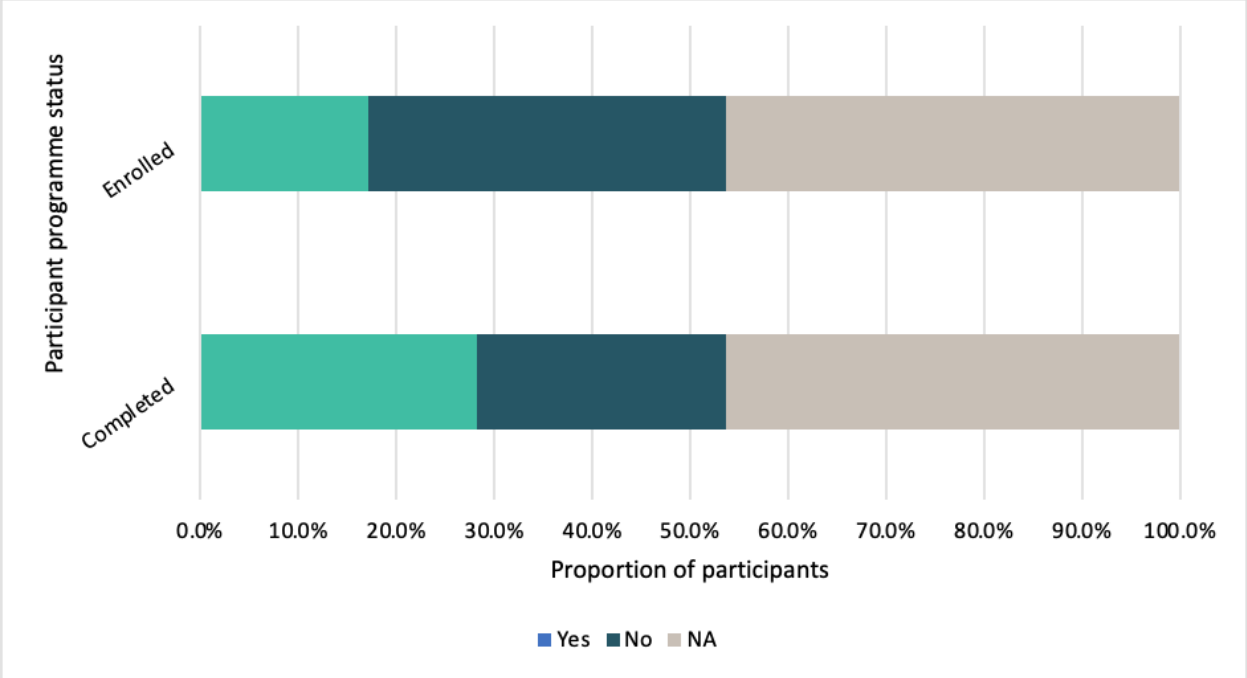


Source: Elemental & Referral data, 2021-2022, duplicates removed (N=5).

4.2.2 Registered disability

The percentage of participants who declared having a registered disability is higher among those who completed the programme than in the overall enrolled group. People with a registered disability constituted 17.2% of those enrolled, but 28.2% of those who completed the programme, while participants without a registered disability constituted 36.6% and 25.6% respectively (see Figure 5). That is, 44% of enrolled participants with a registered disability had completed the programme as of December 2022, compared to 18.9% of those without a registered disability.

Figure 5. Prevalence of registered disabilities in enrolled (N=145) and completed group (N=39)



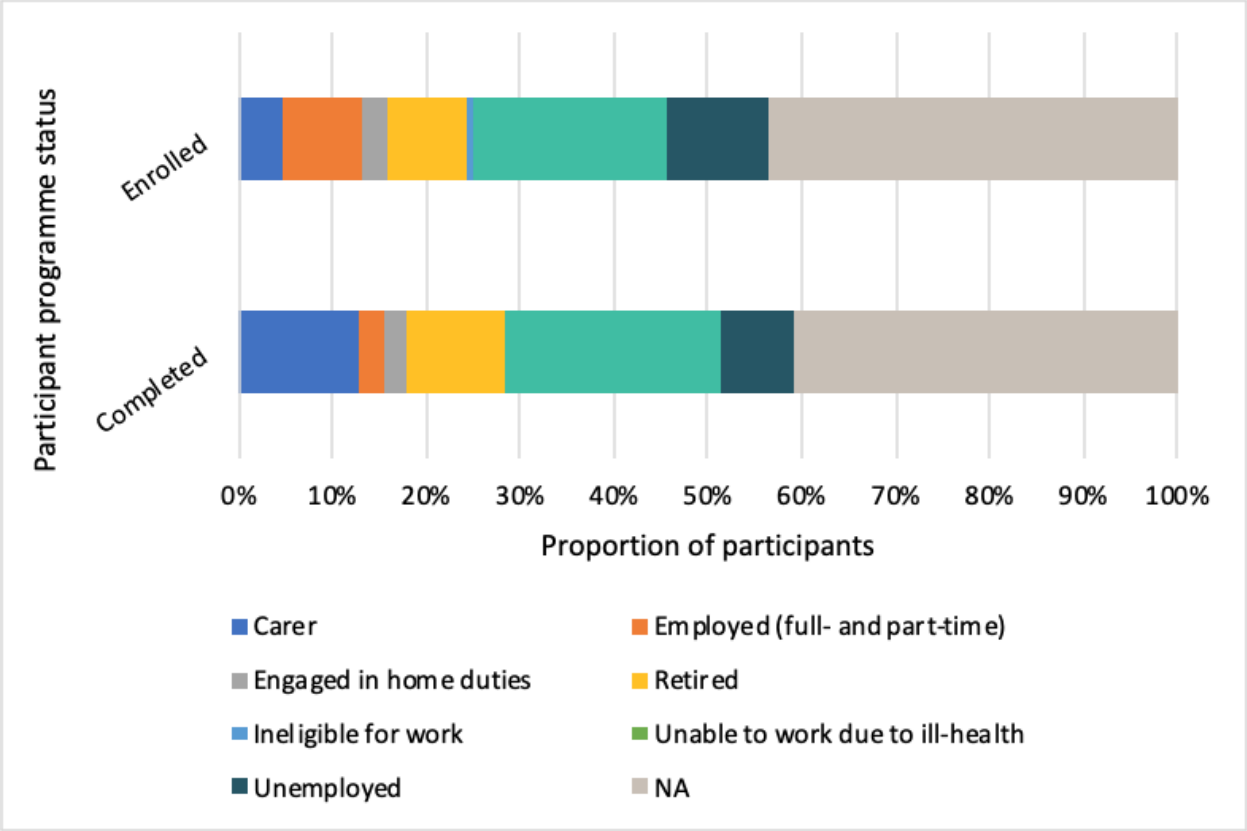
Source: Elemental and Referral data, 2021-2022, duplicates removed (N=5).

4.2.3 Employment status

Twelve of the enrolled participants declared being in (full- or part-time) employment, while only one employed participant had completed the programme by December 2022. In percentages, 8.3% of those enrolled were in employment, compared to 2.6% of those who completed the programme. On the other hand, the proportion of participants who were carers was higher among those who had completed the programme (12.8%), compared to all of those enrolled (4.8%). Differences between the enrolled cohort and

those who have completed the programme were smaller across the other employment statuses (see Figure 6).

Figure 6. Employment status of participants in enrolled (N=145) and completed group (N=39)



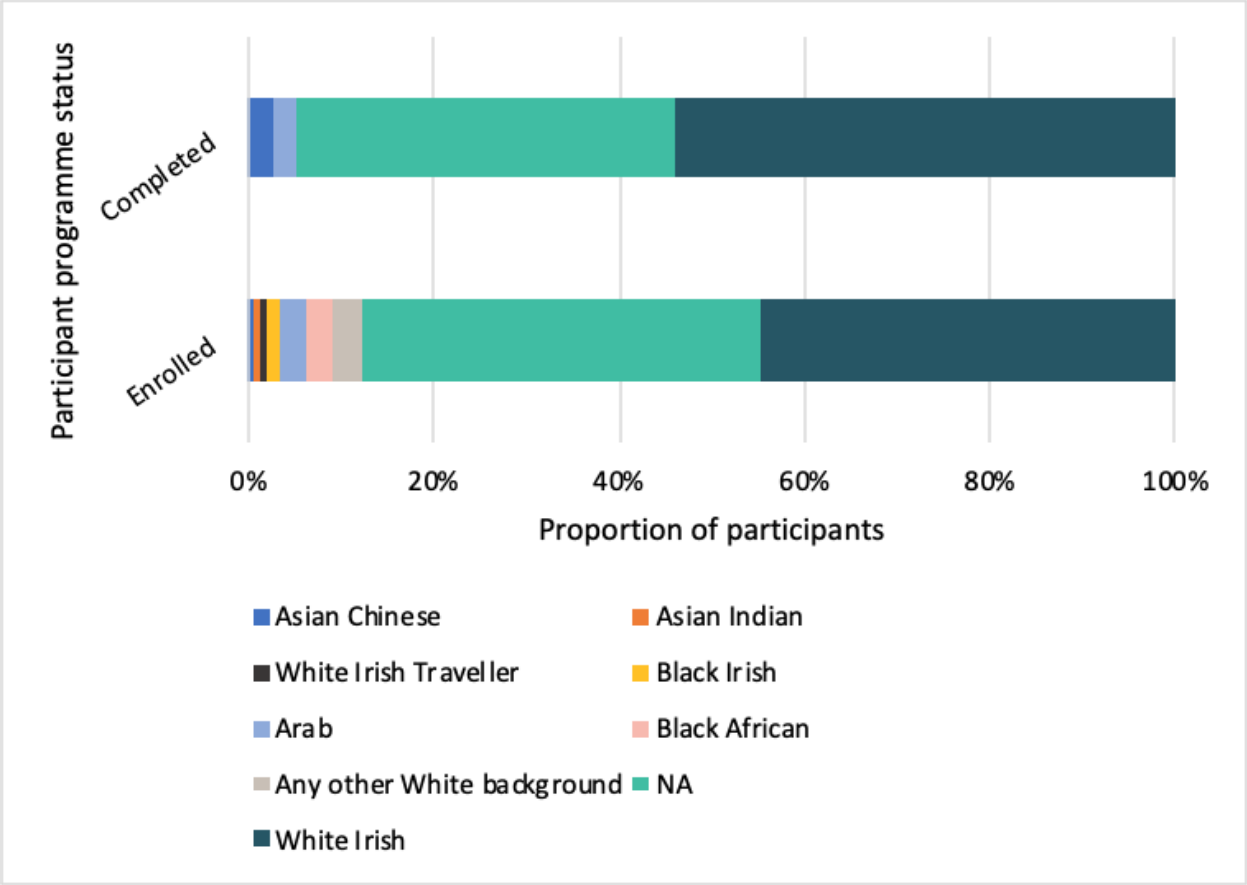
Source: Elemental and Referral data, 2021-2022, duplicates removed (N=5).

4.2.4 Ethnicity

There is less ethnic diversity among the participants who completed the programme, relative to the overall group of all enrolled participants (Figure 7). Only two participants (5.1%) who are not White Irish completed the programme compared to 18 of those enrolled (12.4%). The percentage of White Irish participants was 44.8% in the enrolled group and 53.8% in the completed group.

During data collection, the recording of participants' ethnicity was not standardised and therefore some participants' nationality or country of birth was recorded instead. In such cases, for the purposes of the figures below, it was assumed that each individual belonged to the dominant ethnic group within the named country. The original data containing all categories can be found in Appendix 13.

Figure 7. Ethnicity of participants in enrolled (N=145) and completed group (N=39)

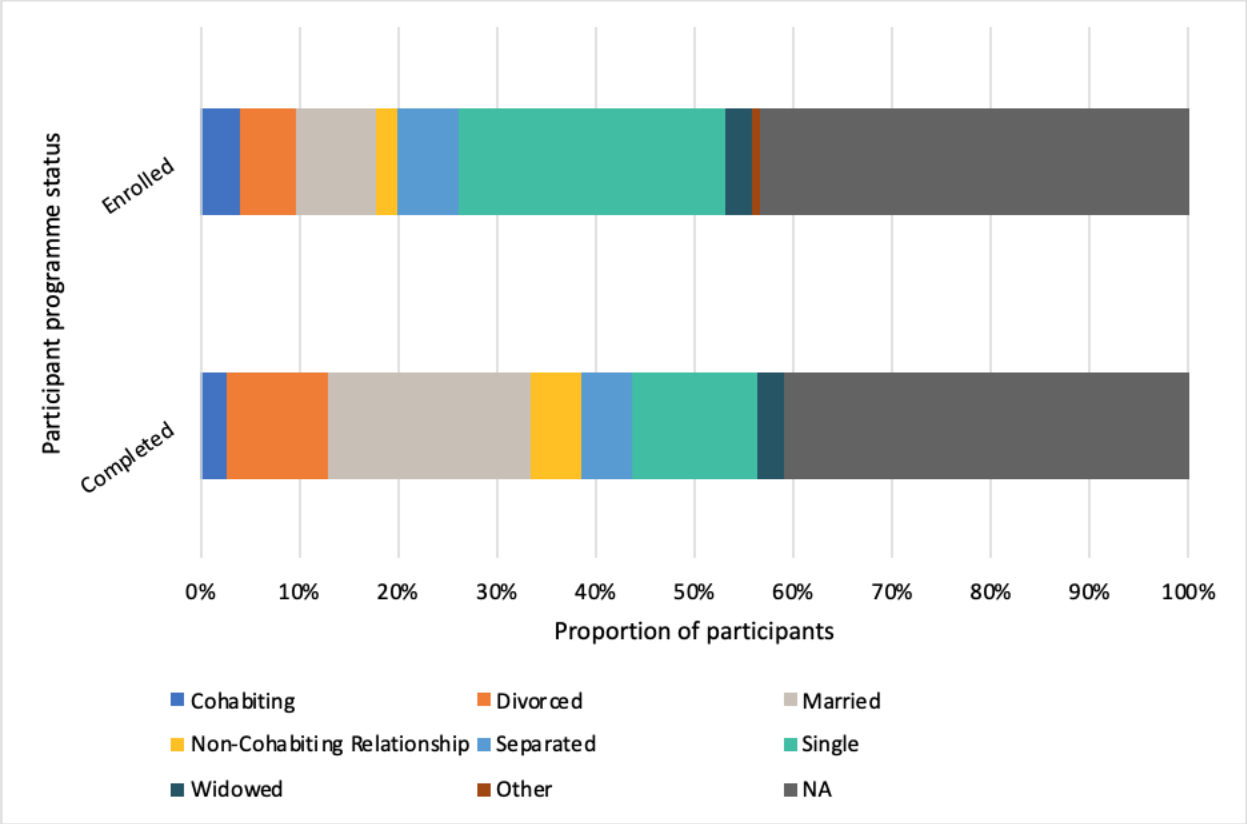


Source: Elemental and Referral data, 2021-2022, duplicates removed (N=5).

4.2.5 Relationship status

As shown in Figure 8, the proportion of married participants is higher in the completed group (20.5%) than the enrolled group (8.3%). On the other hand, the proportion of single people is lower in the completed group (12.8%) than the enrolled group (26.9%).

Figure 8. Relationship status of participants in enrolled (N=145) and completed group (N=39)

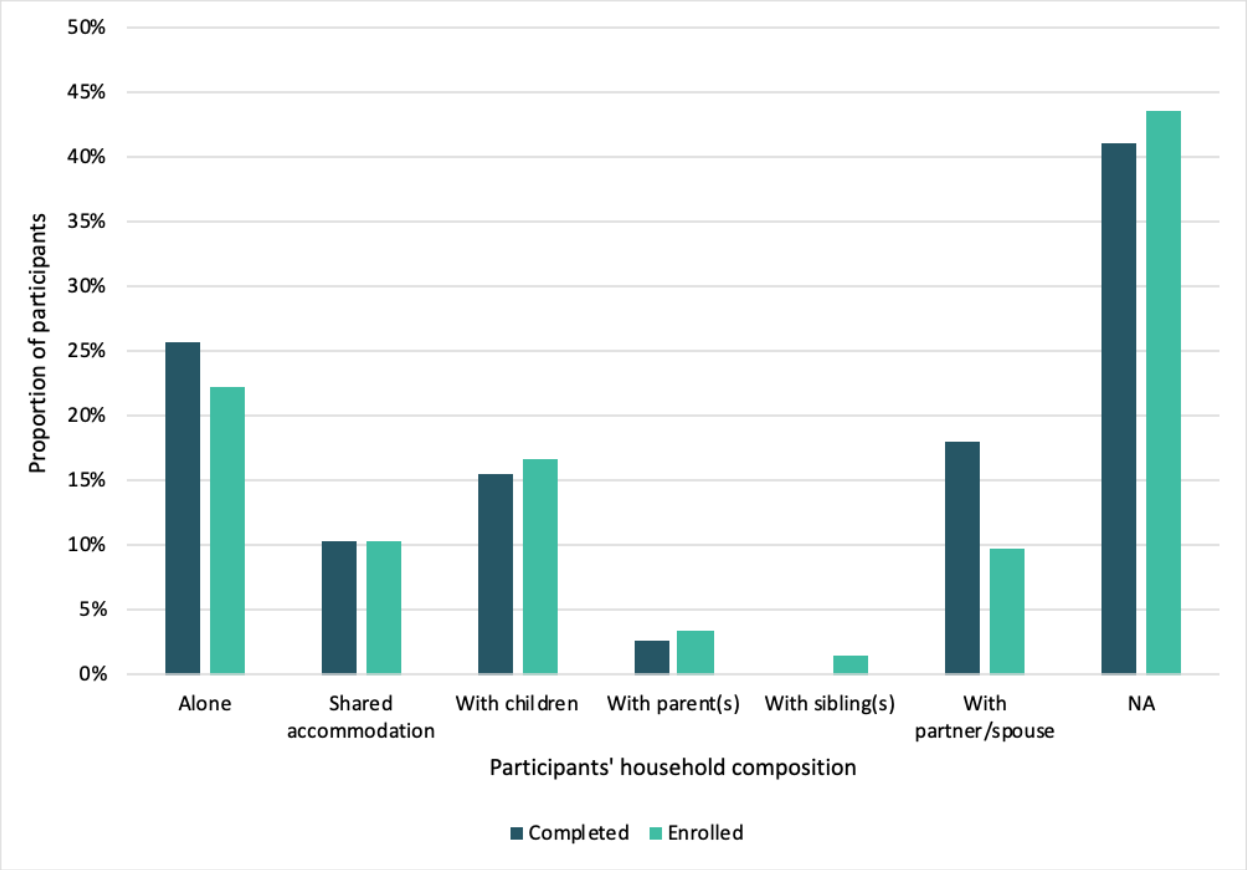


Source: Elemental and Referral data, 2021-2022, duplicates removed (N=5).

4.2.6 Housing occupancy

17.9% of those who completed the programme live with their partner/spouse, compared to 9.7% of those enrolled. However, as shown in Figure 9, the percentage of those living alone is approximately similar, with 22.1% of those enrolled and 25.6% of those who completed the programme living alone.

Figure 9. Household composition of participants in enrolled (N=145) and completed group (N=39)



Source: Elemental and Referral data, 2021-2022, duplicates removed (N=5).
Note: Columns sum to >100% as some participants identified with multiple categories.

4.3 Social prescribing participant programme status

Elemental provides an overview of social prescribing participant status. Social prescribing participants can be tracked through different stages of the process: active, complete, discharged and waiting. Of the 145 clients who were entered into the Elemental database prior to the end of 2022, 63 were closed/discharged, 39 were complete, 34 were active and 9 were waiting (Table 2).

Table 2. Social prescribing participant programme status (as of 31 December 2022)

Case Status Group	Case Status	N	%
Active	Engaging in service	34	23.4
Active total		**34**	**23.4**
Complete	In meaningful activity	10	6.9
	Needs met	14	9.7
	Not specified	7	4.8
	Referred on	8	5.5
Complete total		**39**	**26.9**
Discharged / Closed	Did not attend appointment	3	2.1
	Disengaged	16	11.0
	Inappropriate referral	3	2.1
	No longer requires service	20	13.8
	Not specified	4	2.8
	Referral declined	2	1.4
	Unable to contact	15	10.3
Discharged / Closed total		**63**	**43.5**
Waiting	Appointment booked	2	1.4
	New	2	1.4
	No response	2	1.4
	On hold	3	2.1
Waiting total		**9**	**6.3**
GRAND TOTAL		145	**100.1**[19]

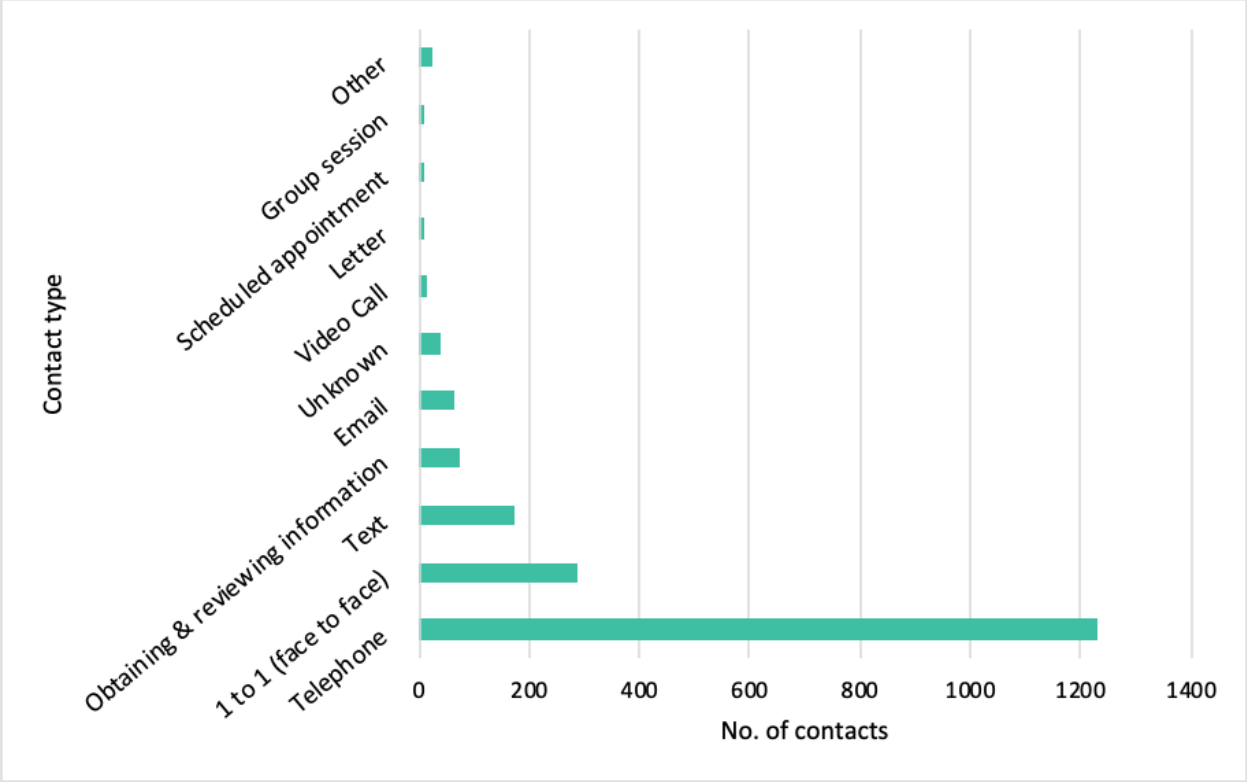
Source: Elemental data, 2021-2022, duplicates removed (N=5).

[19] Total percentage > 100% due to rounding.

4.4 Contacts with social prescribing participants

Healthy Communities Social Prescribing Link Workers track the number of phone calls, text messages, emails, face-to-face meetings and other methods of communication that they have about a particular client's case. Contacts with the client, GPs, therapists, etc., are recorded. The primary method of contact is by telephone. Figure 10 shows the breakdown of the different methods of contact. The most common form of contact was by phone (64%), with the next being face to face (15%) and text (9%). Additional forms of contact include by email (3%), video call (1%) and letter (1%).

Figure 10. Types of contacts with participants (N=150) [20]



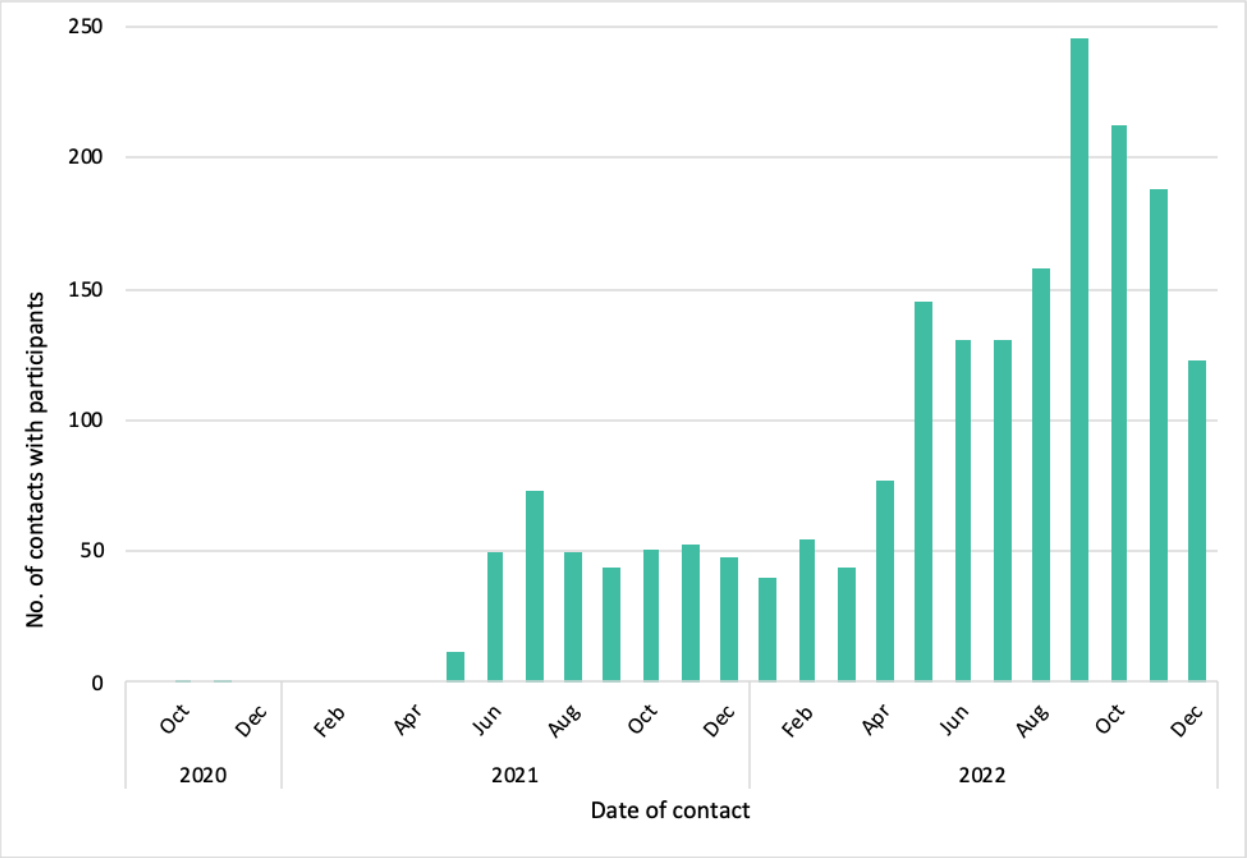
Source: Elemental & Referral data, 2021-2022, contains duplicates (N=5).

Figure 11 shows the frequency of contacts since the start of the projects; the recording of contacts did not happen immediately, as at the beginning of the process, the Healthy

[20] "Other" consists of internal communication (n=8), case discussions (n=7), reminders (n=2), drop-ins (n=2), school visits (n=1), office visits (n=1), and other (n=1), where n=number of contacts, N=number of participants.

Communities Programme was still establishing itself. However, the frequency of contacts increased considerably between 2021 and 2022, with a peak in September 2022.

Figure 11. Number of contacts with participants (N=150)



Source: Elemental, 2021-2022.

4.5 Healthy Communities Programme courses

Course participants are enrolled in courses through a variety of routes (see Appendix 15). Some participants come from within the Healthy Communities Programme, via referrals from the Social Prescribing Link Workers. Additional referrals are received as a result of social media posts, through the Healthy Communities Programme staff (i.e. community health worker) email circulation, from community organisations and HSE departments, posters and leaflet drops, as well as by word of mouth.

In total, the Healthy Communities Programme staff offered and/or facilitated 47 courses on eight topics between 2021 and 2022. These courses were completed by 527 of 709 (74.3%) participants. The majority of courses offered were Healthy Food Made Easy, with 214 participants enrolled in 21 courses; 134 participants (62.6% of those enrolled) completed the Healthy Food Made Easy courses.

Photos of Healthy Food Made Easy Course Participants[21]

.

Source: Co-op, 2023

Three courses, Healthy Food Made Easy Cool Dudes, Health Literacy Health & Community Professionals, and Smoke Free Homes, had a 100% completion rate. The course with the lowest completion rate was We Can Quit, with 22 of 74 participants

[21] These photos were taken with participants' consent.

(29.7%) completing. Additional information about the number of courses run, the number of participants enrolled and the number of individuals who completed are available in Table 3.

Courses were provided at various times throughout the year. Figure 12 provides a visual overview of the course timeline with specific colours representing each of the different courses offered between April 2021 and December 2022. Courses have been and continue to be open to all community members, not just social prescribing clients. The majority of courses offered were Healthy Food Made Easy (21 courses), followed by Healthy Food Made Easy Cool Dudes (12 courses). A gender breakdown of a subset of the courses provided in 2022 is provided in Table 4. A gender breakdown of participants is not available for 2021 courses as the courses were offered online and demographic data were collected by course facilitators at the time. More detailed information on each course is available in Appendix 14.

Table 3. Healthy Communities Programme courses: enrolment & completion statistics (2021-2022)

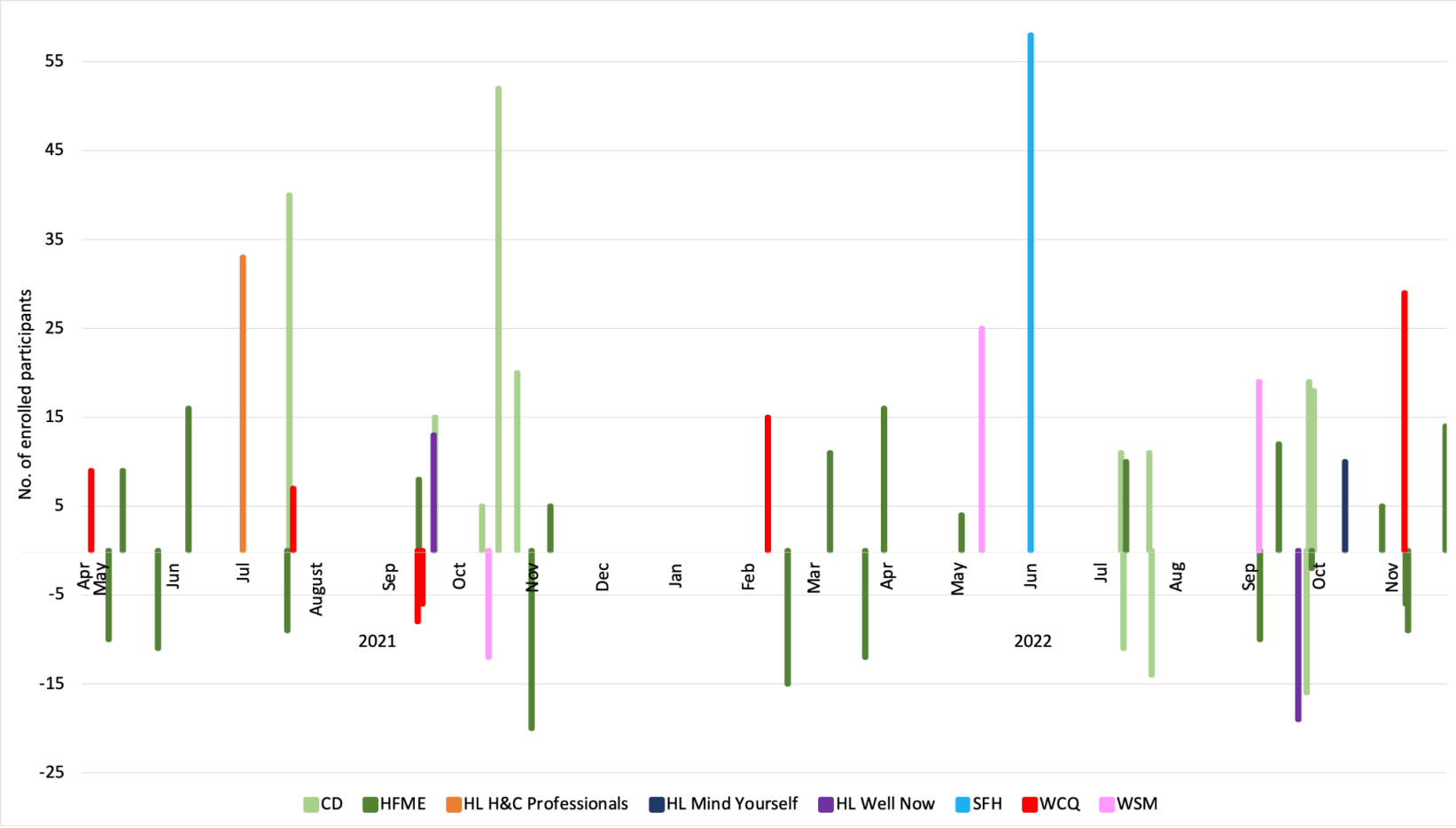
Course Name	Description	Courses Run	Enrolled (N)	Completed[22] (N)	Completed (%)
Healthy Food Made Easy	A six week peer-led nutrition and cookery course. The sessions focus on preparing budget friendly, quick and simple meals along with building nutritional knowledge and healthier habits.	21	214	134	62.6%
Healthy Food Made Easy Cool Dudes	A basic nutrition and cooking skills course. Similar to Healthy Food Made Easy, but specifically designed to be accessible to children	12	232	232	100.0%
Health Literacy Health and Community Professionals	A course which teaches participants how to understand and use health information to support patients and clients	1	33	33	100.0%
Health Literacy Mind Yourself Men's Health	A six week newly developed course that allowed its participants to “delve into different topics we found men lack the confidence to talk about”. It is co-facilitated with a Health Promotion and Improvement Officer. It teaches participants how to understand and use health information to manage their own care.	1	10	2	20.0%

[22] Varies for each course. For example, HFME = attendance of 4 out of 6 sessions; WCQ=must be smoke free or cut down by week 10 or 12 and are also engaging with the programme (e.g. WhatsApp group, phone calls, or taking their nicotine replacement treatment); Wellbeing & Stress Management=3 or more sessions.

Health Literacy Well Now	A ten week programme exploring ways of accessing health information, self-advocacy in a healthcare setting, relaxation techniques and more.	2	32	19	59.4%	
Smoke Free Homes	A four week programme aimed at reducing second hand smoke exposure in people's homes and raising awareness of the health risks associated with second-hand smoke especially to children and young people.	1	58	58	100.0%	
We Can Quit	A smoking cessation programme run in conjunction with the HSE and pharmacies in order to provide adequate social supports and replacement treatment for tobacco use. This 7-12 week programme helps people to quit smoking within a group setting led by qualified peer facilitators on the We Can Quit programme.	6	74	22	29.7%	
Wellbeing and Stress Management[23]	Delivered over six weeks. Topics are informed by the HSE Stress control course delivered through Capacitar methods. Providing participants with tools they can use to identify and manage their own stress and anxiety.	3	56	27	48.2%	
Total			**47**	**709**	**527**	**74.3%**

[23] Though the Wellbeing & Stress Management held at the DPC had a drop-in format, three participants attended regularly enough to have completed the course.

Figure 12. Healthy Communities Programme course timeline (2021-2022)



Note: Size of bar represents the number of enrolled participants in each course by date of course. Negative bars are for visualisation purposes only. Some course dates were shifted by a day in the graph to aid visualisation.

Table 4. Gender breakdown of participants enrolled in Healthy Communities Programme courses (2022)

Course	Courses Run	Enrolled (N)	Female (N)	Male (N)	Comments
Healthy Food Made Easy	15	138	75	63	
Healthy Food Made Easy Cool Dudes	8	115	Unknown	Unknown	for seven courses:58 female, 46 male
We Can Quit	2	45	31	14	
Health Literacy Well Now!	1	18	12	6	
Wellbeing & Stress Management	1	27	27	0	
Wellbeing & Stress Management (DPC)	1	21	Unknown	Unknown	
Health Literacy Mind Yourself!	1	10	N/A	10	
Smoke Free Homes	1	58	N/A	N/A	
Total	**30**	**396**	**114**	**91**	

Source: Co-op, 2023

4.6 Engagement with the Community

4.6.1. Extent of community embeddedness

The Healthy Communities Programme team works in a hybrid environment: remote working coupled with on-site presence at the Co-op offices, meetings with social prescribing clients at the Summerhill Primary Care Centre and offsite work at various locations in the community when facilitating courses or promoting the Healthy Communities Programme.

As a result of this hybrid model, opportunities to meet with clients are limited to when it is possible to book the clinic room at the Summerhill Primary Care Centre. As the available time in the clinic room is limited, this creates a bottleneck in which social

prescribing clients entering and exiting the programme are limited in terms of when they can meet with Social Prescribing Link Workers. Contact with NEIC residents is also limited for the community health workers as the lack of space makes it challenging for them to also meet with NEIC residents in a space which is appropriate and welcoming to addressing health concerns and promoting healthy habits.

4.6.2 General online presence

The Healthy Communities Programme is mentioned in the programming available through the Co-op.[24] the webpage provides a description of the Healthy Communities Programme and includes a video, which is hosted on the Co-op YouTube channel. The Co-op also has a Facebook page (748 followers) and Instagram page (645 followers) which are also used for disseminating information to members of the public.

Three videos were created for the National Cancer Control Programme by various Healthy Communities Programme staff members to support cancer prevention and screening. The three videos were produced in 2021 and covered general cancer awareness, lung cancer and women-specific cancer. [25,26]

4.6.3 Community health workers' presence–key highlights

The community health workers are a constant presence in the NEIC and regularly engage with community members, in accordance with their social care remit. Particular highlights include:

- During the COVID-19 lock-down, the three community health workers personally delivered ingredient packs to the participants of the Healthy Food Made Easy course and were able to share information on the doorstep about supports provided by the Healthy Communities

[24] https://dublincitycommunitycoop.ie/programmes/healthy-communities-project-north-east-inner-city/
[25] HSE press release: https://www.hse.ie/eng/services/news/media/pressrel/hse-national-cancer-control-programme-urging-people-to-act-early-on-potential-signs-of-cancer.html
[26] Example videos: https://www.youtube.com/watch?v=qA9ll87YnBA&t=15s, https://www.facebook.com/HSElive/videos/4669115643137779

Programme. This service was provided for all participants of the online courses in 2021 and three of the courses in 2022.

- Community health workers also strike up conversations with residents when out delivering leaflets for courses and answer any questions people might have. Community leafleting occurs approximately twice per year.

4.6.4 Best practice dissemination

Healthy Communities Programme staff have been presenting the work of the programme to various audiences over the last two years, including:

- Guest lecture to students on the M.Sc. in Community Health at Trinity College Dublin (2021 and 2022)
- Talk to Larkin men's group (2022)
- Peer panel member, Healthy Ireland event (2022)
- Presentation to Primary Care Mental Health Services (2022)
- Presentation to Speech & Language Primary Care Team (2022)
- Presentation to the members of the Dublin North Central Area Committee, Dublin City Council (2022)
- Presentation to senior members of primary care teams (2022)

4.7 Network links and partners

4.7.1 Links to various organisations

- The Larkin Centre
- Care After School Project
- Lourdes Day Care Centre
- Hill Street Family Resource Centre
- Summerhill Primary Care Centre (General clinic & Roma Clinic)
- Inner City Organisations Network
- A.C.E.T. Ireland
- Safetynet Social Inclusion
- Homeless Healthlink Inclusion Hub
- Swan Youth Services
- Foundations Project Parnell City of Dublin Education & Training Board (CDETB)

- Friends of the Elderly
- Family Support Early Learning Ireland[27]
- The Talbot Centre
- Sunflower Recycling Community Employment
- ExWell Programme
- Parnell Adult Education CDETB
- Dublin Adult Learning Centre
- Family Carers Ireland
- Mature Years Access Coordinator UCD
- Crosscare Food

4.7.2 Partnering with local health and community services

The Healthy Communities Programme has strong links to health and social care teams providing services in the NEIC. For example, there are a large number of organisations tied to the social prescribing programme via the referral process (Appendix 15). There are 27 organisations that referred clients into the social prescribing programme, a full list of which is available in Appendix 1. Social prescriptions have been made to 54 organisations (Appendix 2). In addition, there are a variety of organisations which have hosted various courses with the Healthy Communities Programme (e.g. SAOL Project and the Dublin Adult Learning Centre).

4.7.3 Partnering with cancer services

In addition to the three videos created to support the National Cancer Control Programme (as described above in the section on social media presence), the Healthy Communities Programme team has been working with the HSE's National Screening Service to review and improve their Equity Tool in advance of online publication. The Healthy Communities Programme have also received an additional request to support the development of promotional material for the HSE's National Screening Service's Retinal Scan Easy Read Project.

[27] No website or other link available.

The Healthy Communities Programme project coordinator currently sits on the National Cancer Control Programme Early Diagnosis of Symptomatic Cancer Steering Group, alongside the Director of Public Health in the HSE's National Screening Service.

Figure 13. Well Now! Poster

Source: Co-op, 2023

4.8 Facilitation and programme development

4.8.1 Influencing direction of course development

Healthy Communities Programme staff have actively supported the development of multiple courses to be offered to the community. This includes the Well Now! Health Literacy course and Mind Yourself! Men's health guide, both of which took place in 2022. There are other courses in development for 2023 and beyond.

4.8.2 Course facilitation

Since 2022, the three community health workers have been trained in facilitating the Healthy Food Made Easy and Healthy Food Made Easy Cool Dudes courses and have been conducting them at various locations. By being present as Healthy Communities Programme community health workers and course facilitators, the visibility and autonomy of the project is heightened in the community. Social prescribing interview participants and community focus group participants highlighted the importance of having peers, with lived experience facilitating the Healthy Food Made Easy course which helped to make the material more accessible to them. Two Healthy Food Made Easy Cool Dudes courses were co-facilitated by a Healthy Communities Programme community health worker and an additional five courses were facilitated solely by the Healthy Communities Programme community health worker.

Two members of the Healthy Communities Programme team co-facilitated the Health Literacy course called Mind Yourself! Men's Health Guide in 2022, alongside the HSE's Health Promotion and Improvement Officer. This course was a Healthy Communities Programme initiative which was co-developed in partnership with the HSE Health Promotion division. As mentioned previously, the Healthy Communities Programme was actively involved in its development.

The Smoke Free Homes course took place in 2022 and was also co-facilitated by the HSE and the Healthy Communities Programme team. One of the Healthy Communities Programme community health workers took the lead on the programme rollout.

4.8.3 Innovation: Healthy Communities Programme coffee mornings & 'taster' sessions

The Healthy Communities Programme coffee mornings are an innovation which came out of a recognised need to connect more fully with the NEIC residents, as well as continuing opportunities for contact with present and past social prescribing participants. These mornings offer a weekly opportunity for individuals to connect with each other, as well as meet with the Healthy Communities Programme staff. The Healthy Communities Programme also takes the opportunity to present programmes to potential participants by offering 'taster' sessions in which participants are able to meet with invited speakers/guests from different community organisations.

4.8.4 Healthy Communities Programme Participant case study

Box 1: Healthy Communities Programme participant case study (December 2021 - January 2023)[28]

In late December 2021, we received a referral for Tom[29]*, in his early 60s, living in sheltered accommodation for individuals experiencing homelessness.*

Tom and his partner had separated; he had no contact with his family and he was experiencing homelessness. He was quite alone, struggling with multiple physical and mental health needs and isolated in his room for days at a time because of accommodation unsuited to his needs (i.e. a broken lift). His key worker had referred him to the Healthy Communities social prescribing programme to help him with back problems. Aside from this initial referral, the key worker had had very little contact with him. This may have been due to staff

[28] This case study documents the journey of Tom, a social prescribing participant from December 2021 to January 2023. Tom was contacted by the HCP and gave consent for his story to be included in this report. The case study was written by TASC with the support of two HCP staff who had direct contact with Tom and played key roles in his journey through the programme.

[29] A pseudonym.

turnover and large staff workloads. He was already in receipt of weekly counselling services.

The Social Prescribing Link Worker organised a first meeting with Tom in early January 2022. The meeting took place at the Summerhill Primary Care Centre with COVID-19 restrictions still in place. Tom's needs were listened to and he agreed to link in with recommended on-line services. Tom began to engage with the three recommended courses (January-February 2022).

The first service Tom attended was the Living Well Programme run by the HSE Health and Wellbeing division in which peer leaders model positive health behaviour and encourage self-management. It is delivered by trained peer leaders living with at least one chronic condition. Tom attended one on-line session but couldn't continue with the course as he was admitted to hospital. He later completed it when his medical situation had improved.

Tom also attended the Co-op's Healthy Communities Programme online Healthy Food Made Easy course. Although offered online, the Healthy Communities Programme facilitated his needs by ensuring that ingredients were delivered at the homeless accommodation to allow him to participate. The Social Prescribing Link Worker also encouraged Tom to enrol in an online programme with ExWell Medical - a non-profit, community-based organisation that facilitates exercise groups for people with long-term health conditions.

The Social Prescribing Link Worker sought out other resources that would improve Tom's life, referring him to occupational therapy and social work teams at the Summerhill Primary Care Centre. They identified the barriers that his mobility challenges created and helped him complete a referral form for a mobility scooter, which was received in the summer of 2022.

Face to face services started to open again and Tom began an in-person activity. However, he faced challenges accessing its location as the building did not have a lift and he stopped attending. The Social Prescribing Link Worker found an alternative option - a social group run by Friends of the Elderly, which was held in an accessible venue. This made a big impact with Tom increasing his attendance from one to two or three times per week. As Tom's mobility increased, he was also able to access a variety of community services and participate in family events, including his mother's funeral.

Having been in the programme for seven or eight months, Tom and his Social Prescribing Link Worker set a date for completing it. At this stage, Tom had been engaging in a variety of community supports and the primary cause of his referral (back pain) had been addressed. Shortly afterwards, Tom was back in hospital again and discussed continuing the Living Well course. Tom confided to the course facilitator that he was having suicidal thoughts. The course facilitator communicated this to the Social Prescribing Link Worker who discussed the circumstances with the Healthy Communities Programme Coordinator and devised a safety plan. The Social Prescribing Link Worker then discussed the situation with Tom and made sure that he was immediately seen by the mental health team.

Tom confided in the Social Prescribing Link Worker that he was feeling anxiety and stress about the status of his accommodation and the challenges that he was facing with the staff at his supported accommodation. In late 2022, it was decided not to discharge him from the social prescribing programme until his housing situation was addressed. From the end of 2022 to the beginning of 2023, the key worker (tied to the supported accommodation he was living in) changed. The new key worker did not maintain contact with Tom and was absent for two months. Tom was entirely reliant on the Social Prescribing Link Worker, who was also fulfilling the role of a social worker.

The Social Prescribing Link Worker spent nearly eight weeks addressing Tom's housing challenges. It was necessary to complete multiple housing applications to different local authorities. Months of delays resulted because of historic residency in different parts of Dublin, finding an accessible property and waiting for feedback from the appropriate authority. Due to limited support, the Social Prescribing Link Worker also referred Tom to Inner City Organisations Network, a support and advocacy service for NEIC residents.

While participating in the social prescribing programme, Tom was constantly in and out of hospital. For example, he caught COVID-19 in March 2022. Another hospitalisation occurred when Tom injured himself trying to self-inject his insulin with no available staff to assist him in his supported accommodation. These hospitalisations and illnesses were disruptive to his life and his attempts at engaging with the community. Tom's GP was 8km away (40-50 minute bus

journey) from the NEIC and he would often seek medical help from the hospital accident and emergency department instead. The Social Prescribing Link Worker advised Tom that Safetynet also provided access to a GP.

While Tom was enrolled in the social prescribing programme he was primarily supported by his Social Prescribing Link Worker, with additional support given by other members of the Healthy Communities Programme team. He also attended the Wellbeing & Stress Management and Chair Yoga courses and social prescribing coffee mornings.

Over 14 months, Tom's Social Prescribing Link Worker kept in weekly contact, supporting him to: participate in community activities, meet people and improve his physical and mental health and to:

1. *Identify his needs beyond those on his initial referral*
2. *Link him in with a variety of services suited to his needs*
3. *Support him in facing the challenges of his living situation and the inadequacies of his supported housing*
4. *Assist him in acquiring a mobility scooter*
5. *Identify the link between his poor mental health and housing*
6. *Assist him in taking proactive measures to seek adequate accommodation*
7. *Support him in acquiring a mobility scooter to reconnect with family abroad.*

Tom last met face to face with his Social Prescribing Link Worker towards the middle of January 2023. He was on the housing list and his access/mobility needs were being considered. Since engaging with the social prescribing programme Tom has been invited to be a member of the committee of a service in which he had been participating. He had become not only a self-advocate, but was now advocating for other service users. Tom's life has changed dramatically since engaging with the Healthy Communities Programme. His accomplishments would not have been possible had it not been for the consistent and dogged support of his Social Prescribing Link Worker and the support of the Healthy Communities Programme team.

5.0 Discussion

5.1 Introduction

This research report has demonstrated the positive impact that the Healthy Communities Programme team and partners have had in effectively implementing the Healthy Communities Programme in the NEIC between October 2021 and January 2023. The project is:

- **Strengthening community action** through enabling and empowering programme participants with information and resources to make informed decisions to improve their health. Increasing social connectedness of community members and organisations to work on shared goals;
- **Creating supportive environments** that encourage sustainable behaviour changes, supporting residents to access programmes and services that result in reduced numbers living in isolation, and increasing confidence, for example, through participation in the social prescribing course;
- **Developing personal skills** of 1) the Healthy Communities Programme team through building capacity and education 2) the local community through peer-led programmes such as We Can Quit and improved healthy eating habits through the Healthy Food Made Easy programme;
- **Developing partnerships** and the value of intersectoral work, creating strong relationships with all stakeholders, which form the foundations for successful implementation for the overall Healthy Communities Programme in the NEIC.

The discussion explains the themes of the analysis, which include the referral pathways for programmes, the positive outcomes from participation in programmes, the development of healthier habits, the key strengths and values of the project and its team. It also examines how data is managed and evaluated within the project before looking ahead to its future plans.

This section also reflects on the challenges and complexities in implementing this project, all of which impacted individuals' participation in the programmes, including:

- Traumatic events
- Bereavement
- Addiction
- Homelessness
- Caring for other family members
- Loss of employment/income
- Housing insecurity/precarity
- Chronic mental health
- Chronic physical health
- Domestic violence
- Exposure to community violence

5.2 The impact of the healthy communities project team

The Healthy Communities Programme has been effective in connecting with the local community and service providers in the area. These connections have been made in a variety of different ways. Key highlights include:

- The ability to connect with NEIC residents
- Interview and focus group participants recounting positive relationships with the Healthy Communities Programme team
- Positive interview feedback from healthcare providers who make referrals to the Social Prescribing programme
- Increase in Healthy Communities Programme delivery in 2021 in comparison to 2022, with an increased community presence
- The effective ways in which community health workers are able to access the community (e.g. leafleting, coffee mornings and programme delivery.)

5.2.1 Overview of referral pathways into Healthy Communities Programme

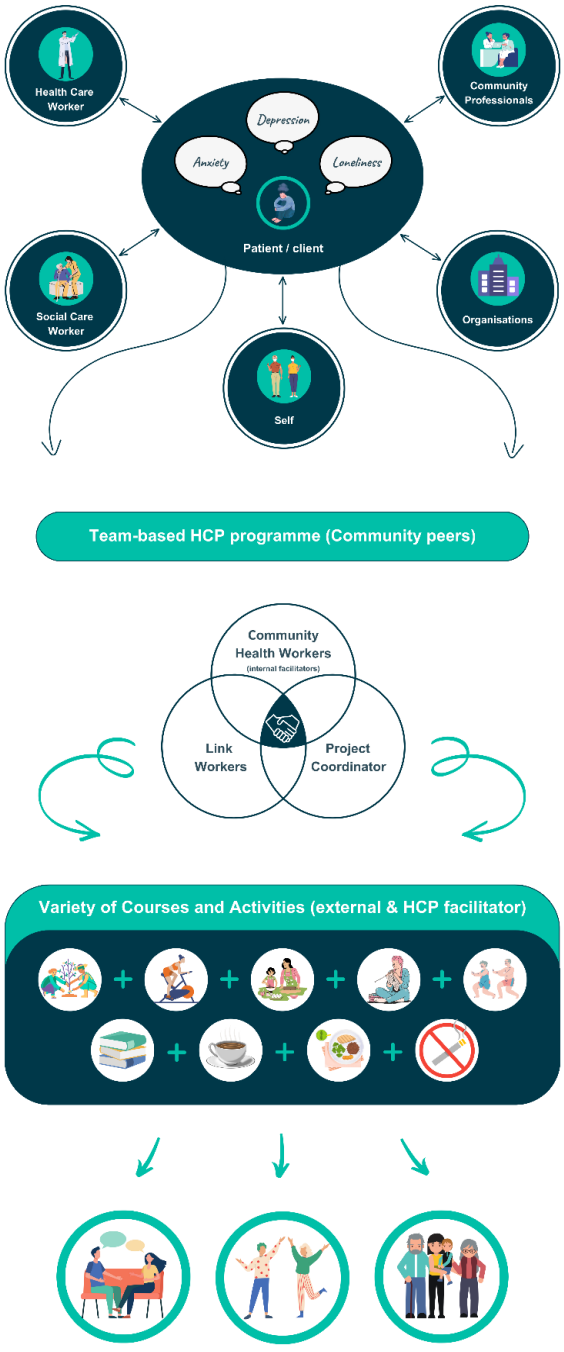
The Co-op Healthy Communities Programme uses a team-based approach to provide supports to clients. Patients/clients who are experiencing anxiety, loneliness and depression and other health challenges (e.g. diabetes) are referred onto the social prescribing programme through various routes. Here, the

project coordinator, Social Prescribing Link Worker, and the community health workers work together to support clients' needs. Individuals who are not involved in the social prescribing programme are also clients as they may attend courses facilitated by community health workers or interact with staff at coffee mornings.

Although each role functions independently, the Healthy Communities Programme team members complement each other to provide a full network of support for clients. Those participants who engage with the social prescribing programme are in receipt of a bespoke response to their specific needs in which different Healthy Communities Programme staff (i.e. the project coordinator, Social Prescribing Link Worker, and community health workers) interact repeatedly with participants to ensure that the support provided is specifically tailored to the participants' changing circumstances.

Figure 14 shows a schematic overview of the Healthy Communities Social Prescribing model and how community members may become involved with the Healthy Communities Programme, highlighting the various ways in which participants may engage with community services. Clients engage in programmes, courses and activities that benefit their physical and/or mental health as well as expand their social networks. Clients receive benefits throughout all stages of interacting with Healthy Communities Programme staff and the benefits are specific to the client's needs, wishes and personal goals.

Figure 14. Healthy Communities Programme team-based support services



Source: TASC, 2023

A variety of positive outcomes of the Healthy Communities Programme for the NEIC residents are summarised and discussed in the sections below.

5.3 Increased wellbeing

5.3.1 The Wellbeing & Stress Management course–NEIC community

The individuals that attended this course varied from week to week in order to allow for the maximum number of people to benefit from the course teachings. It was delivered to two groups of participants (N=12; N=25) in a venue close to the Co-op. Individuals did not have to attend the previous session in order to benefit. Participants completed questionnaires pre- (N=31) and post-courses (N=22). These indicated improvements across a variety of areas designated as important by Capacitar: wellbeing, physical energy and managing negative emotions. A visual comparison of the pre- and post-course wellbeing scores is available in Appendix 16.

During the course, participants' comments were all positive. One was 'glad' that they "got up in the morning to go to this class and every morning for the last four weeks has been great." Similarly, another described how the different elements of exercise, laughter and group activity were beneficial to both her health and sense of community:

> *This is an absolutely brilliant class and I'm sorry I missed some of it because I wasn't well. I find the exercise, the Tai Chi, and the exercise we did today really good, not just because they're exercises but because they make us laugh and they say laughter is the best medicine, and it makes us all feel like we're part of a group and part of a little community just here in the room. It was absolutely fantastic.*

Written comments from the course facilitator indicate that techniques learned in the course are being transferred to the wider community:

> *One woman used the Head Holds[30] on her daughter who has difficulty sleeping and she slept very well after it. She also did Tai-Chi movements*

[30] Head holds are a specific technique mentioned here and also by other participants as helpful in managing stress. This technique appears to be particularly easy to teach to others.

when she felt stressed. She then did Tai-Chi with her Grandchildren in the mornings. This woman asked if the course could be extended as it was doing her good.

A young woman who suffered severe panic attacks on a daily basis said she didn't have one in the six weeks in which she was on the course. She said she didn't recognise stress in her body before doing the course. As communicated by the course facilitator, two participants felt that paired with physiotherapy, the Capacitar techniques taught in the Wellbeing & Stress Management course helped with their physical pain. One stated:

I have used some of the movements in combination with my physiotherapy and believe I have felt the benefit from it physically. It has reduced the pain from being constant to much more manageable.

The course also brought participants a heightened awareness of themselves and their own needs. Another participant commented (as quoted by the facilitator):

My self-esteem has greatly improved and I am much more aware of how much I need to practice self-care, not just for myself but for my [family's] benefit too.

The course helped reduce stress and anxiety, while also improving sleep, tension and increasing flexibility. Participants found many of the specific exercises useful. Tai Chi and finger holds were particularly helpful in managing their stress and anxiety.

5.3.2 The Wellbeing & Stress Management course–bespoke Direct Provision Centre

A third bespoke Wellbeing & Stress Management course was provided on site to Direct Provision Centre residents in the NEIC. They were familiar with the space and the location was convenient. This was a pilot course, the first attempt at providing a course to this population, with the aim of meeting them on their own terms in their own space. The hope was that Direct Provision Centre residents would become familiar with the work of the Healthy Communities Programme and

the Co-op by providing a course onsite. The Healthy Communities Programme staff made every effort to make the space feel as private as possible. A total of 21 individuals attended the Direct Provision Centre Wellbeing & Stress Management course. There is no available data on their demographics or completion rates. The course was run on an open door basis and intended to be flexible by not requiring residents to commit to a fixed programme.

5.3.3 Social prescribing participants

The MYCaW, SWEMWBS and WHO-5 assessments use different questions to assess wellbeing (see Appendix 6 for more detail). Questions in the latter two centre on positive emotions and higher scores reflect a better state of wellbeing. The average change of direction in their scores was calculated to provide an overview of wellbeing for all questions. These average scores were automatically aggregated by Elemental. Therefore it was not possible to determine if scores were consistent across the different questionnaires for each individual participant. In addition, the number of total responses varies as not all participants who exited completed all of the questionnaires.

Seventeen social prescribing participants responded to the WHO-5 questions in which the average direction of change in pre- vs post-intervention scores indicates improved outcomes. The trend for the SWEMWBS scores across the 18 participants also showed an overall increase in participant wellbeing.

Responses to the MYCaW questions came from 17 individuals. The average change in MYCaW scores are all negative, as higher MYCaW scores indicate a higher state of worry or concern. Here, MYCaW scores decreased between the pre- and post-course answers, showing improved state of wellbeing for social prescribing participants. A summary table of the change in social prescribing participant wellbeing scores across all three questionnaires is available in Appendix 6.

For some individuals, pre- and post-course scores indicated a decrease in wellbeing (data not shown). Such a decrease could result from a variety of factors,

for example, a changed perception of themselves/their health over time, a change in their health status and/ or changes in their personal life.

Overall, the wellbeing scores indicate average increased wellbeing for the group of participants included in the Elemental data. Social prescribing participants show improved wellbeing after completing the programme, but taken on their own, these results could be a temporal association, rather than a causal factor. The data in Elemental are not adequate to determine what factor or factors occurred that might be responsible for the score changes observed. Without more information from participants (e.g. qualitative interviews or additional knowledge of psychological or counselling supports) and/or an experimental study design, it is not possible to identify the causal factors or attribute benefit to any one type of intervention (e.g. Paterson et al., 2007). However, qualitative interviews with social prescribing participants and focus groups with NEIC community members indicate that they did attribute improved wellbeing to participating in the programme.

5.3.4 Reduced isolation and increased confidence

The Well Now course was an eight week programme run by the Healthy Communities Programme, in partnership with the Dublin Adult Learning Centre.[31] The course was designed to explore different aspects of good health including ways of accessing health information, self-advocacy in a healthcare setting, relaxation techniques, exercise and healthy eating habits.

A previous evaluation[32] reported that the Well Now course has enabled participants to acknowledge their own health and underlined a role for them in maintaining it. As one woman concluded: "it's not just mental health, it's all the everyday things we do to keep well". They leave equipped with movement and relaxation activities they can take away and use at home as well as information on local services. And, having practiced communicating in healthcare settings and created their own AskMe3 reminder cards to use as a tool at medical appointments, the women have grown in confidence.

[31] https://adlitting.wordpress.com/2022/11/14/well-now-programme/

[32] Helena McNeill, Facilitator, November 2021

In addition, a Well Now course was run in 2021, for a potentially hard to reach group of women in addiction, through a partnership with the SAOL Project. It was run by an independent facilitator, who conducted an evaluation and documented the positive outcomes for participants.

Mind Yourself! A Men's Health Guide, a newly developed course, similarly allowed its participants over the six weeks to 'delve into different topics we found men lack the confidence to talk about,' as the co-facilitator of one group explained in their staff reflection. As with many of the other courses, one session can have a profound impact on someone's life.

For example, in the first session, there is a group activity called '[I]t'll be grand.' This session was found to be particularly powerful for participants. After the second session, one participant suffered from abdominal pain that was affecting his work and went to A&E, where he was diagnosed with a hernia and would need to be treated. He told the facilitators that "if it hadn't been for the activity, the week previous, he more than likely would not have gone to get it checked".

Interaction with the programme is life-changing for some participants, as illustrated by the case study in Box 2.

Box 2: Life changing impacts of Healthy Communities Programme participation

During an interview, Mary[33] spoke about her struggles with depression and how, even with encouragement from her family, it was difficult to leave the bedroom, let alone the house. Mary even had difficulty speaking to her partner and avoided her grandchildren and daughter when they came around to visit. Mary was 'petrified to go outside of the house and on the rare occasions when she was able to leave it and go to the shop she actively avoided people that she knew. Her struggles began before COVID-19 lockdowns—things which she had been suppressing for years, but she

[33] A pseudonym.

specifically mentioned a long-term illness in the family, caring responsibilities and a bereavement as factors that pushed her increasingly into isolation. On the day that Mary visited the GP she was diagnosed with depression, prescribed antidepressants, referred to counselling and given a flier for the Co-op Healthy Communities Programme team.

The close proximity of the Healthy Communities Programme/Co-op offices to Mary's home made it easy for her to stop by. She stated that the contact with the Co-op was 'life changing' as the staff were 'easy to talk to' and really listened to her. Although the initial conversation with Healthy Communities Programme staff was emotional and long (two hours), Mary felt that she was really being listened to for the first time. Subsequent conversations were informal and held within the natural context of social interactions. They began slowly with five minute walks, and then slowly increased to ten and then 15 minute walks until the participant felt comfortable being out of doors and around people.

Since engaging with the Healthy Communities Programme, Mary has attended the Healthy Food Made Easy course, Tai Chi and the Community Coffee Mornings. These have helped her to not only get out of the house again, but also spend valuable time with her family and reconnect with old friends and acquaintances. She has also made new connections in the courses she has attended. At the end of the interview, she said that 'you can't fix yourself when you are feeling down' and went on to explain that sometimes you can't tell where it starts and you need someone to help you. With help from the Healthy Communities Programme, Mary is still improving and is 'getting more good days now than bad days.'

Participants felt that Healthy Communities Programme staff supported them in addressing the challenges faced in re-connecting with the NEIC community. One participant who had lived there for her whole life explained that:

> *The community is […] changing a lot. Everybody knew everybody. And I know things have changed. Now people park their cars every day to go to work. They park outside your door. You say good morning and they don't even look at you […] At one time I could sit outside my door and 15 people would stop and talk to you […] you don't get that now.*

The Direct Provision Centre focus group participants felt that the management at the centre had also been very supportive—especially of new arrivals who did not go through Balseskin Reception Centre and were in need of support in accessing services. Participants didn't feel tied to any geographical sense of the NEIC. Their community was defined by the walls of the Direct Provision Centre, rather than the NEIC itself. Within the centre they say hello to each other, support each other and cook together.

A secondary source of community connections exists through work colleagues, who support them. However, it is challenging talking about asylum seeking status, as they fear negative reactions. Outside the Direct Provision Centre, they only speak about their refugee status when necessary (e.g. to management if leave is needed for an appointment/meeting or they need advice).

The need for social prescribing in the NEIC is evident. Social prescribing participants enjoyed engaging with Healthy Communities Programme staff and that they would welcome more opportunities in the NEIC. One of the Healthy Communities Programme staff reflected that:

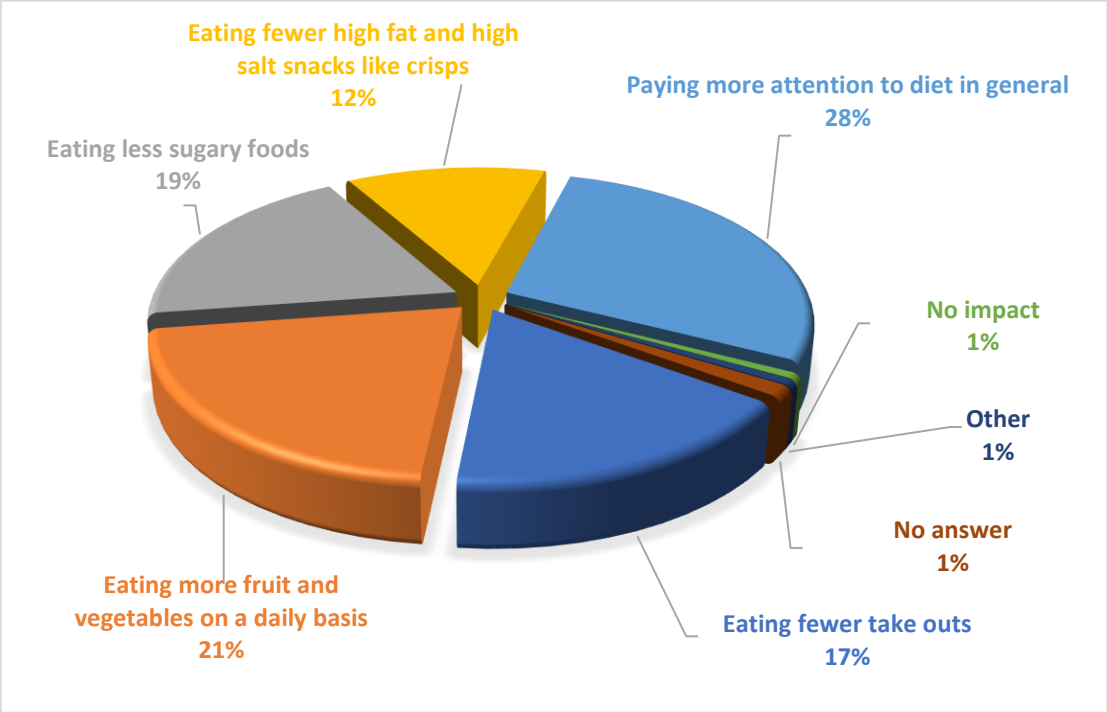
> *It would be great to take on new challenges like building connections with homeless accommodations,* Direct Provision Centres *in the area. I believe these people are hard to reach and more disadvantaged and they will benefit greatly from projects like stress management and Healthy Food Made Easy.*

The Healthy Communities Programme is constantly innovating by listening and responding to the needs of the community and seeking its feedback. Its staff are continuing to reach out more widely to new communities through various routes, including established and new organisations.

5.3.5 Healthier habits

The Healthy Food Made Easy course also had a positive effect on participants. At a group level, respondents had seen improvements in their eating habits, spending on food, health, and whether they will plan meals from now on[34] (Figure 15).

Figure 15. Healthy Food Made Easy: categories of changed eating habits



Source: TASC, 2023

Key changes include:

1. Eating more fruits and vegetables
2. Spending less on food due to changes in diet and shopping in new stores
3. Increased energy and capacity to focus and overall feeling better

[34] Pre-course questionnaires were completed by 106 participants (61% female, 38% male, 1% unknown; average age of 45.4 years). Post-course questionnaires were completed by 59 participants (66% female, 34% male; average age of 39.5 years). Two empty responses were removed. Questionnaire responses were recorded anonymously, therefore it is not possible to track the pre- and post-course answers at the individual level.

4. More home cooking and plans to increase fruit and vegetable intake

One respondent indicated that there was no change to their eating habits as they were diabetic and already on a strict diet plan.

During an interview, a social prescribing participant specified some of the changes she had made to her diet after completing a Healthy Food Made Easy course. Prior to the course, she used to eat bread and butter for breakfast in the mornings and now eats porridge and Weetabix for breakfast. Now she also eats fruit and healthier food in general.

Ninety-eight percent of respondents indicated that they would recommend the course to others. These positive findings from the questionnaires are in line with previous results from the February 2022 TASC report.

After a six-week Healthy Food Made Easy courses held at the Simon Community, many members of the group (all of whom were experiencing homelessness) told the course facilitator that they 'hadn't cooked for themselves in months or years' and that they had 'decided to create a cooking group once a week to take place [after the course was completed]'.

This staff member provided another example during their staff reflection which shows the cascading impact that one course can have on an individual's skills, self-confidence and the way in which they interact with those around them:

> *Another example of a positive incident that happened during a class was more recently with a class that took place in Ballybough. I had some local adults, some migrants and some young people who were currently living in emergency accommodation. One of the young people (a homeless teenager who [was] also on the autism spectrum) stood out to me with an initial improvement straight away. We met in the first class and prepared a simple dish (Bruschetta). During the class I gave each of the participants a different task to do. For the young guy in question, I got him to slice and toast the bread we were going to be using. While he was doing this task*

we got talking and he told me that he never has cooked for himself and didn't even know how to use a toaster. The following week we baked bread and made soup. He also brought his girlfriend with him that week as it was her birthday and he wanted them to cook a meal together. After we completed the meal for that week, he told me that his hostel has a group cooking session and that week in question he planned to cook the soup and bread again on his own for the other members of his hostel. I found his quick turnaround from little to no cooking skills to going to cook an entire meal for his fellow housemates to be really uplifting.

5.3.6 Support in smoking cessation: We Can Quit and Smoke Free Homes

The Healthy Communities Programme offers two courses designed to reduce smoking in the community. Both courses focus on making lifestyle changes but take different approaches. The We Can Quit programme delivered by the Healthy Communities Programme is an example of the value of participating in, but perhaps not completing, an intervention. Some participants on this course had begun smoking when they were children and were heavy smokers.[35] While they were clear on their reasons for quitting, which included health, cost and feeling better about themselves; there was still an understandable reluctance to enrol:

A man […] in his early 70s was smoking for nearly 60 years was really reluctant [to join] and scared to do the 10 week 'We Can Quit' programme but his doctor suggested he should, (his mother died at 40 when she quit smokes) so was concerned if that's why she died. (Fast Forward) he completed [the] 10 week programme and could not believe he quit and would've loved the course to be even longer as he loved going to the group he felt really supported.

These barriers had been overcome by some through receiving support from family members or friends in order to participate in the We Can Quit course. This

[35] Data was collected from April 2021 until November 2022. Pre-course questionnaires were completed by 61 participants (80% female, 20% male, average age of 50.6 years). 'Health reasons' (N=16) was the most common response when participants were asked why they wanted to quit. Additional responses included 'cost' (N=12) and 'feel better about myself' (N=11).

made a difference in their participation. Additionally support was also found from the Co-op's partner pharmacy on the training programme (by 59% of completed participants); some of whom shared stories of their own experiences of stopping smoking.

Despite the barriers, all those who completed the course stated that they had either reduced their smoking (24%) or completely stopped smoking (76%) as a result (see Appendix 17 for detail on number of cigarettes smoked) and now have additional money to spend on social activities with friends.

The majority of those who completed the course stated that the most important aspect of the course was the group atmosphere, chiefly, the support received from their peers and the facilitator. Facilitators provided support to participants over the phone and through text messages. Participants supported each other in between sessions through WhatsApp groups. All respondents felt that they would recommend this course to others.

The four week Smoke Free Homes programme is another option for those who want to become smoke free or reduce their consumption of tobacco products. It encourages them in smoking cessation, including only smoking outside or in one room of the house with the aim of making their homes healthier for everyone (e.g. for children and adolescents). It also encourages them not to smoke in a car if children are present.

The Smoke Free Homes course was co-delivered by Healthy Communities Programme and the local HSE Health Promotion and Improvement team. A full evaluation was designed into the course implementation programme and therefore no direct evaluation is included in this report.

Preliminary results from the HSE draft report[36] state that the course was well received and met the project aims by supporting households in reducing their smoking. The HSE draft reports online survey results in which 93% of respondents stated that they would continue to keep their homes and/or vehicles

[36] Smoke Free Homes programme report draft version 5 HSE CHO DNCC and the Co-op as part of the NEIC HCP.

smoke free areas; 75% were motivated to consider quitting smoking; 56% requested information on smoking cessation and all respondents stated that they would refer others onto the course.

The HSE draft report also included statements from programme participants describing how the course served as the support they needed for taking steps to quit smoking. One participant commented:

> *Prior to the programme I had started a quit attempt. Thanks to the programme and the resources I received I have now quit and I am less reliant on nicotine replacement treatments. It was also great having someone check in.*

5.4 Programme strengths

5.4.1 The Healthy Communities Programme team

Programme coordinator

The Healthy Communities Programme project coordinator guides the Healthy Communities Programme team by ensuring that the vision and aims of the project are being actively pursued through every aspect of the team's work. This includes providing support and supervision directly to staff, and being reactive to the needs of those accessing services and the NEIC community as a whole.

By being an active presence in the community, the project coordinator understands the needs of individuals in the NEIC and makes herself available to them. Another point of contact to assist them on their journeys. Where necessary, feedback becomes action. This reactivity comes in the form of ensuring that the number and location of courses being provided meets the needs of community members.

The project coordinator also plays a prominent role in networking with stakeholders and project partners. This is accomplished through maintaining close partnerships with the HSE and other community organisations active in the NEIC and also by taking every opportunity available to promote the work of the Healthy Communities Programme.

As such, the project coordinator ensures that the work of the Co-op Healthy Communities Programme is known locally, nationally, and across various sectors. This includes liaising with staff working in community organisations and providing community services to make them aware of the support services available through the Healthy Communities Programme.

Community health workers

Community health workers can be an effective means of reaching out to disadvantaged communities and improving health outcomes. Their presence is highly beneficial to participants' happiness, stress reduction and willingness to participate in programmes. They are a source of support for individuals in the process of becoming knowledgeable advocates for their own health and wellbeing. They require cultural understanding and should come from the communities that they serve. This helps to build trust, bridge

communication gaps, and overcome cultural barriers, which can be crucial in disadvantaged communities where there may be a mistrust of formal healthcare systems.

Community health workers are also accessible to the NEIC residents and provide services within the community and speak directly with people in their homes and on the street. Transportation, limited finances or language barriers may serve as barriers to access that may be difficult for some populations to overcome. Community health workers supplement the work of the Social Prescribing Link Workers by providing community education, referrals and necessary support to suit an individual's needs in a culturally sensitive and acceptable manner.

Community health workers connect community members and formal healthcare systems. They can help individuals navigate the healthcare system, schedule appointments, follow up on treatment plans, access interpreters and ensure continuity of care. This can be particularly important for disadvantaged populations who may face challenges in accessing and understanding healthcare services.

They are also skilled in health promotion and education, which allows them to provide information about preventive measures, healthy behaviours, and health management tailored to the community's needs. This can empower individuals to make informed decisions about their health and wellbeing. By being embedded within the community, trained in programme delivery, and being 'peers', they act as health ambassadors. The information provided by the Healthy Communities Programme community health workers can be more inspirational and moving to a course participant than from a facilitator without lived experience.

In addition, the community health workers have a strong role in community engagement and advocacy. They raise awareness about health disparities and social determinants of health, contributing to community-driven solutions (e.g. videos on lung cancer, various talks and presentations to both academia, policy makers and community members).

Community health workers work well as a part of a team embedded in the community and provide a host of benefits to community members, as detailed above. However, it's important to note that their effectiveness requires ongoing support (e.g. training, integration with the healthcare system, availability of resources and project management/supervision). With ongoing inputs, community health workers can play a significant role in reaching out to disadvantaged communities, improving access to healthcare, promoting health education, and facilitating culturally appropriate care. Due

to the high level of marginalisation known to exist in the NEIC, community health workers appear to be a necessary approach to meet the varied needs of the NEIC residents.

We welcome any opportunity to continue with this part of the programme to allow for further evaluation with a view to examining the evidence base for this type of capacity building approach. Further work is necessary to understand the role and impact of the community health worker, the Co-op model and the potential for its rollout in other communities.

Social prescribing link worker

The Social Prescribing Link Worker role within the Healthy Communities Programme is well supported by the project coordinator and the community health workers, thus allowing the Social Prescribing Link Worker the time to adequately support clients through all phases of the social prescribing process.

The Social Prescribing Link Worker supports clients by taking a person-centred approach. They get to know their wants and needs, as well as the challenges they face. This process starts at the very beginning, with social prescribing clients feeling supported and listened to from the first meeting. The support offered is consistent to the needs and goals of the specific client. Some clients may need to see a friendly face the first time they join a new activity. Others, although in receipt of one social prescription, may need referral to another service.

Social prescribing clients who might have challenges understanding and communicating in spoken English, have a hearing impairment or are in need of an interpreter provide additional challenges to the Social Prescribing Link Worker. This adds an additional dynamic to supporting clients. The Social Prescribing Link Worker considers all of the client's needs, including their interests, communication, age and mobility when engaging with the client and recommending courses and activities.

There are also some clients that either may never officially be enrolled in the social prescribing programme, or enrol and do not officially complete it (i.e. those that don't exit). The Social Prescribing Link Worker still may engage heavily with these individuals as well. For the individual who was enrolled in the programme the Social Prescribing Link Worker might determine, after contacting the individual and/or the referring agents, that

the individual received an inappropriate initial referral to the social prescribing programme (e.g. due to severe mental illness or addiction). On the other hand, an individual might move outside of the catchment area while still being enrolled in the social prescribing programme and the Social Prescribing Link Worker may spend considerable time trying to find new support for them in their new location.

Embedded in and trusted by the community

The Co-op is a trusted organisation in the NEIC and has extensive networks. Healthcare workers are continually referring participants to social prescribing. The project has already grown rapidly and its services are much sought after.

Staff bring a variety of personal and professional experiences to their current roles: addiction services, community development, homeless services, SP, and lived experience in the NEIC, migrant background, administration & organisation, communication and social skills.

As highlighted in the staff profiles, Healthy Communities Programme staff have connections in the NEIC, having grown up, lived and having worked in the area prior to joining the Co-op Healthy Communities Programme team. The lived experience of staff members assist the project coordinator, Social Prescribing Link Workers, and community health workers in reaching out to clients:

> *I would say I bring a knowledge of my own area, of the people and mind-sets of how people live and think being from the NEIC. I also understand how people interact with services and groups within this area and what would be more likely to attract people to them. Being a sports person, I also have a deep understanding of how important my own health and wellbeing is to me and the effects it can have on a person. I like to use my perspective on this to help other people and give them advice if needed when facilitating groups and talking with clients.*

Participants can divulge personal information, underlying stressors and trauma to staff during their interactions in person or over the phone. Multiple staff members mentioned influencing different aspects of client's lives through knocking on doors, delivering posters for different courses and organising activities.

The Healthy Communities Programme staff have access to a lot of information about the outcomes of programme participants: improved health, decreased stress levels, smoking cessation, reduction in depression and suicidal ideation were themes that came

up regularly in the staff interviews and the staff reflections. Many of these stories are very personal and information from interviews and focus groups with social prescribing participants show how trusted the Healthy Communities Programme staff are and how they become a part of people's lives.

One focus group participant shared what it felt like when she had just been diagnosed with cancer: "I was close to shutting the door cause I was so hurt […] there are a lot of people out there like me. And when you have a sickness you are full of fear. Full of […] full of fear. Full of fear". She described the connection that she made with Healthy Communities Programme staff:

> *[They] did more for me than anything. [The staff member] brought me inspiration to come back to life. Small steps maybe. It's done me a world of good. To even know that [the staff member] cares for me. Rings me. Texts me. […] Listening to me. There are things out there. Telling me about this group. Putting me on to little things. Opening doors for me. Cause I didn't have the mind to.*

The social prescribing participants interviewed recognise the importance of contacts with the staff and have indicated that these interactions are of vital importance to project and course engagement. Type of contact may include a text message, a phone call or an in-person meeting. In interviews and focus groups, multiple social prescribing and course participants stated that receiving a text message from a member of the Healthy Communities Programme could help them through their day. Evidence from other studies shows that confidence building and pre-engagement reminders supported by Social Prescribing Link Workers is essential to participation and engagement by the client/participant (e.g. in England; IEC, 2023).

5.4.2 A ‘give it a go’ approach

All of the social prescribing interview participants mentioned the approachability of the Healthy Communities Programme staff, which makes them feel respected, valued and listened to. This is partly generated by the flexibility of staff to meet people where they are. Social prescribing participants really appreciate this and speak highly of the programme and the staff who facilitate it.

The Healthy Communities Programme is structured to foster a sense of ownership within the social prescribing programme and Healthy Food Made Easy, We Can Quit and other course participants. Participants direct their own social prescription by choosing the activities that they wish to engage with. Staff provide support and encouragement in enrolling and attending courses. Social Prescribing Link Workers and community health workers don’t put undue pressure on people to attend courses and they do not monitor if someone has followed up on a social prescription.

There is a ‘give it a go’ mentality when it comes to encouraging people to attend courses, especially a course which they might not be familiar with or one which is held in a neighbourhood which they do not know. This is particularly important for people to feel that they have ownership of their own health and wellbeing, and are not being spied on. However, this can be challenging from a research perspective, as it is not always clear from the information recorded in Elemental why people have been referred on to the programme. This is because the reason(s) for the initial referral rarely provide the full picture, which often only comes from developing a trusting relationship with the client, over time and with experience.

The supportive management structure, trusting work atmosphere and sensitivity of the Healthy Communities Programme staff to the needs of the community have allowed the team to come up with innovations which have supported participants and increased the visibility of the Healthy Communities Programme in the community. Recently, staff set up social prescribing information coffee mornings. For one staff member, they proved to be “a great opportunity for [them] to get to spend more time working with the other members of the Healthy Communities [Programme] Team which [they] do not often get to do”. They went on to comment that:

> *The group was also a good experience to be part of allowing people to engage at whatever level was comfortable for them, some attending for one week, or a specific week because of interest in a particular service or activity. We also had people who attended every week which was a new experience for some.*

5.4.3 Wide-ranging provision responding to need

A key strength of the project is the range of courses on offer. The Healthy Communities Programme offers seven courses, with additional courses currently in development. These address a variety of areas which can improve individual's health outcomes: healthy eating (i.e. Healthy Food Made Easy and Cool Dudes), smoking cessation/supports (i.e. We Can Quit and Smoke Free Homes), stress and wellbeing, healthy self-advocacy (i.e. Well Now! and Mind Yourself!). Some of these courses are targeting particular groups that might have been challenging to reach otherwise or needed a specific type of targeted intervention, for example, Cool Dudes for school age children and Mind Yourself for men). For detailed descriptions of the courses, please see Appendix 14.

Previous TASC reports have documented that there is high demand for various courses in the NEIC, particularly those focused on stress relief. Data from course questionnaires show their benefit. Participants spoke well of them during interviews and focus groups, particularly Healthy Food Made Easy and Wellbeing & Stress Management. Such courses have impacted the lives of participants and have a knock-on effect to those around them, through both referrals, changed habits and passive learning.

The Healthy Communities Programme staff are also reactive to the needs of the community and working on developing additional courses as interventions to target community needs.

5.4.4 External collaboration

Partnership and cross-sectoral working

The Healthy Communities Programme in the NEIC is a great example of partnership working, involving representatives from the local community and voluntary sector, HSE, the DOH and the local authority working towards a shared goal. This partnership incorporates experience, skills and knowledge from different sectors, adds value and depth to the project and allows for future collaboration on new developments and opportunities within the area.

Stakeholder Engagement

The involvement of key stakeholders occurred early in the project. Continued involvement based on their interest and influence on the implementation of the Co-op Healthy Communities Programme, has been crucial to its success. Stakeholders meet on a regular basis to hear project updates and provide feedback and support. Such consistent stakeholder engagement ensures 'buy-in' which then supports the sustainability element of the project.

Building Capacity

Supporting local community health workers to build their capacity through education and other opportunities to support local communities is a unique element of the Healthy Communities Programme in the NEIC. Relationships and trust are quickly established within the community which develops participation.

Communication

The regular and timely communication among all stakeholders involved on specific actions and opportunities helps foster positive and productive relationships, while continuing to build and reinforce trust among stakeholders.

Problem solving

Due to positive working relationships, challenges are discussed in a timely manner allowing for suitable solutions to be discussed and procedures put into place to ensure project delivery in-line with the Grant Aid Agreement between the Co-op and the HSE.

Empowerment and Participation

The Healthy Communities Programme is underpinned by the health promotion principles of empowerment and participation where local communities are more involved in their health and wellbeing. Providing information and resources through programmes in a way that people can understand and make informed decisions to increase their health protective behaviours is key to addressing health inequalities in areas such as the NEIC.

5.4.5 Valuing and supporting staff

The health team is well supported by Co-op management with the staff feeling comfortable going to management with issues or concerns that they may have. Both the Healthy Communities Programme Coordinator and the CEO were highly praised in staff

interviews and staff reflections for their support and care of staff in the workplace. One excellent example of their active care and support of staff is in the Employee Assist Programme, which was adopted in 2021 based on staff suggestions and supported by management:

> *In 2021, a number of the Health Team had Social Prescribing Clients present with trauma and some of these were triggering for the staff and had the potential to impact the service delivery. I went to the CEO about this and suggested we needed some external supervision. The CEO agreed that this would have a positive impact and wanted to include all staff in the organisation, and he followed up [with] another member of the Co-op staff to source a company to do this and set it up. As a result all staff have six free sessions per year to use as they need.*
>
> *The CEO's response and support made [me] feel that I was valued and my experience and understanding of the situation was important. There have been other initiatives I have approached the CEO with and have had a similar response. This has aided in building my confidence in my own experiences and assessments of situations and has led me to trust my own judgement more.*

5.5 Programme challenges

5.5.1 Complex cases, complex lives

One Healthy Communities Programme staff member described their experience working with a client who they had just been on a call with:

Box 3: Complex lives

They have faced many traumatic events in life including, bereavement of many close family members, addiction, being homeless (which they are still navigating at this moment). Despite all of this, they are working very hard to make changes and improve [their] quality of life. They have made goals in line with this, one of which is to get back to work part time and introduce some structure into their day. We set about together to figure out what a realistic plan would look like for them, and they decided on community employment. We then found a suitable scheme that they could be referred to. The phone call today was to let me know that they had attended the scheme and had a start date for mid-January.

This is one of the many changes that in my role I have the privilege of witnessing. These changes are different for everyone. What seems like a very small action to one person may be an enormous and extremely brave step for another. Having a person who is extremely isolated and frozen with anxiety at the thought of leaving their house attend in-person for the first registration is an intervention and a huge achievement for some people. Being a part of that process is something that I do not underestimate and makes me very grateful to be in the position to encourage and support this action. I have been privileged to have someone confide in me about suicidal thoughts and ideation and I've been able to link them into the appropriate supports. That's another extremely brave action to reach out for support at such a difficult time and I am happy to be a link in that support.

Participants are not necessarily always available to attend every session. A number of women mentioned have caring responsibilities that often take priority over attending a course or linking back in with staff. These responsibilities can impede their abilities to attend and individuals can face an urgent situation at the last minute that needs to be attended to.

The complexity of participants' lives also came out in interviews and community focus groups. Initially, they were quick to use nondescript or superficial terminology/phrasing when discussing their reasons for being referred—often using 'loneliness' and 'isolation.' However, after the first five or ten minutes in an interview, they would begin to mention multiple underlying factors in their lives that could have influenced their feelings of loneliness and isolation.

As previous evaluations have outlined, dedicated time, expertise and patience is required in supporting those referred to the programmes. Social prescribing referees often have complex health issues, coupled with social isolation and depression, and require consistent support and communication. Enrolling course participants into courses can be challenging for staff. For example, staff explained how tricky it is to make referrals to the We Can Quit smoking cessation course. As participants lead complex lives, smoking might be one way of managing stress. They may enrol in the course, and attend some of the sessions, but not enough to be considered to have completed the course. In 2022, 29% completed the course.

One staff member highlighted the challenges of getting people to sign on to the We Can Quit course, commenting that "it is such a struggle to get people to sign up as they have so much other stuff going on in their lives".

The social prescribing programme has had a large number of referrals, but a relatively small number of participants who have completed the programme. This has made assessing outcomes challenging for this report. Evidence from four interviews indicate that those who are on the programme or have completed it are doing well. Evidence of increased wellbeing is also seen in the average change of the wellbeing assessment scores.

Due to the small number of individuals who have completed the social prescribing programme, it is difficult to assess the wellbeing scores on an individual level. However, there was some individual variation in the magnitude and direction of change, with some individuals providing lower wellbeing scores post-programme. These results are supported by findings from other studies indicating that most participants benefit from significant improvements in wellbeing (Chatterjee et al., 2018).

From the staff perspective, the low numbers of those who have completed the social prescribing programme are largely due to the complexity of people's lives who are referred on to it, coupled with the (at times) late referral received. As illustrated by the social prescribing participant case study, those referred to the Healthy Communities Programme may face multiple challenges not initially identified by referring organisations/individuals. In addition, other challenges may become apparent over the course of their journey through the social prescribing programme. Secondly, Healthcare workers might not make the referrals early enough and could be using the social prescribing programme as a last resort, rather than part of their medical tool kit. For some patients struggling with loneliness and anxiety, social prescribing could be coupled early with counselling and clinical interventions.

As more data become available in Elemental, future analyses should include an assessment of the pre- and post-course wellbeing scores, coupled with interviews to better understand the impact of the social prescribing programme on individual outcomes.

5.5.2 Barriers to participation

The Direct Provision Centre focus group respondents identified a number of barriers to participation in the NEIC community: knowledge of opportunities, legal status, the lack of recognition of previous qualifications, concerns of stigma and negative attitudes if identified as an asylum seeker. When asked directly, no one had experienced any racism or prejudice that would prohibit them from utilising community resources. However, they had witnessed discrimination being directed towards others and behaved in ways to minimise potential conflict: not speaking about their international protection applicant status.

They did not have much, if any, contact with long-term NEIC residents. They did not come across any working in the local shops or have any friends in the area who were born/raised in the NEIC. When asked about Co-op activities, they mentioned that some were not culturally acceptable. For example, when asked why no one attended the Big Scream Halloween event the group responded that they felt that was not necessarily linked to their culture or interests and therefore they had not brought their children along. They commented that they would welcome more outreach to migrants and would be interested in engaging with the Co-op for courses and events that related directly to their needs.

Due to challenges of attendance and completion, it is essential that the Healthy Communities Programme staff continue to promote the project and ensure ongoing referrals onto it, particularly when there are fluctuations in Healthcare worker staff, and

new staff are not aware of the Healthy Communities Programme, or Healthcare workers don't have the capacity to follow up with patients regarding a referral. In addition, links to other referrers with contacts with new arrivals to the area, would support continued work with migrant communities.

Healthy Communities Programme staff have been promoting the Healthy Communities Programme in the local community and among health care staff who would refer patients. Programme promotion includes word of mouth, flyers made visible at local hospitals and GP practices and through people's doors. For examples, please see Appendix 14. Information provided within the flyers includes descriptions of the social prescribing programme and its benefits, examples of the types of activities and how individuals may get involved.

The NEIC focus group also expressed a lot of fear and concern about their physical environment and the lack of connection to other community members. The conversation was dominated by the ways that they felt disconnected from each other (e.g. lack of safe social space, addiction, drug use, antisocial behaviour, road blocks/barriers being put up in laneways, people moving away, renovations to social housing, etc.) and the challenges they faced from their mental and physical health concerns.

One female participant who was a lifelong resident of the NEIC commented:

> *There are things going on in the area […] things that people is going through. You know like with the addiction and children and the alcohol with the kids and other things as well […] and we are just learning about the health stuff as well. And when you are sick. After being sick you are just left on your own. You have to go for a psychiatrist.*

Later, she continued:

> *There is a lot more to do now than there would have been in the 70s. There is a lot more going on now than there was then […] the problem is getting the information about them because sometimes people don't know even though they live in the area. Do you know what I mean? People don't see it really and people don't have the phones […] There are a lot of people in this area that need help.*

There is also the need for more projects. As one participant stated: “There is good projects in the area. There is good projects, but I think that there could be a good bit more”.

One respondent suggested setting up community supports in a central location:

> *There is the Rutland street school and it is close and it’s a big school. If that was maintained and the room done up […] that would be just the best thing that could happen to this area. [...] We need support. We need support as well, through that other stuff. Or I do. I believe that school should be open.*

Both members of the Direct Provision Centre and NEIC focus groups raised concerns around the transient nature of the NEIC, expressing feelings of loneliness and isolation, fear and marginalisation. They were all concerned that the NEIC did not feel like a community or a neighbourhood, or a safe place for them to spend time interacting with family or friends. The NEIC has good transport links and many people come to the area for that purpose. However, because a wide range of people use the area to access buses, trains, etc. it is difficult to identify who lives in the area and who is using the space. It is not a place where you could get to know your neighbour. A few focus group participants commented on the lack of corner stores where they could chat with neighbours, that the local post office[37] had closed (and the GPO is the closest alternative), and the ‘neighbourhood feeling’ had gone with the replacement of the flats with new developments. They went on to discuss that these did not foster social interactions, but served to further people’s feelings of isolation from each other and disenfranchisement from society. The lack of cleanliness and concerns about the prevalence of antisocial behaviour in the area were also primary concerns.

The Direct Provision Centre group agreed with the NEIC focus group that they would like more projects available to them. They would also like increased access to safe social space for themselves and their children. Although they did not suggest a specific location (e.g. Rutland Street) they did specify the need for clean streets free of antisocial behaviour and that a community park/green space would be beneficial.

[37] Note: there are a number of post offices open in the NEIC area, but they just may not be close to where these individuals live.

All felt that more safe opportunities to spend time out of doors would benefit them, but there are no/few safe and accessible parks or green spaces in which to walk or play.[38] Other social prescribing research has found that the health and wellbeing of individuals have been positively impacted by both the contact with and the connection to nature: higher mental wellbeing and lower anxiety (Mugha et al., 2022; Seers et al., 2022a, 2022b). However, access is not uniform; and there are barriers to accessing public parks and natural spaces, with those with low incomes more likely to face those barriers (Mugha et al., 2022).

5.5.3 Staff workloads

Although there was no assessment of staff workloads included in this study design, other studies have found that they are heavy. There is certainly a need for a high degree of support of some participants in order to encourage enrolment and attendance. Even when they agree to join, they may not show up to a course in which they have professed to have an interest.

However, data from social prescribing participants and the challenges faced by the research team in inviting them to interview suggest that some individuals are just not readily contactable. For example, seven social prescribing participants agreed to an interview, but either never answered the phone, returned the call or missed their interview appointment. Multiple challenges include not having a mobile phone, not responding to calls from unknown numbers, not responding to text messages from unknown numbers, forgetting or double-booking the appointment.

The Healthy Communities Programme staff have a high workload and manage it with great sensitivity to their client's needs. Their regular team meetings and WhatsApp group are certainly beneficial for raising issues with colleagues and asking for advice. However, every effort should be made to ensure that the staff have a dedicated office area. This will both benefit both the staff as well as the clients that they support.

[38] Note: There are parks and green spaces in the NEIC. However, participants felt that these were not adequate for their needs, unsafe (e.g. due to antisocial activity) or difficult to access (e.g. too far from their homes in the case of those with mobility challenges or barriers put up to block access through direct routes).

5.5.4 Barriers created by built environment

Healthy Communities Programme staff currently work in a hybrid environment, meeting with each other on a regular basis. One constraint they have is limited office space, but can find available space 'on demand.' This is due to both limited office capacity in the building as well as the part-time hours that some staff are working. The lack of dedicated office space has come up repeatedly during the course of data collection: lack of private space in the office to meet with social prescribing participants, external colleagues or guests, and the lack of office space for the team to meet. Staff all mention space when asked what would support further in their work:

> *A dedicated office space for the Health Team based in the community would be welcome. However, I am aware that this is beyond the control of the Co-op and is unlikely to become available anytime in the future. In the absence of a Health Space, additional storage as close as possible to the Co-op office would be of support.*

Another Healthy Communities Programme staff member went on to discuss what having a dedicated space would mean for their work and the place of the Healthy Communities Programme in the community in serving as a touchpoint for people who lead complex lives and are hard to reach:

> *A space that the team could be housed in would allow us to [be] embedded more fully in the community, to have a place that they know at any given time there would be some members of the Healthy Communities Programme team present to speak to and gain support or information on whatever would help improve the wellbeing of the community. It would also facilitate a much more practical way of collaborating on plans and projects as a team. [As well as space for] upskilling and training to continue to engage in professional development in line with our roles.*

Having their own office space and private meeting room would also further the project's visibility among referrers. For the time being, however, the Health Team bridges this gap by meeting on a regular basis to discuss their work. There are regularly scheduled meetings on Zoom, but also a group chat on WhatsApp, which allows them to raise issues immediately with colleagues.

There is also a lack of space for participants. However, the Healthy Communities Programme uses a variety of different locations to meet the need for space. The Co-op's

own meeting room is available on Tuesdays and Thursdays for use by the Healthy Communities Programme team. This space needs to be booked in advance as other Co-op projects/staff also look to use it as well.

The Co-op has also hired the local community hall right beside the office by block booking and paying for its use on Mondays, Wednesdays and Tuesday evenings. When not in use for specific Healthy Communities Programme training the space is available for Healthy Communities Programme staff to use for meetings.

In addition, the Healthy Communities Programme has access to a clinical room at Summerhill Primary Care Centre, which is located 250m from the Co-op. At the end of 2022, the clinical room was available to the Healthy Communities Programme on Tuesdays (14-17:00h) and Wednesdays and Thursdays (09-13:00h) and offered the opportunity to meet programme participants face-to-face in a private environment. However, the time that this space is available for use by Healthy Communities Programme staff is limited, and may not be available if someone were to walk in the door of the Co-op looking for support from Healthy Communities Programme staff.

For many participants, the first visit to the social prescribing programme is a little intimidating. For some, meeting in a clinical setting may provide reassurance that they are meeting in a professional, credible and safe space. However, the clinical atmosphere might not be the most appropriate setting for a community and person-centred service. It should be acknowledged that a clinical space will be off-putting for some clients.

The Direct Provision Centre had a space available for communal use (a widened area connecting the stairs, bathrooms and kitchen) that is regularly used for meetings. It had been used for the Wellbeing & Stress Management course as well as a focus group. However, those attending could be overheard, and also viewed, by other residents or guests who were not participating in the activity but also needed to use the space. The Healthy Communities Programme staff recognised early on in the Wellbeing & Stress Management course that the space being used was not entirely appropriate for the course or the participants. They decided to continue with the momentum that the course had gained in the first few weeks and the benefits of being visible for Direct Provision Centre residents to drop in from week to week. Finding an appropriate space, which is both accessible to the Direct Provision Centre residents and easy for them to attend is a challenge in accessing this and similar groups in the NEIC.

5.5.5 Elemental software as a client management tool

Elemental software is a client management tool which allows for a smooth and efficient referral process, easing the workload on Healthy Communities Programme staff. Demographic data are standardised and the programme also allows staff to manage and access client data from any location–which facilitates the hybrid work environment in which the Healthy Communities Programme staff function. Also, multiple client cases can be assessed and managed easily by team members and it is possible to quickly generate figures and tables from certain data.

Elemental is an integral part of the social prescribing programme and essential to managing social prescribing participant data. When contacted, the company that makes the software has been open to making modifications to it to further facilitate the needs of the Co-op Healthy Communities Programme staff and TASC researchers. However, there are costs associated with modifying Elemental to better fit the needs of the Healthy Communities Social Prescribing programme. It has been made clear by other social prescribing programmes that options available within Elemental are limited for them as well.

Not all referring organisations currently use the electronic/automatic referral process. Some work should be done to understand the reasons why they prefer the paper-based system. Although this is potentially easier for the referrers, it is an administrative burden which creates an extra burden on the Co-op Healthy Communities Programme staff. However, it is acknowledged that making the referral process as easy as possible for Healthcare workers is to the benefit of programme participants.

If this process is going to continue, it would be helpful for the monitoring of the referrals if the Co-op would be able to manually enter the organisations into the system which are not currently referring directly. At present, these are listed as referrals coming from the Co-op.

Quantifying the human experience with an electronic database is challenging. For example, the data on Elemental is an underestimate of the number of contacts (or attempts) that the Healthy Communities Programme staff has with their clients. This undercount is because, in a minority of cases, staff do not always have time to log a brief call, text message, or an impromptu conversation with a course participant on the street.

Various types of contact are recorded in Elemental and these data are automatically aggregated. That is, it is not possible to see the number of contacts per individual participant. It is also not possible to distinguish between contacts with the participant

themselves or contacts with health care workers/referrers about a participant. Ideally, it would be useful to be able to monitor the number and types of contacts per individual and compare that to outcome indicators (e.g. duration in the programme, wellbeing scores and qualitative interviews).

What we can tell from Elemental data is that Healthy Communities Programme staff are regularly keeping in touch with social prescribing participants and Healthcare workers. Interviews with Healthcare workers and social prescribing participants indicate that these contacts are timely, and useful for promoting programme engagement as well as managing/monitoring participants' needs.

In addition, Elemental can't tell us about the quality of interactions between clients and staff. However, the data from the qualitative interviews and focus groups indicate that the interactions are of high quality and beneficial to participants.

The Elemental data included in this report are for 150 social prescribing participants, many of which are still progressing along their journeys. Social prescriptions suggest that participants face multiple challenges and that putting an expected completion date down at the beginning of someone's journey might be counterproductive.

5.5.6 Long and complex journeys

The social prescribing programme at the Co-op is just one piece of the puzzle. Some participants have long-term engagement with the programme, which can't be assessed on the short timescale of this research as tracking patient/client needs is often challenging when dealing with complicated cases/multidimensional problems.

Through the process of this action-based research project, staff mentioned that they will often refer participants on to other programmes. The number of social prescriptions from the programme is twice that of referring organisations/services into the programme. To date, the reasons behind social prescriptions are unclear as such information is not systematically captured in Elemental (e.g. it may be located in the case notes, however) and it may be difficult to follow up with participants directly. Social prescriptions may depend on the level, type, complexity of need, or the appropriateness of the initial referral received by the Co-op (e.g. in the case of active/ongoing addiction). Fifty-three organisations were identified receiving social prescriptions from this project, including legal aid, employment, community development, adult learning and addiction support.

Based on the current data available there is no way of knowing if participants engage with the social prescriptions. However, this information could provide insight into the complex needs of participants. To fill the gap in information available in Elemental, the Healthy Communities Programme team has provided a list of organisations which have received client social prescriptions (please see Appendix 15).

This evaluation confirms that the Co-op works with individuals who face high levels of multiple disadvantage. Barriers include poor mental health, unemployment, education disadvantage, poor quality accommodation, poor health status, addiction, social exclusion and marginalisation. The Healthy Communities Programme provides a much needed source of support and a range of valuable interventions for this NEIC community.

Healthy Communities Programme staff are both building trust with community members at an individual level and investing in the community as a whole. The Healthy Communities Programme plays a key role in integrating services in the NEIC. It is particularly necessary when health care workers are unable to both effectively signpost and encourage high-need patients to attend community-run services.

Residents feel connected with the Co-op and its partner organisations, they trust their staff and are motivated to participate in programmes. The project has grown and its services are in increasing demand. Participants are referred for a range of reasons but often isolation and loneliness are initially cited and then on further conversation, underlying barriers emerge. Social prescribing participants have stated that participating in the programme has resulted in increased self-confidence, decreased loneliness and social isolation, increased community engagement, increased sense of purpose and support in accomplishing goals. Observational research supports the growing body of knowledge about the benefits of social prescribing (e.g. Liebmann et al., 2022).

The average improvement in wellbeing scores indicates that the participants in the social prescribing programme are experiencing good outcomes and benefiting from the Healthy Communities Programme support. Positive outcomes have also resulted from the Wellbeing & Stress Management course, including increased self-esteem, reduced stress and anxiety and learning techniques to manage pain, improve mood and sleep. Similarly, men enrolled in the Mind Yourself men's health sessions gained confidence to talk about difficult topics. Participants on the Healthy Food Made Easy course cited positive impacts on their lives that included eating more fruits and vegetables; spending less on food due to changes in diet and shopping in new stores; increased energy and capacity to focus and overall feeling better and more home cooking and plans to increase fruit and vegetable intake. The average improvement in wellbeing scores indicates that

outcomes are good for those participating in the social prescribing programme and that they are benefiting from the Healthy Communities Programme support.

Even with more challenging courses that participants may not complete, such as the smoking cessation We Can Quit course, those that did attend spoke of the importance of connecting with others and the supportive atmosphere created by other participants. The most important aspect of the course was the group atmosphere. All respondents said that they would recommend this course to others.

The Co-op's format allows for social prescribing participants to craft their experiences in the way that they connect with social prescribing and its associated programmes. This includes having a flexible approach. Evidence from this report provides further evidence of how co-design and co-production is of benefit to the social prescribing process. The data show that Healthcare workers are referring patients on to the social prescribing programme who then are supported to get out more and meet people in their community. This is achieved through engagement in skill building activities conducted in a social setting. In addition to enrolling in courses offered by the Healthy Communities Programme, social prescribing participants are also going on to engage in courses run through other programmes. People are also linked to other support services in their community, such as housing support or counselling services. The social prescribing programme is tailored to the needs of the participant and is the link to the social prescribing participant accessing wider community based services outside of the Healthy Communities Programme programmes.

Social prescribing participants are recommending the Healthy Communities Programme courses and the social prescribing programme to their family and friends. Such courses have impacted the lives of participants and have a knock-on effect to those around them, through both referrals, changed habits and passive learning. As part of co-production, the project is responsive to the needs of the community and works on developing targeted additional courses for them.

The project's staff are a huge asset. They are motivated and able to build trust and rapport quickly, partly because they consist of peers and advocates with lived experience working with marginalised communities. This approach is advantageous as participants tend to respond favourably to someone who they can identify with on some level (e.g. Neuhaus et al., 2022). Staff feel supported by Co-op management and are able to go to

them with issues or concerns. Their roles are also supported by ongoing training and development.

However, the project faces challenges including constraints on creating safe and welcoming spaces for residents. Participants, who may already have feelings of disenfranchisement (Mulvey, 2017) have commented that their first visit can be daunting and that meeting in a clinical setting may not be the most appropriate environment for a community and person-centred programme such as social prescribing.

Although this research spoke to a small proportion of those who are resident in the area a wide range of voices were heard. Coupled with the continued increase in the number of international protection applications and beneficiaries of temporary protection from the Ukraine to the area, there are increased numbers of vulnerable individuals needing support. Residents continue to face barriers to participating in the programme. In focus groups at Direct Provision Centres, respondents described their fear of discrimination, concern of stigma and negative attitudes if identified as asylum seekers, their limited knowledge of opportunities, precarity of legal status, and lack of recognition of their previous qualifications. Staff spend much of their time following up contacts and encouraging attendance with vulnerable participants. The evaluation notes that their role involves a difficult balance between supporting clients and encouraging commitment to attend the programme.

Staff also face a range of challenges. They face high workloads, partly due to the amount of time devoted to following up with participants with complex needs, but also due to the process of referral. As discussed earlier, they refer their clients to many organisations, including legal aid, employment, community development, adult learning and addiction support. Despite the intensity of resources used in this process, there is currently no data to confirm whether or not participants engage with these ongoing referrals. This also leaves less time for the necessary continued promoting of the programme and retaining visibility of the Co-op and its courses within the community to ensure ongoing referrals.

Workloads are not alleviated by the limitations of the social prescribing software. This includes the amount of administration that is still done by hand, missing data on incoming and outgoing referrals and limits to what data is recorded during participation on the programme. Constraints on space and the impact on delivery is also a recurrent theme in feedback from staff. This presents a range of challenges, including lack of private space to meet with participants on a one to one basis, for confidentiality, or to meet with external guests, such as partner organisations. The team currently bridges this gap by meeting on

a regular basis on-line and through group chat on WhatsApp, which allows them to raise issues immediately with colleagues.

The study has shown the need to develop internal evaluation of the quality of programmes and the importance of continuous (external) evaluation of participant outcomes in order to increase engagement with Healthy Communities Programme courses and improve social prescribing programme outcomes (e.g. wellbeing scores). The use of Elemental has been helpful for the Healthy Communities Programme staff in managing client data. However, the effectiveness of the data management software to assess outcomes needs addressing (e.g. limited reporting access to researchers, aggregated equality monitoring data, etc.). Finally, it is important to develop protocols for including those who disengage with the social prescribing programmes and courses so that the impact of social prescribing on individual outcomes is better understood.

6.0 Conclusion

To conclude the findings of this report, one of the greatest strengths of the Healthy Communities Programme project is the relationships that its staff have developed with the community, including extensive networks with the people living in NEIC, the community partner organisations and statutory bodies. One of the key assets of the NEIC model is that it employs local staff that understand the community and are effective in addressing its needs. Many have lived experiences that allow them to build trust and to connect with people in the community. This greatly helps in both informing and motivating them in their roles.

While the staff are an invaluable support, an important objective of the project was that participants felt they were empowered to take ownership of their health. By applying a person centred approach this has enabled participants to choose activities that they want to engage in. In conjunction with the evidence-based programmes, this has led to greater participation and increased engagement in the community.

The success of the programmes is seen in the levels of participation between 2021 to 2022. In total, 527 participants attended courses such as Healthy Food Made Easy (253), We Can Quit (22), Smoke Free Homes (58), Health Literacy Well Now (19), Wellbeing & Stress Management (27), and Health Literacy Mind Yourself (2). Overall completion rates for courses was high at an average of 74%. This resulted in increased wellbeing, increased confidence to talk about difficult topics, developed healthier habits and ways to stop smoking. Other findings highlighted included the building of self-efficacy in personal health and wellbeing, building relationships and friendships with others in the group, gaining skills and experience that could be applied in their daily lives as well as a reduction in depression and isolation.

The need for secure and private space remains a challenge for the project. Therefore, a long-term goal is to find adequate space for these invaluable supports. Although the project is running effectively as it stands, this challenge may grow in complexity due to

increased interest in programmes as well as a growing population in the area. Ongoing evaluation is needed to ensure the project continues to tackle health inequalities and meet the complex and evolving needs of the population of the NEIC.

7.0 Highlights 2023

Establishing a community project like this takes time, but the Healthy Communities Programme has already achieved significant milestones, including:

- The addition of an extra clinic day for Social Prescribing each week (Fridays, 9am to 5pm until September 2023) in Summerhill Primary Care Centre, This helping to alleviate the pressure on wait times, albeit only sustainable until September 2023.

- Collaboration with Larkin Community College to deliver the Healthy Food Made Easy course to 24 first-year students in the football development programme. This has been led by a community health worker. The positive feedback from the evaluation prompted Larkin Community College to offer the course to all first-year students in 2023/24.

- Following a Healthy Food Made Easy course for men in the Salvation Army residential centre, the Healthy Communities Programme team is developing a 12-week Health Programme that covering Health Literacy, Wellbeing, and Stress Management. This programme, facilitated by external experts and the community health workers, aims to empower men in the programme.

- Responding to the popularity of Social Prescribing coffee mornings and feedback from participants, the Healthy Communities Programme now hosts community coffee mornings every Monday (10am to 12pm). This helps foster relationships the community health workers and provides a platform for health-related discussions from external health experts. It also increasing community engagement, simply through offering a drop in service for a chat and cup of tea with local people.

- Expanding upon the success of the Social Prescribing coffee mornings and relaxation sessions, the Healthy Communities Programme introduced a six-week Wellbeing & Stress Management program, accessible to the broader NEIC community, alongside a six-week Chair Yoga course

- The Healthy Communities Programme also offered the Healthy Food Made Easy programme to We Can Quit participants for an additional six weeks after the We Can Quit programme was complete. This extension was a direct response from participants' interest and requests to do more programmes future. It was held in the same venue and at the same time as this suited the participants, therefore increasing engagement in the Healthy Communities Programme.

- Training took place with two local school teachers in Healthy Food Made Easy in 2022, followed by access to the Cool Dude training in January 2023. This allowed the Healthy Communities Programme to collaborate with the home school community liaison to deliver a Cool Dude programme, focusing on particularly vulnerable children in local primary schools.

- Following on from the success of the Smoke Free Homes Campaign in 2022, where 58 homes participated, the Healthy Communities Programme repeated the campaign in 2023, with an impressive 104 homes taking part and completing the programme.

- Significant efforts have also been carried out to enhance public awareness and strengthen partnerships of the programme through participation in national conferences and events, such as the Health Promotion Annual Conference at National University of Galway in June 2023.

- Increasing visibility and partnership with the HSE through activities like having a stand at the Hill Street Family Resource Centre Intercultural Family Fun Day and making presentations at Larkin Community College's awards ceremony.

8.0 Recommendations

These recommendations are based on research conducted between October 2021 and January 2023. The evaluation consisted of both quantitative and qualitative data analysis, drawing on site visits, interviews, focus groups and meetings with participants, staff and stakeholders.

1. Leveraging Local Expertise and Community Engagement

The strength of the Healthy Communities Programme lies in its community-centred approach, underpinned by the involvement of staff members who are from the area and the diverse array of courses that are offered. This approach has been instrumental in the successful implementation of the project in the NEIC. Having team members who share a deep understanding of cultural nuances, geographical factors, and accessibility challenges, benefits the project in a number of ways.

It ensures smooth running of the project and increases participation as the participants are empowered to sign up as they either know the person facilitating or know that the community health workers will also be in attendance. Therefore, it fosters trust through personal connections and word-of-mouth, empowering participants to engage with confidence.

2. Investing in Sustainable Staffing

Another recommendation for this project is for increased funding to ensure the sustainability of staff working on the team. Thus far, significant time and effort have been spent upskilling the staff and creating strong relationships between staff and other community members. Increased investment and job security would ensure longevity of staff contracts and therefore ensure the sustainability of the implementation of the project.

The project can contribute to addressing chronic non-communicable diseases by investing in behavioural change and prevention strategies, the. Neglecting investment could exacerbate health disparities and marginalisation. Long-term funding fosters partnerships built on trust, yielding positive outcomes in collaboration between community organisations and the HSE.

3. Enhancing Evaluation and Data Management

Continuous monitoring of programmes should encompass a validated evaluation component, standardised across all Healthy Communities Programmes. This includes both pre- and post-course measures, employing a mix of quantitative and qualitative methods. Ensuring participants input in the monitoring process is essential for accurate insights. Additionally, efforts to track long-term participant progress, acknowledging the complexity of their journeys, can contribute to determining lasting behavioural changes.

External monitoring of programmes and their impact on the broader population is crucial. Strengthening the evaluation process, including measuring the social return on investment, can provide a comprehensive view of health promotion and community development outcomes over the long term. Expanding the functionality of Elemental, would enable deeper data analysis and systematic follow-up.

In collaboration with the HSE and the social prescribing network, the implementation of a national standard solution for client data management is advisable. This standardisation should encompass programme structure, questions, and mandatory fields. A unified approach would facilitate outcome comparisons across various Sláintecare Healthy Communities Programmes, fostering research opportunities and ultimately enhancing individual and community outcomes.

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10.0 Appendices

Appendix 1: Referral organisations

Table A1. List of organisations, services, and individuals who refer into the social prescribing programme

Organisations, services and individuals who refer into the social prescribing programme	Website
ALONE Support Coordinator	https://alone.ie/
Ballymun Child and Family Resource Centre	https://ballymunfrc.org/
Balseskin Health Screening Centre	https://www.hse.ie/eng/services/list/1/lho/dunlaoghaire/social-inclusion/
Clúid Housing	https://www.cluid.ie
Dublin City Community Co-operative	https://dublincitycommunitycoop.ie/
Dublin Northwest Partnership	https://dublinnorthwest.ie/
Dublin Simon Community	https://www.dubsimon.ie/
Focus Ireland	https://www.focusireland.ie/
H.O.P.E Hands On Peer Education	https://hopehandson.com/
Homeless Healthlink	https://www.healthlink.ie/
HSE (e.g. Health Promotion, Mental Health, Social Inclusion Hub)	https://www.hse.ie/eng/about/who/healthwellbeing/our-priorityprogrammes/mental-health-and-wellbeing/
Inchicore Family Doctors	http://www.inchicoredoctors.ie/
Marino Tolka Mental Health Service	http://www.stvincentshospital.ie/marino-tolka
Mater Community Mental Health	https://www.mater.ie/services/community-adult-psychiatr/
Mater Hospital	https://www.mater.ie/
Navan Road Primary Care	https://www.centricgp.ie/

North Strand Mental Health Team	https://www.dublincypscdirectory.ie/ireland/health-wellbeing/h se-north-strand-mental-health-services
Northside Partnership	https://www.northsidepartnership.ie/
Respiratory Integrated Care	N/A
Ripley Court, Shielding Unit	https://ie.depaulcharity.org/
Safetynet Primary Care Social	https://www.primarycaresafetynet.ie/
Self Referral	https://healthservice.hse.ie/staff/benefits-and-services/occupational-health/self-referral/
Southside Partnership	https://southsidepartnership.ie/
Summerhill Family Practice	https://www.medicalhair4u.com/medicare/8ac8874/summerhill-family-practice
Summerhill Primary Care Centre	https://www.summerhillgp.com/
Whitworth Medical Centre	https://whitworthmedical.ie/

Source: Co-op 2023, data modified by TASC

Appendix 2: Social prescriptions (linked organisations)

Table A2. List of organisations and services included in social prescriptions

Social prescriptions from social prescribing programme to other organisations/services	**Website**
AgeAction	https://www.ageaction.ie/
AkiDwA	https://akidwa.ie/
Acquired Brain Injury Ireland	https://www.abiireland.ie/
Aware	https://www.aware.ie/
Beaumont Mindfulness and Relaxation Centre	http://www.beaumont.ie/marc
Chrysalis Addiction Support	https://chrysalisproject.ie/
CDETB Parnell Street	https://cityofdublin.etb.ie/
Crosscare (e.g. Café, Food Poverty Programme, Migrant supports)	https://crosscare.ie/
Women's Group, Support Clinic	
Daughters of Charity Henrietta Adult and Community Education	https://doccs.ie/
Dublin Adult Learning Centre	http://www.dalc.ie/
Dublin City Community Co-operative	https://dublincitycommunitycoop.ie/
Dublin City Therapy and Counselling	https://www.citytherapy.ie/
Dublin Northwest Partnership	https://dublinnorthwest.ie/
Early Learning Initiative	https://www.ncirl.ie/
Exwell Program	https://www.exwell.ie/
Family Carers Ireland	https://familycarers.ie/
Foundation Project CDETB	https://foundationsproject.ie/
Free Legal Aid Clinic	https://www.flac.ie/

Friends of the Elderly	https://friendsoftheelderly.ie/
Headway	https://headway.ie/
Hill Street Family Resource Centre	https://hillstreetfrc.ie/
Hill Street Counselling	https://hillstreetfrc.ie/
Homeless Health Link Social Inclusion Hub	https://www.neic.ie/news/countrys-first-social-inclusion-hub-opens-in-neic
HSE European Health Insurance Card (Travel Allowance)	https://www2.hse.ie/services/schemes-allowances/ehic/
Inner City Organisations Network	https://www.iconnetwork.ie/
Intro Parnell Street	https://www.gov.ie/en/directory/page/f9b71d-intreo-centre-parnell-stre et-dublin-1/
Irish Heart Foundation Stroke Support	https://irishheart.ie/
Irish National Organisation for the Unemployed	https://www.inou.ie/
Larkin Centre Men's Health Programme	https://www.dublingaa.ie/health-wellness/latest-news/larkin-centre-me ns-health-programme
Living Well Programme	https://www.hse.ie/eng/health/hl/selfmanagement/living-well-programme/
Lourdes Day Care Centre	https://www.facebook.com/lourdesdaycarecentre/
LYCS Lourdes Youth & Community Service	https://www.lycs.ie/
Macro Community Resource Centre	https://www.macrocommunity.ie/
Tusla (Meitheal Programme)	https://www.tusla.ie/
Mud Island Gardening	https://www.dublincommunitygrowers.ie/all-gardens/featured-gardens/mud-island-community-garden/
NEIC Parenting Programme	https://www.neic.ie/
New Communities Partnership	https://www.newcommunities.ie/

North Wall Community Development Project	https://www.nwcdp.ie/
Northside Partnership	https://www.northsidepartnership.ie/
Oasis Centre	https://oasiscentre.ie/
Ozanam House	https://www.ozanamhouse.ie/
Peter McVerry Trust	https://pmvtrust.ie/
Primary Care Teams Central Referrals Office	N/A
Purple House Cancer Support	https://www.purplehouse.ie/
SafetyNet Primary Care	https://www.primarycaresafetynet.ie/
Sean O Casey Community Centre	http://www.seanocaseycommunitycentre.ie/
Snug Counselling Support	https://www.macrocommunity.ie/the-snug-counselling-service
South Dublin City Council	https://www.sdcc.ie/en/
Summerhill Primary Care Team	https://www.summerhillgp.com/
Sunflower Recycling Project	http://www.sunflowerrecycling.ie/
Swan Regional Youth Service	https://swanyouthservice.org/
The Spellman Centre RDRD	https://www.rdrdthespellmancentre.ie/
University College Dublin Access & Lifelong Learning Centre	https://www.ucd.ie/all/cometoucd/applying/lifelonglearning/

Source: Co-op 2023, modified by TASC

Appendix 3: Healthy Communities Programme referral form

If returning by post:
Unit 1 Killarney Court,
Buckingham Street,
Dublin 1,
D01 F6Y7

Healthy Communities Project

Social Prescribing Referral Form

Name: Click or tap here to enter text.

Address: Click or tap here to enter text.

Date of Birth:

Contact Number: Click or tap here to enter text.

Email : Click or tap here to enter text.

Signature of Client: Click or tap here to enter text.

Referred by:

Name: Click or tap here to enter text.

Discipline: Click or tap here to enter text.

Contact No: Click or tap here to enter text.

Email:

Date of Referral

Reason for Referral:

Click or tap here to enter text.

Source: Co-op, 2023

Appendix 4: Elemental data sources

Table A3. Overview of Elemental data sources

Reports	Data utilised
Monitoring Tools	Wellbeing scores & comments
Report List Referrals	Referrals
List Cases	Overview: number of cases, prescriptions (programmes/services the person was supported to attend), tools used (i.e. SWEMWBS [Shah et al., 2021], MYCaW® [Paterson et al., 2007], WHO-5 [Topp et al., 2015]), reasons for referral, days open, gender, age, participant cohorts
Case Management Contacts	Number of contacts (e.g. phone, text, in person appointment, etc.), contact type, visit time spent
Health Impact	Wellbeing overview (averages)
Equality Monitoring	Demographic information (i.e. ethnicity, disability, health condition, have a carer, caring responsibilities, living situation, employment status, substance abuse, relationship status and gender)

Source: TASC, 2023.

Appendix 5: Healthy Communities Programme participant information form

Dublin City Community Co-operative

Healthy Communities Project Social Prescribing Programme

Participant Information Form

Registration Date: __/__ /____

First Name: _____ Surname: _____

Preferred Name: _____

Address: _____

_____

Town: _____ County: _____

Phone: Email: _____

Date of Birth: __/__ /____

Preferred Contact Method: Email Mobile Landline

How did you hear about Social Prescribing?

Name and address of GP: _____

_____

How often did you visit your GP (or CareDoc) in the last 12 months? _____

How often did you visit A&E in the last 12 months _____
<P>
Your age range (Please circle): 18-30 31-45 46-60 61-75 76 or above

ACCESS AND DISABILITY		
Do you have any support or access needs? e.g. mobility, neurodiversity or literacy		
Do you have a registered disability?	Yes	No
Do you have any long term chronic conditions	Yes	No
If yes, what are the condition/s		

Source: Co-op, 2023

GENDER – please circle		
Male	Female	Prefer not to answer
Non-binary	Transgender	Other, please specify _____

EMPLOYMENT STATUS – please circle all that apply		
Employed Full Time	Unemployed	
Employed Part Time		Retired
In Education/Training	Engaged in Home duties	Carer
Unable to work due to ill-health		

EDUCATION – please circle		
Which of the following describes the highest level of education you have completed?	Primary School	Junior/Intermediate Certificate or equivalent
	Leaving Certificate (or equivalent)	Third Level Qualification

HOUSING – please circle		
Private Owned	Council Tenant	Direct Provision Centre
Private Rented	Housing Association	Homeless Accommodation
Other	If you circled other, please describe: _____	

HOUSEHOLD OCCUPANCY – please circle all that apply		
Live Alone	Live with Partner/Spouse	Live with Parent
Live with children	Live with Friends	Live with Siblings
Living in shared accommodation		

RELATIONSHIP STATUS – please circle			
Single	Cohabiting	Non-Cohabiting Relationship	Widowed
Married	Divorced	Separated	Other

ETHNICITY	
How do you describe your ethnic background? A White 1 Irish 2 Irish Traveller 3 Roma 4 Any other White background	

B Black or Black Irish 5 African 6 Any other Black background C Asian or Asian Irish 7 Chinese 8 Indian/Pakistani/Bangladeshi 9 Any other Asian background D Other, including mixed group/background 10 Arabic 11 Mixed, write in description 12 Other, write in description _____ _____	

COMMUNITY INVOLVEMENT – please circle				
How involved are you in your community? e.g. groups, activities 1 = Not at all 4 = Very Involved	1	2	<P><P> 3	4
How would you rate your level of knowledge of the services in the community? 1 = I have no knowledge at all 4 = I know every service	1	2	3	4
How likely are you to use them? 1 = Less likely 4 = Very likely	1	2	3	4

Do you have use of your own transport? Yes / No

Do you have access to public transport? Yes / No

Do you have any specific interests / hobbies?

_____

_____

Other relevant information:

_____

_____

_____

_____

Participant Signature _____ Date:_____

Social Prescriber Signature: _____ Date: _____

Client Code: (office use only):

Appendix 6: Wellbeing questionnaires

The MYCaW, SWEMWBS and WHO-5 use different questions to assess wellbeing. In comparison to the MYCaW, the SWEMWBS and WHO-5 questions centre on positive emotions and higher scores on the latter two assessments reflect a better state of wellbeing.

The average change in scores from the MYCaW, WHO-5, and SWEMWBS was calculated to provide an overview of wellbeing for all questions. MYCaW, SWEMWBS, and WHO-5 assessments indicate that social prescribing participants expressed an overall increase in wellbeing (Table A4).

Measure Yourself Concerns and Wellbeing (MYCaW) questionnaire

This was originally developed as a measure of evaluating cancer services and seeks to discern the aims, values, and treatment effects that are prioritised by individuals, enabling each individual to provide an unambiguous assessment of change over time (Paterson et al., 2007). The MYCaW questionnaire includes four questions which can be scored on a scale of 0 (not bothering me at all) to 6 (bothers me greatly). MYCaW scores are very responsive to change.

MYCaW asks the patient three questions that are compared pre- and post-intervention:

1. How would you rate your general feeling of wellbeing now? (How do you feel in yourself?)
2. How would you rate your concern that you would like us to help you with? (concern/problem 1)
3. How would you rate your concern that you would like us to help you with? (concern/problem 2 [optional])

Short Warwick-Edinburgh Mental Wellbeing Scale (SWEMWBS)

This was developed as an interval scale measure of mental wellbeing (Shah et al., 2021). The SWEMWBS uses statements about thoughts and feelings relating to functioning and is scored on a scale of 1 (none of the time) to 5 (all of the time):

1. I’ve been feeling optimistic about the future.
2. I’ve been feeling useful.
3. I’ve been feeling relaxed.
4. I’ve been dealing with problems well.
5. I’ve been thinking clearly.
6. I’ve been feeling close to other people.
7. I’ve been able to make up my own mind about things.

5-item World Health Organisation Wellbeing Index (WHO-5)

This short questionnaire consists of five simple and non-invasive questions, which tap into the subjective, global wellbeing of the respondents (Topp et al., 2015). It is a highly useful tool that can be applied in both clinical practice (e.g. to screen for depression) and in research studies in order to assess wellbeing over time or to compare wellbeing between groups. The WHO-5 questionnaire consists of five questions which can be scored 0 (none of the time/absence of wellbeing) to 5 (all of the time/maximal wellbeing):

1. I have felt cheerful and in good spirits.
2. I have felt calm and relaxed.
3. I have felt active and vigorous.
4. I woke up feeling fresh and rested.
5. My daily life has been filled with things that interest me.

Higher scores in this assessment indicate a more positive state of wellbeing.

Table A4. Average change across wellbeing assessments pre- vs. post-programme completion

Assessment	Item	N	Average change
Measure Yourself Concerns and Wellbeing (MYCaW)	Wellbeing	17	-1.06
	Concern 1	17	-3.12
	Concern 2	11[39]	-2.91
Short Warwick-Edinburgh Mental Wellbeing Scale (SWEMWBS)	Dealing well with problems	18	+0.33
	Feeling close to people	18	+0.67
	Feeling optimistic	18	+0.44
	Feeling relaxed	18	+0.56
	Feeling useful	18	+0.94
	Make up own mind	18	+0.33
	Thinking clearly	18	+0.11
World Health Organisation Wellbeing Index (WHO-5)	Cheerful and in good spirits	17	+0.71
	Calm and relaxed	17	+0.65
	Active and vigorous	17	+1.47
	Fresh and rested	17	+0.71
	Things that interest me	17	+0.94

Source: Elemental & Referral data, 2021-2022, contains one duplicate

[39] MYCaW Concern 2 questionnaire was optional. N=6 individuals chose not to complete it.

Appendix 7: Social prescribing participant interview topic guide [40]

Introduction

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

Demographic profile of social prescribing programme participants

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

Social prescribing programme

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

[40] Note: questions will vary with interview participant background and experience.

Appendix 8: Focus group topic guide[41]

Introduction

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

Demographic profile of social prescribing programme participants

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

Residence

- Is the [name of Direct Provision Centre] the first place you have lived in since arriving in Ireland? If not, where else have you lived?
- How long have you lived here in the [name of Direct Provision Centre]?

Community

- Do you feel that you have a community here?
- Where does your sense of community come from? What is your community?
- What are some of the challenges that you have faced around developing or finding your sense of community here?
- What are your experiences of using local amenities? For example, shops, schools, colleges or gyms?
- Are there any barriers to you using local amenities? Do you feel comfortable and safe using these resources?
- Do you think that there should be more outreach (to migrants) regarding social prescribing and activities in the community?

[41] Note: the name of the DPC has been omitted to protect the residents.

Appendix 9: Healthy Food Made Easy bespoke questionnaire

Table A5. List of items on the Healthy Food Made Easy questionnaire

Type	Number	Question
pre-course	1	Date of birth
pre-course	2	Gender
pre-course	3	How many times have you seen your GP over the past year?
pre-course	4	Do you suffer from any long-term health conditions? If yes, what are they?
pre-course	5	Have you experienced any significant health issues over the past year? If yes, what have they been?
pre-course	6	In general how would you rate your physical health?
pre-course	7	In general how would you rate your mental health?
pre-course	8	Do you feel connected to your local community?
pre-course	9	How often do you worry about living expenses?
pre-course	10	What are your concerns about your eating habits? Tick all that apply.
pre-course	11	Do you look at the ingredients of the food you buy?
pre-course	12	How often do you snack per day?
pre-course	13	What do you eat as snacks?
pre-course	14	How often do you eat takeaway?
pre-course	15	How often do you eat pre-prepared meals?

pre-course	16	How often do you cook your own meals?
pre-course	17	How often do you eat dessert?
pre-course	18	How would you describe your food costs?
post-course	1	Date of birth
post-course	2	Gender
post-course	3	Gender description
post-course	4	How has the course affected your eating habits?
post-course	5	Describe other
post-course	6	How has the course affected your spending on food
post-course	7	How has the course affected your health?
post-course	8	Describe other
post-course	9	How will you plan meals from now on?
post-course	10	Would you recommend this course to friends and family members?

Source: TASC, 2023

Appendix 10: We Can Quit bespoke questionnaire

Table A6. List of items on the We Can Quit questionnaire

Type	Number	Question
pre-course	1	Date of birth
pre-course	2	Gender
pre-course	3	Do you have any long-term health conditions? If yes, what are they?
pre-course	4	Have you had any significant health issues over the past year? If yes, what have they been?
pre-course	5	In general, how would you rate your physical health?
pre-course	6	In general, how would you rate your mental health?
pre-course	7	Do you feel connected to your community?
pre-course	8	How many cigarettes do you smoke during the day?
pre-course	9	When did you start smoking?
pre-course	10	When do you smoke during the day?
pre-course	11	Why do you want to quit?
pre-course	12	How familiar do you think you are with the risks of smoking?
pre-course	13	Have you taken a smoking class before? If yes, why do you think you did not quit then?
pre-course	14	Outside of class, are there factors that would help you quit smoking?
post-course	1	Did your smoking habits change during the course?

post-course	2	What do you feel you learned in the course? Tick all that apply.
post-course	3	What was the most important aspect of the course for you?
post-course	4	Is there anything you would suggest changing?
post-course	5	Did the Facilitator help you to change your smoking habits?
post-course	6	How did the Facilitator help, if they did?
post-course	7	Did the pharmacist help you to change your smoking habits?
post-course	8	How did the pharmacist help, if they did?
post-course	9	Were you encouraged by a family member or friend to take the course?
post-course	10	If yes, did that make a difference to your participation in the course?
post-course	11	Would you recommend this course to someone else?

Source: TASC, 2023

Appendix 11: Staff training courses

Table A7. List of training courses available to staff by provider and type

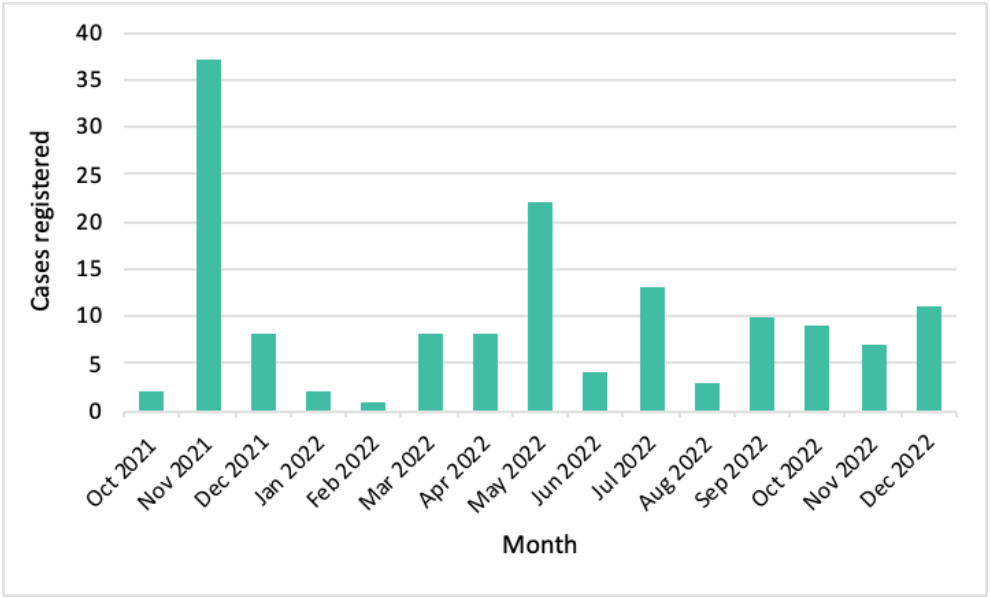
Training	Provider	Type
Anti-racism Training	Pavee Point	
ASIST Suicide Prevention Training	LivingWorks	Certified
Boundaries for carers	Co-op	In house
Children First	Túsla	Certified
Community Development	Co-op	In house
Elemental Shared learning	Elemental	Uncertified
Elemental Software Package Training	Elemental	Uncertified
Engage Men In Health		Certified
Equality and Diversity		
First Steps in Ethnic Equality Monitoring		
GDPR Training		
Healthy Food Made Easy Facilitator Training		Certified
Healthy Food Made Easy Cool Dudes Facilitator Training		Certified
Hidden harm: the impact of parental alcohol and other drug use		
HSE Best Practice Guidance for Mental Health Service (Module 1)	HSE	Certified
Human Trafficking Awareness Training	MECPATHS & Migrants Rights Centre Ireland	Uncertified
Human Trafficking Awareness Training	Inner City Organisations Network	
Introduction to Ethnic Equality Monitoring		Certified
Introduction training	Co-op	In house
Making Every Contact Count - Enhancing your Skills Workshop	HSE	Certified
Making Every Contact Count (6 Modules)	HSE	Certified

Motivational Interviewing		
Overview of Supports for Family Carers	Family Carers Ireland	
Path 3 Training Information Session	TUD	
Professional and personal boundaries	Co-op	In house
Safeguarding Adults at Risk of Abuse	HSE	Certified
Social determinants of Health	Co-op	In house
Social Prescribing Training Module	HSE	Certified
Social Welfare Entitlement training	INOU	Uncertified
START Suicide Prevention	LivingWorks	
Suicide Bereavement Training for Professionals	LivingWorks	
The Fundamentals of GDPR		Certified
Understanding Trauma Supporting Needs of People Fleeing War or Persecution		Certified

Source: TASC, 2023

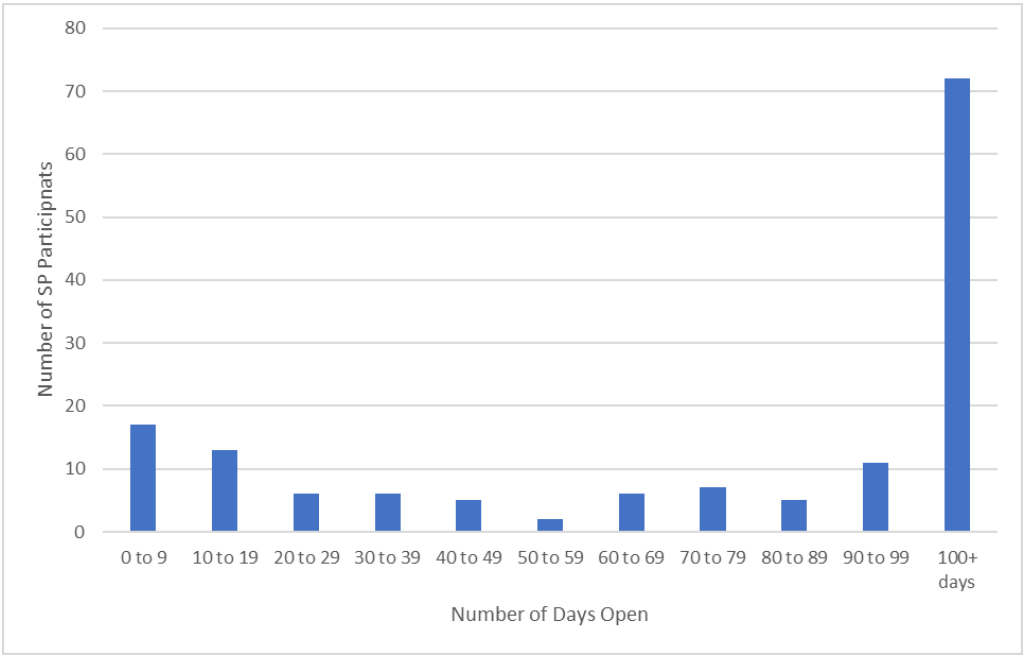
Appendix 12: Elemental recording of participants

Figure A1. Temporal distribution of participants' registration in Elemental



Source: Elemental & referral data, 2021-2022, duplicates removed (N=145)

Figure A2. Social prescribing programme participation by number of days enrolled



Source: Elemental data, 2021-2022

Appendix 13: Social prescribing participant profiles

Demographic information is not available for all participants. However, the data presented below should provide a general profile. Table A8 provides a summary of the available demographic information on participants, comparing all participants enrolled in the programme as of December 2021 regardless of status (N=145), to the subset of participants who have completed the programme (N=39).

Table A8. Breakdown of social prescribing participants' demographic profiles: enrolled and completed (as of 31 December 2022)

Characteristic	Enrolled (N = 145)		Completed (N = 39)	
	N	%[42]	N	%[41]
Age (years)				
19-29	16	**11.0**	2	**5.1**
30-39	21	**14.5**	5	**12.8**
40-49	27	**18.6**	9	**23.1**
50-59	25	**17.2**	4	**10.3**
60-69	39	**26.9**	13	**33.3**
70-79	9	**6.2**	3	**7.7**
80-89	4	**2.8**	1	**2.6**
90+	1	**0.7**	-	**-**
NA	3	**2.1**	2	**5.1**
Gender				
Female	42	**29.0**	10	**25.6**
Male	40	**27.6**	12	**30.8**
Transgender (Unspecified)	1	**0.7**	1	**2.6**
NA	62	**42.8**	16	**41.0**

[42] For some characteristics, values do not add to 100% due to rounding.

Registered disability				
Yes	25	**17.2**	11	**28.2**
No	53	**36.6**	10	**25.6**
NA	67	**46.2**	18	**46.2**
Long-term chronic health conditions				
Yes	31	**21.4**	8	**20.5**
No	24	**16.6**	4	**10.3**
NA	90	**62.1**	27	**69.2**
Highest level of education				
Junior/Intermediate Certificate (or equivalent)	13	**9.0**	2	**5.1**
Leaving Certificate (or equivalent)	17	**11.7**	5	**12.8**
NFQ Level 5 Certificate	6	**4.1**	2	**5.1**
NFQ Level 6 Certificate	1	**0.7**	-	**-**
No education	1	**0.7**	1	**2.6**
Primary School	19	**13.1**	8	**20.5**
Third Level Qualification	23	**15.9**	5	**12.8**
Unknown[43]	2	**1.4**	-	**-**
NA	63	**43.4**	16	**41.0**
Highest level of education (CSO)				
Higher secondary	17	**11.7**	5	**12.8**
Lower secondary	13	**9.0**	2	**5.1**
post-leaving certificate	8	**5.5**	2	**5.1**
Primary or below	20	**13.8**	9	**23.1**
Third level	23	**15.9**	5	**12.8**
NA	64	**44.1**	16	**41.0**

[43] Level of education could not be determined from the information provided.

Employment status				
Carer	7	**4.8**	5	**12.8**
Employed full-time	6	**4.1**	1	**2.6**
Employed part-time	6	**4.1**	-	**-**
Engaged in home duties	4	**2.8**	1	**2.6**
Retired	12	**8.3**	4	**10.3**
Ineligible for work (International Protection Applicant)	1	**0.7**	-	**-**
Unable to work due to ill-health	30	**20.7**	9	**23.1**
Unemployed	16	**11.0**	3	**7.7**
NA	63	**43.4**	16	**41.0**
Ethnicity				
African	2	**1.4**	-	**-**
Albanian	1	**0.7**	-	**-**
Any other White background	4	**2.8**	-	**-**
Arab	3	**2.1**	1	**2.6**
Black or Black Irish	2	**1.4**	-	**-**
Chinese, Mandarin	1	**0.7**	1	**2.6**
Egyptian	1	**0.7**	-	**-**
Mauritian	1	**0.7**	-	**-**
South African	1	**0.7**	-	**-**
Ukraine/Nigerian	1	**0.7**	-	**-**
White Irish	65	**44.8**	21	**53.8**
White Irish Traveller	1	**0.7**	-	**-**
NA	62	**42.8**	16	**41.0**
Relationship status				
Cohabiting	6	**4.1**	1	**2.6**

Divorced	8	**5.5**	4	**10.3**
Married	12	**8.3**	8	**20.5**
Non-Cohabiting Relationship	3	**2.1**	2	**5.1**
Separated	9	**6.2**	2	**5.1**
Single	39	**26.9**	5	**12.8**
Widowed	4	**2.8**	1	**2.6**
Other[44]	1	**0.7**	-	**-**
NA	63	**43.4**	16	**41.0**
Housing				
Couch-surfing	1	**0.7**	1	**2.6**
Council Tenant	28	**19.3**	11	**28.2**
Direct Provision Centre	6	**4.1**	1	**2.6**
Homeless Accommodation	15	**10.3**	2	**5.1**
Housing Association	9	**6.2**	3	**7.7**
Private Owned	11	**7.6**	3	**7.7**
Private Rented	10	**6.9**	2	**5.1**
NA	65	**44.8**	16	**41.0**
Household occupancy[45]				
Live alone	32	**22.1**	10	**25.6**
Live in shared accommodation	15	**10.3**	4	**10.3**
Live with children	24	**16.6**	6	**15.4**
Live with parent(s)	5	**3.4**	1	**2.6**
Live with sibling(s)	2	**1.4**	-	**-**
Live with partner/spouse	14	**9.7**	7	**17.9**
NA	63	**43.4**	16	**41.0**

[44] Relationship status could not be determined from the information provided.
[45] Values add to >100% as some participants identified with multiple categories.

Access to own transport				
Yes	11	**7.6**	4	**10.3**
No	69	**47.6**	18	**46.2**
NA	65	**44.8**	17	**43.6**
Access to public transport				
Yes	73	**50.3**	20	**51.3**
No	7	**4.8**	2	**5.1**
NA	65	**44.8**	17	**43.6**

Source: Elemental data, 2021-2022, duplicates removed (N=5)

Appendix 14: Course descriptions

The Healthy Food Made Easy course teaches participants how to identify healthy foods and incorporate them into their diets. Individuals participating in the courses are not necessarily social prescribing clients, but can be anyone from the community. Healthy Food Made Easy courses have been promoted to potential participants and Healthcare workers in a similar manner as the social prescribing programme: word of mouth, flyers and posters. Examples of the posters used to promote the course are available below.

The Healthy Food Made Easy course teaches basic nutrition and cooking skills to help people cook easy and healthy meals, change their eating habits, and plan meals on a budget. Course content is based on guidelines on healthy eating from the DOH and is funded by HSE Health and Wellbeing[46]. Healthy Food Made Easy course participants spend six weeks learning about healthy foods, budgeting, and shopping. Sixty-eight percent of participants completed the Healthy Food Made Easy course. The courses are offered in an applied format where participants obtain practical experience on the topics discussed as well as opportunities to engage directly with each other and with the course convener. Course participants cook and prepare food, which they can take home with them as part of the course.

The Health Literacy course teaches participants how to understand and use health information to manage their own care. Health Literacy training is provided for health and social care workers in the community and community members

The Wellbeing & Stress Management course provides participants with tools they can use to identify and manage their own stress and anxiety.

We Can Quit is a smoking cessation programme run in conjunction with the HSE and pharmacies in order to provide adequate social support and replacement treatment for tobacco use.

[46] HFME course description: https://www.youtube.com/watch?v=E1BHHptMvzM

The social prescribing programme may link programme participants into a variety of courses and activities provided by other community organisations, not necessarily the Co-op.

Similarly, the Co-op delivers a newly developed course, Mind Yourself. It runs for six weeks and has been developed by a working group following two of the Healthy Communities Programme community health workers attending the Engage Men training provided by the HSE. The working group was a collaboration of one of the community health workers, Healthy Communities Programme Coordinator, HSE Senior Health Promotion Officer, and a second HSE Health Promotion Officer and is bespoke to the Co-op Healthy Communities Programme. From its early stages, staff have seen the course making an impact on men's health in the community.

Figure A3: Healthy Community Project social prescribing leaflet

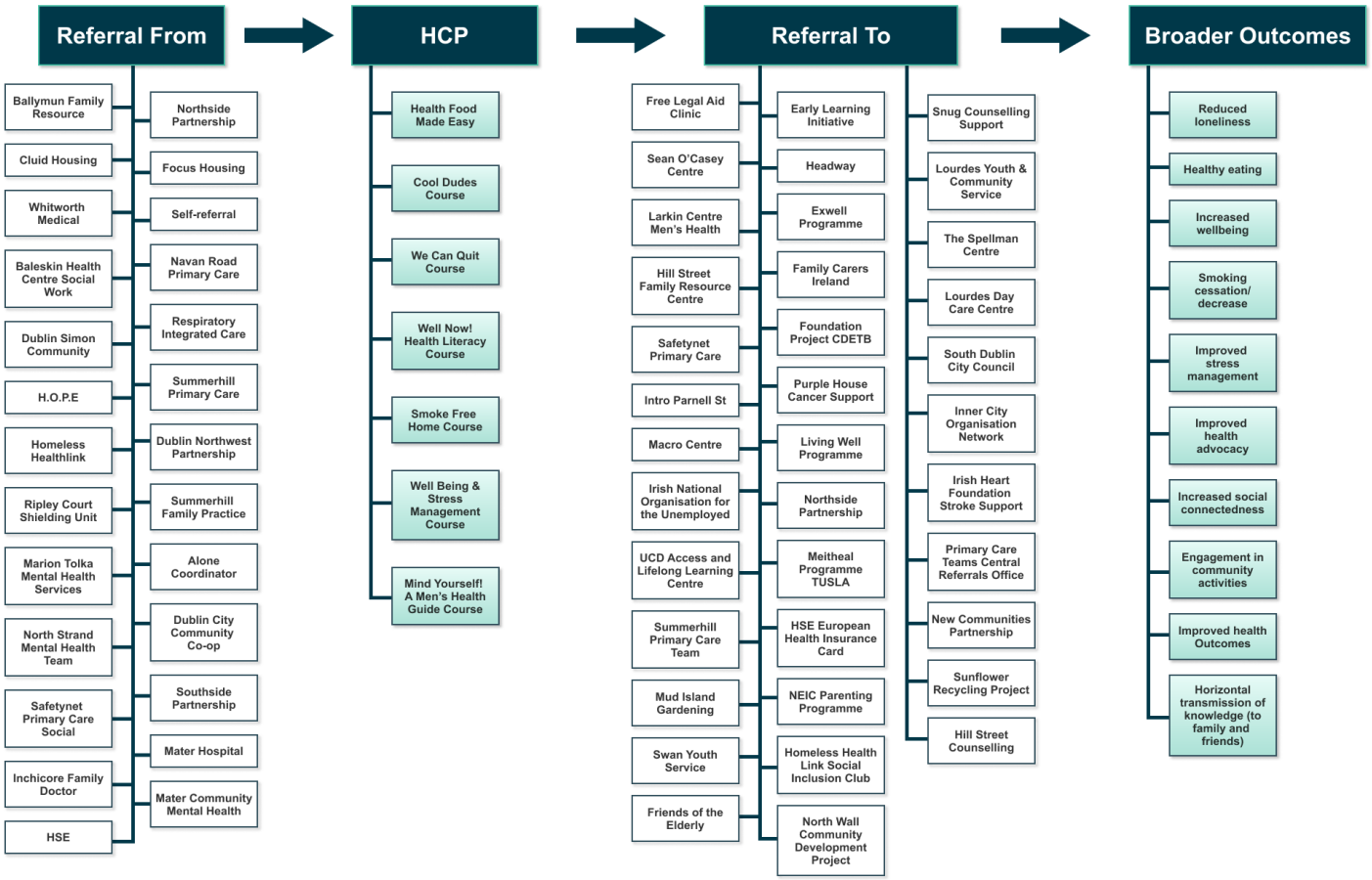
Source: Co-op, 2023

Figure A4: Healthy Food Made Easy course leaflet

Source: Co-op, 2023

Appendix 15: Organisations providing and receiving social prescriptions

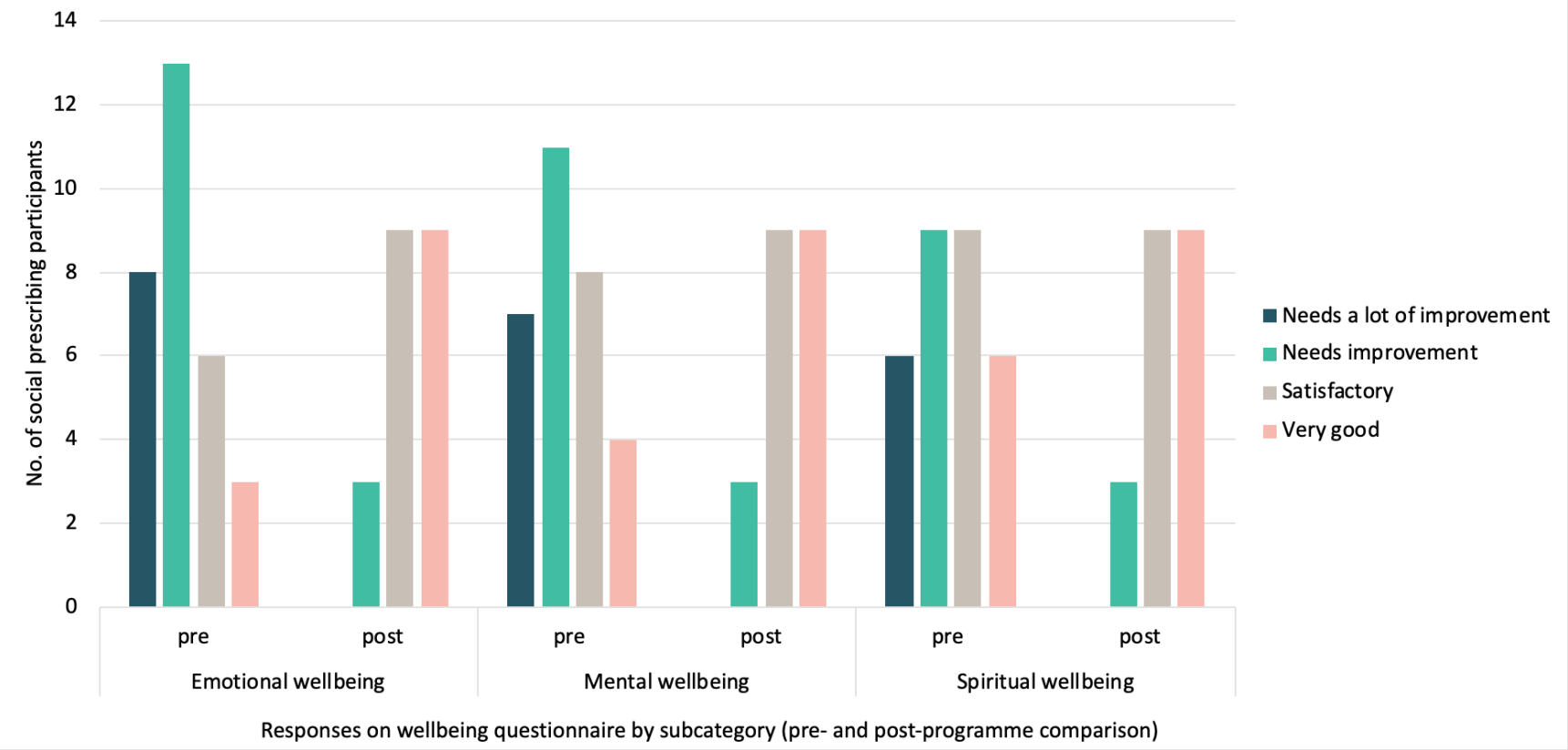
Figure A5: Flowchart of organisations providing and receiving social prescriptions



Source: TASC, 2023

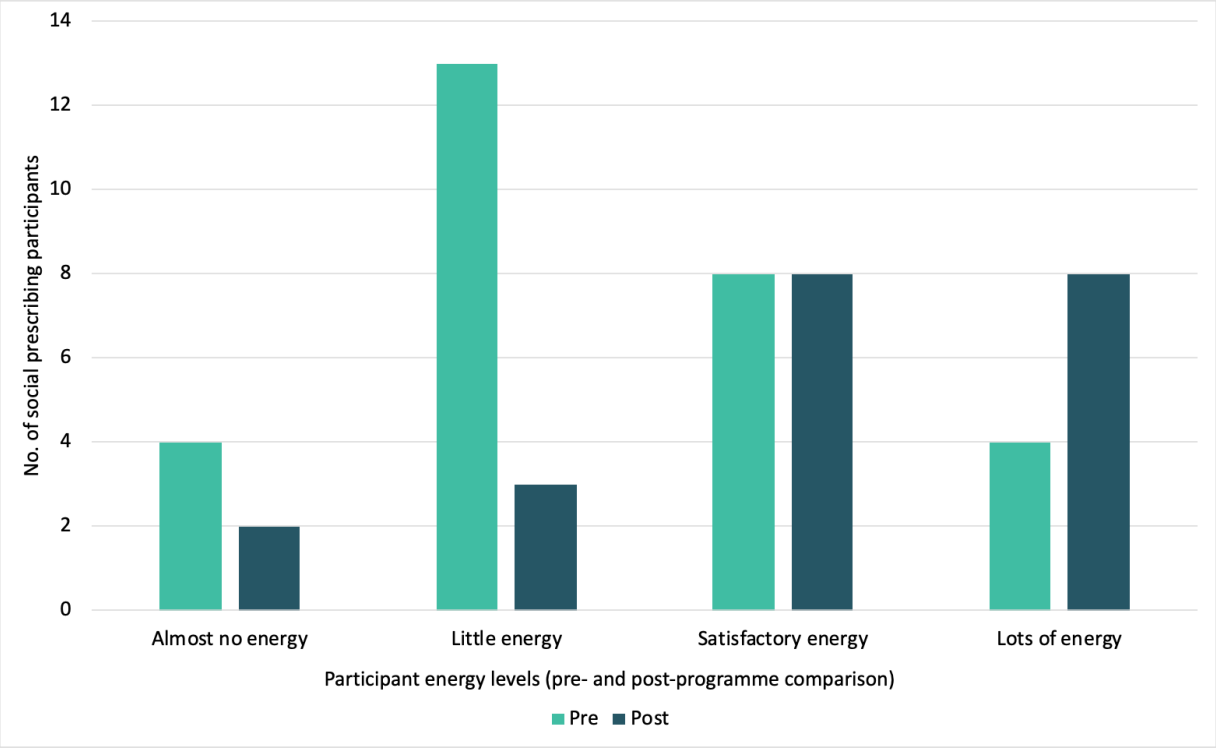
Appendix 16: Wellbeing & Stress Management Questionnaire Pre- and Post-Course results

Figure A6. Comparison of emotional, mental, and spiritual wellbeing pre- vs. post-completion of social prescribing programme



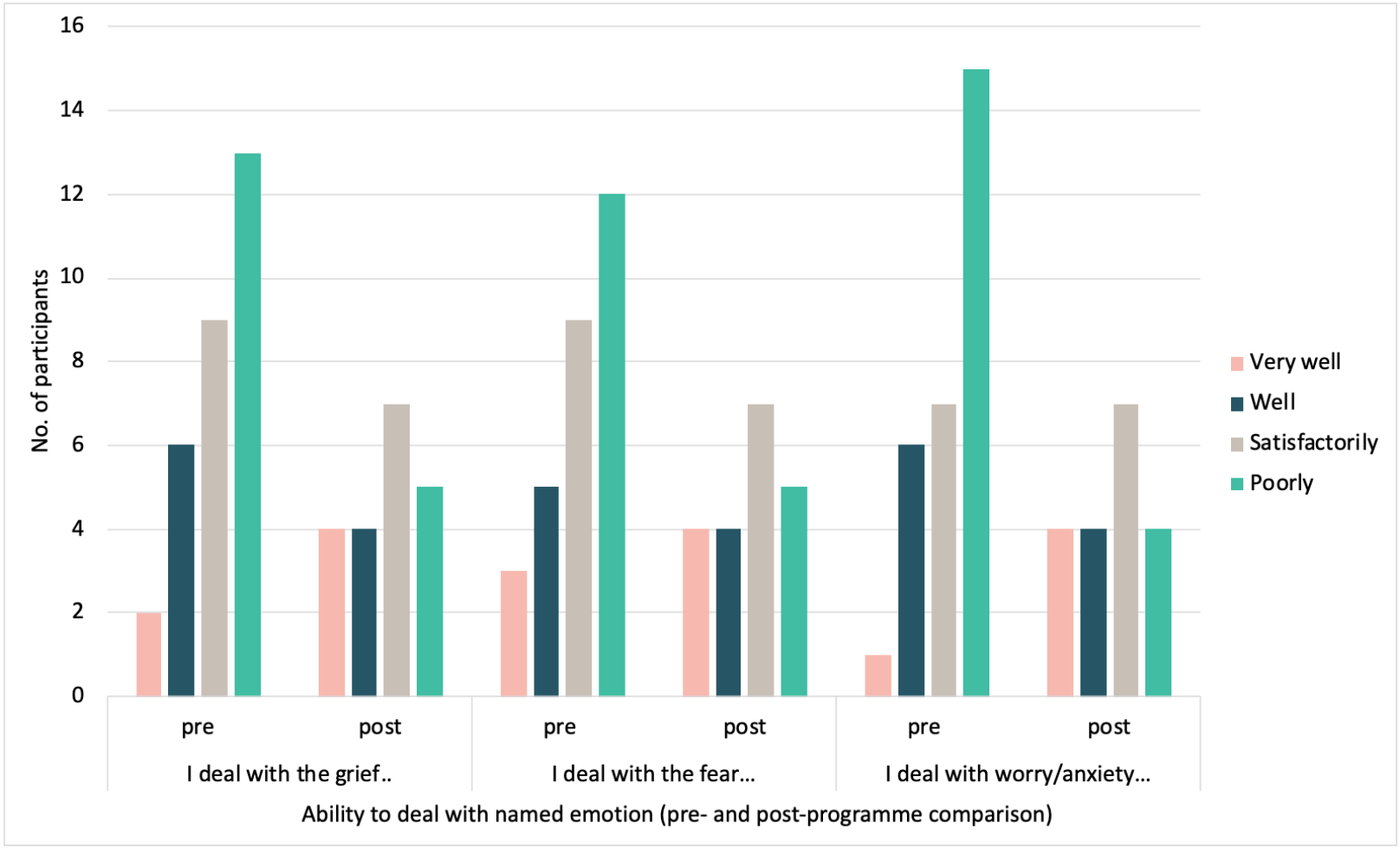
Source: Co-op, 2023

Figure A7. Reported levels of participants' energy pre- and post-Wellbeing and Stress Management course



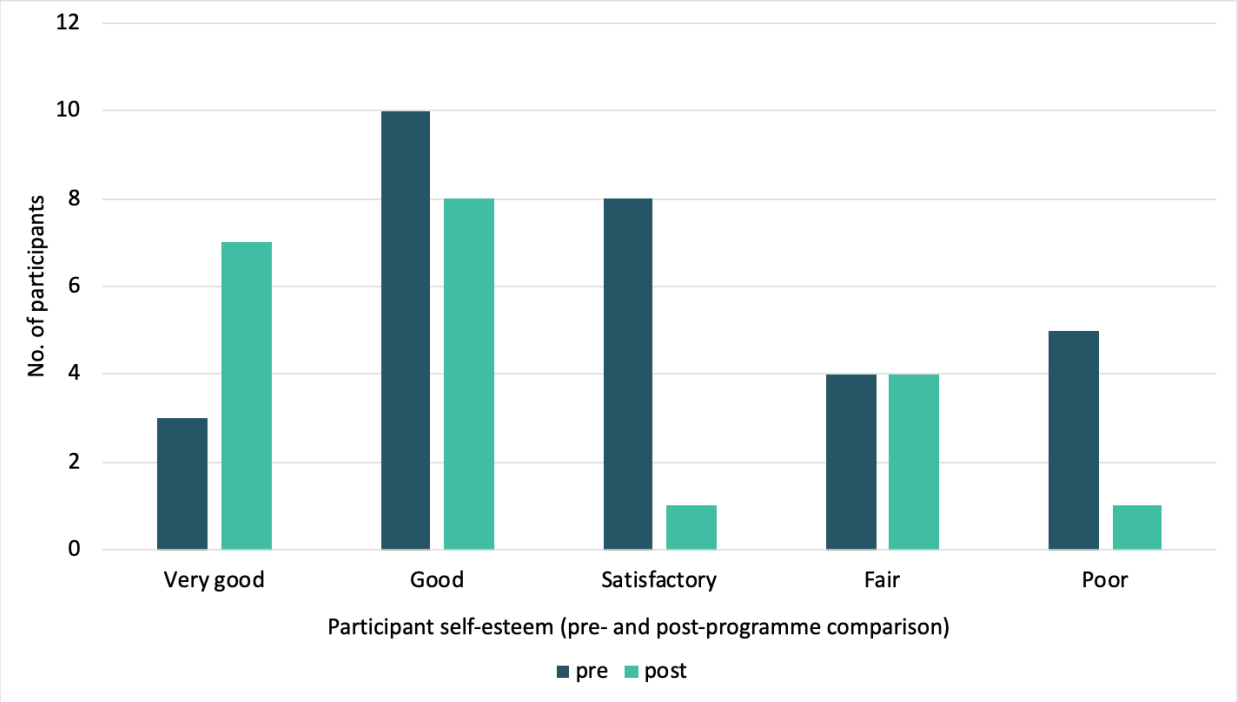
Source: Co-op, 2023

Figure A8. Dealing with grief, fear, and anxiety



Source: Co-op, 2023

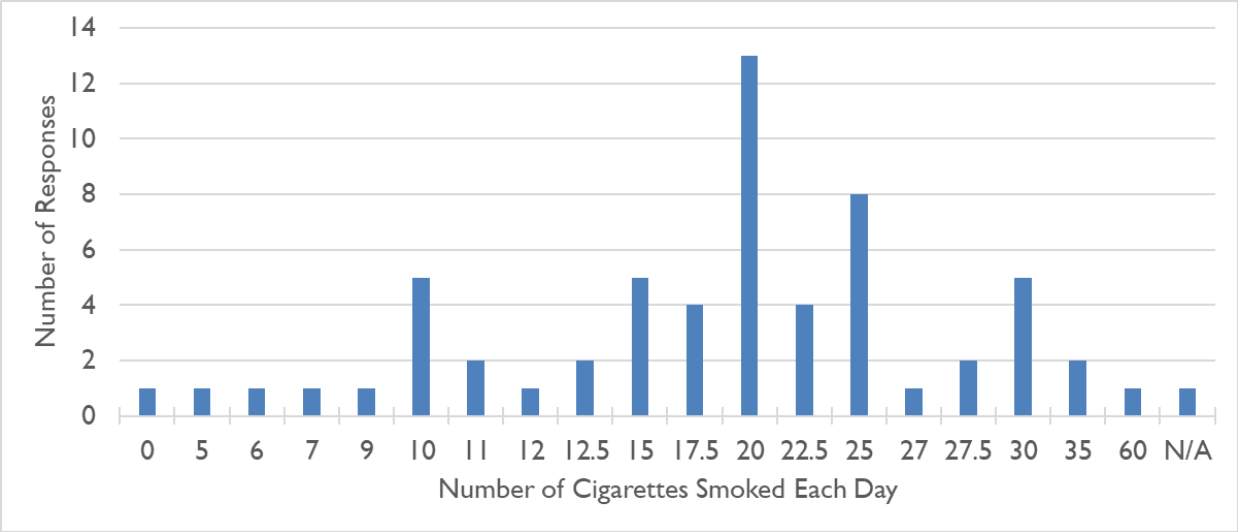
Figure A9. Self-esteem



Source: Co-op, 2023

Appendix 17: We Can Quit – Cigarettes Smoked Per Day by We Can Quit Participants Pre-Course (N=61)

Figure A10. Number of cigarettes smoked per day by participants pre-programme



Source: TASC, 2023

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Dublin City Community Co-op