

South Dublin County Partnership

Evaluation of the Tallaght Social Prescribing Service

August 2025



Rialtas na hÉireann
Government of Ireland



Rialtas Áitiúil Éireann
Local Government Ireland



South Dublin
County Partnership
Páirtíocht Chontae
Átha Cliath Theas

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Section 1: Introduction and Context

1.1. Introduction to the Report

This report sets out the independent and objective external evaluation of the Tallaght Social Prescribing Service, a service funded by the Health Promotion & Improvement/Health and Wellbeing Section of HSE via Sláintecare Healthy Communities and delivered by South Dublin County Partnership (SDCP). The Tallaght Social Prescribing Service provides 1-1 support for adults over the age of 18 who require additional support for their health and wellbeing by supporting them to engage with groups, supports and services in their locality.

This report sets out an evaluation of the Tallaght Social Prescribing Service¹, presenting an overview of both the delivery and impact of the service over a 12-month period from mid-2023 to mid-2024.

1.2. Report Objectives

As set out in the terms of reference, this evaluation seeks to capture key learnings from service delivery between mid-2023 and mid-2024, consolidating these learnings to promote the advancement of social prescribing and facilitate the development of best practice. The specific objectives of the evaluation report are to:

- Analyse client journeys against national framework guidelines, identifying emerging themes in client demographics and social prescriptions.
- Explore service outcomes and client journeys in a meaningful way.
- Identify elements of best practice and key quality indicators in service delivery for the client e.g., why do certain strategies work for particular clients and not others?

1.3. Report Structure

- **Section 2** Introduces the Tallaght Social Prescribing Service, providing context to delivery
- **Section 3:** Outlines service implementation and delivery between mid-2023 and mid-2024
- **Section 4** Sets out the evaluation methodology including data collection, data analysis, and limitations of the research

¹ SP is a free service that helps people connect with community connections to improve well-being. From exercise groups to arts programmes, social prescribing provides practical & emotional support.

- **Section 5** Presents the findings of the evaluation including quantitative delivery and outcomes data, survey data, and the findings of the qualitative consultation process
- **Section 6** Includes discussion and reflections on the evaluation
- **Section 7** Sets out the evaluation's conclusions and recommendations

1.4. Project Deliverer: South Dublin County Partnership

South Dublin County Partnership (SDCP) is a local development company which, through collaboration with partner organisations, develops and delivers projects to tackle poverty and social exclusion in the South Dublin area. Focusing on the most vulnerable groups within the South Dublin community, SDCP seeks to create neutral spaces and opportunities for parties to work together on solutions, initiate, develop and deliver projects, enable and empower communities, and influence policy and decision making.

1.5. Project Funder: HSE and Sláintecare Healthy Communities

The Health Service Executive (HSE) manages all of the public health services in Ireland including personal social services. The HSE is also responsible for community care and personal social services to help people remain living in their communities, especially when they have difficulties doing so because of illness, disability or age.

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

Other programmes and service provided by the HSE are detailed here <https://about.hse.ie/our-work/what-the-hse-does/>.

Section 2: Introduction to the Service

2.1. Introduction

This section introduces the Tallaght Social Prescribing Service and provides context to its delivery.

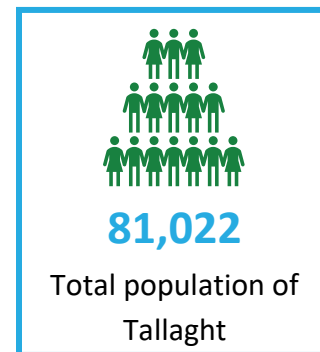
2.2. Introduction to the Tallaght Social Prescribing Service

The Tallaght Social Prescribing Service is one of several health and wellbeing initiatives implemented by SDCP. Social prescribing is a 1-1 support service for adults over the age of 18, enabling referral to a range of local, non-clinical services, primarily provided by the community and voluntary sector. Social prescribing aims to improve health and wellbeing, social connectedness and community involvement by supporting people to engage with groups, supports and services in their locality, seeking also to reduce clinical caseload and GP presentation.

There is a growing body of evidence that social prescribing can lead to a range of positive health and wellbeing outcomes and reduce social isolation and loneliness. The social prescribing model recognises that health is heavily determined by social factors such as poverty, isolation and loneliness and adopts a holistic approach focused on individual needs and preferences, allowing people to play an active role in improving their health and wellbeing.

2.3. Introduction to the Tallaght Area

Tallaght is a southwestern outer suburb of Dublin, located in the South Dublin County Council area. Whilst there is no legal definition of the boundaries of Tallaght, there are 13 electoral divisions designated as Tallaght. The total population of these electoral areas is 81,022, up 6.44% over six years.² Considering the combined electoral areas, Tallaght is the largest settlement on the island of Ireland without city status. The following provides an overview of the demographics of Tallaght, captured by the 2022 Census.



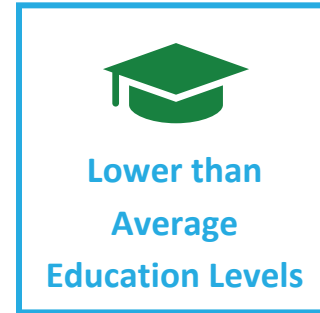
The majority of Tallaght residents identify as White Irish (73%), whilst a further 11% identify as being from another White Background. 7% identify as Asian or Asian Irish, 5% as Black or Black Irish, and 1% as White Irish Travellers. 3% identify as from 'other ethnicities'.³

² Central Statistics Office (2022) *Population*. Available at: <https://data.cso.ie/table/SAP2022T1T1AED>

³ Central Statistics Office (2022) *Usually resident population by ethnic or cultural background*. Available at: <https://data.cso.ie/table/SAP2022T2T2ED>

2.3.1. Education Levels in Tallaght

15% of the Tallaght population aged 15 and over did not progress past primary-level education, compared with 11% of the population of the State.⁴ This figure is significantly higher in certain electoral divisions including Killinardan (26%), Avonbeg (25%), and Millbrook (22%). **11 of the 13 Tallaght electoral divisions exceed the State average for populations who have not progressed past primary-level education.**



35% of the Tallaght population aged 15 and over accessed post-secondary education, compared with 56% of the population of the State. This figure is significantly lower in certain electoral divisions, including Killinardan (14%), Avonbeg (20%) and Tymon (28%). **All 13 of the Tallaght electoral divisions fall below the State average for populations who have accessed post-secondary education.**

2.3.2. Employment Levels in Tallaght

Whilst the proportion of the Tallaght population aged 15 and over who are in employment is consistent with the State (55% vs. 56%), **7 of the 13 Tallaght electoral divisions have lower employment levels than the State.** This is particularly pronounced in Killinardan and Tymon where just 46% and 48% of the populations are in employment, respectively. 8% of the Tallaght population are registered as unemployed or looking for their first job, compared with 5% of the State. 5% of Tallaght’s population aged 15 and over are unable to work due to sickness or disability, matching the rate of the State. This rate stands at 9% in both Avonbeg and Killinardan.⁵

2.3.3. Health in Tallaght

87%	11%	2%
Of the Tallaght population rate their general health as ‘Good’ or ‘Very Good’, compared with 89% of the State	Of the Tallaght population rate their general health as ‘Fair’, compared with 9% of the State	Of the Tallaght population rate their general health as ‘Bad’ or ‘Very Bad’, matching the rate of the State

Whilst data on the general health of the Tallaght population is largely consistent with the State, **6 of the 13 Tallaght electoral divisions exhibit greater population proportions in bad or very**

⁴ Central Statistics Office (2022) Population aged 15 years and over by Sex and Highest Level of Education Completed. Available at: <https://data.cso.ie/table/SAP2022T10T4ED>

⁵ Central Statistics Office (2022) Population aged 15 years and over by Principal Economic Status and Sex. Available at: <https://data.cso.ie/table/SAP2022T8T1ED>

bad health. This is particularly pronounced in Avonbeg where 79% of the population are reported to be in good or very good health, and 5% are reported to be in bad or very bad health.⁶ 23% of the Tallaght population identify as having a disability, compared with 21% of the State. **The rate of disability is greater than the State in 10 of the 13 Tallaght electoral divisions,** and is particularly pronounced in Avonbeg (33%), Millbrook (29%), Killinardan (29%) and Tymon (29%).⁷

2.3.4. Deprivation in Tallaght

Each of Tallaght’s 13 electoral exhibit deprivation, with 9 electoral areas rated as marginally below average, 3 rated as disadvantaged, and 1 rated as very disadvantaged (Killinardan -26.09).⁸

2.4. Strategic Context

The Tallaght Social Prescribing Service is strategically relevant and linked to a range of national and local policies. Social prescribing was first formally recognised in Irish government policy through the Stronger Together Mental Health Promotion Plan 2022 – 2027, calling for the integration of social prescribing across the HSE, community and voluntary sectors and highlighting this as a priority. The following image provides a graphic overview of the pivotal policies which synergise with the Tallaght Social Prescribing Service, given their alignment and link to the context of the service.



Figure 1: Strategic Context for the Tallaght Social Prescribing Service

⁶ Central Statistics Office (2022) *General Health of Population*. Available at: <https://data.cso.ie/table/SAP2022T12T3ED>

⁷ Central Statistics Office (2022) *Persons with a disability*. Available at: <https://data.cso.ie/table/SAP2022T12T1ED>

⁸ Pobal (2022) Pobal HP Deprivation Indices. Available at: <https://data.pobal.ie/Portal/apps/sites/#/pobal-maps>

Section 3: Implementation and Delivery

3.1. Introduction

This section outlines the implementation and delivery of the Tallaght Social Prescribing Service between mid-2023 and mid-2024.

3.2. Service Structure and Governance

The Tallaght Social Prescribing Service is funded by the HSE via Sláintecare Healthy Communities and delivered by the Health and Wellbeing Team within South Dublin County Partnership (SDCP). The Tallaght Social Prescribing Team is comprised of a Senior Health and Wellbeing Manager and two Social Prescribing Link Workers from the SDCP Health and Wellbeing Team.

SDCP meet with the HSE Sláintecare Healthy Communities team on a quarterly basis, providing a report on delivery and progress, as well as an update on any emerging opportunities or arising issues. Social Prescribing Link Workers have the opportunity to meet separately with members of the Sláintecare Healthy Communities team through a local Peer Network which brings together Link Workers from multiple sites, allowing for knowledge sharing and peer support. Additionally, the HSE provides ECHO education sessions designed in collaboration with social prescribers and facilitates a 2 day ‘Essential Skills for Social Prescribing’ training for new Link Workers. Internally, the Tallaght Social Prescribing Team meets on a monthly basis to monitor and discuss the service; Social Prescribing Link Workers have a further opportunity to access internal and external support.

The administration of the Tallaght Social Prescribing Service is supported by a Salesforce system which streamlines the management of client data, interactions, and referral processes.

3.3. Delivery Model

The following presents an overview of the delivery model employed through the Tallaght Social Prescribing Service.



Figure 2: *Social Prescribing Pathway*

3.3.1. Client Referral

The Tallaght Social Prescribing Service supports individuals over the age of 18 who live within the service catchment area, including people with long-term conditions; mild-moderate mental health issues; loneliness or social isolation; frequent GP attendances; and complex social needs which affect their health and wellbeing. The service cannot support people who are currently in crisis and require more specialised care, people who present with severe and unaddressed mental health conditions, or people who are unable to leave their home and return safely.

Individuals are referred to the Tallaght Social Prescribing Service by a range of community and voluntary sector and healthcare professionals including GPs, Practice Nurses, and social workers. Individuals within the Tallaght area can also self-refer to the service. The HSE has a dedicated SHC online referral system allowing for referral all SHC programmes components, across all Dublin South and Kildare SHC areas. The Salesforce system enables a streamlined referral process whereby all referrals can be submitted via the same form. To build the referral network, Tallaght Social Prescribing Link Workers contacted and met with a range of healthcare professionals and teams, including those within the community and consultants, nurses and physiotherapists at Tallaght University Hospital. Presentations and information flyers were shared to raise awareness of the availability of the service whilst an online social media campaign was developed and delivered on SDCPs social media channels, cascaded through partner and stakeholder channels. During the evaluation period mid-2023 to mid-2024, a waiting list for potential clients was operated in line with service oversubscription and demand for support.

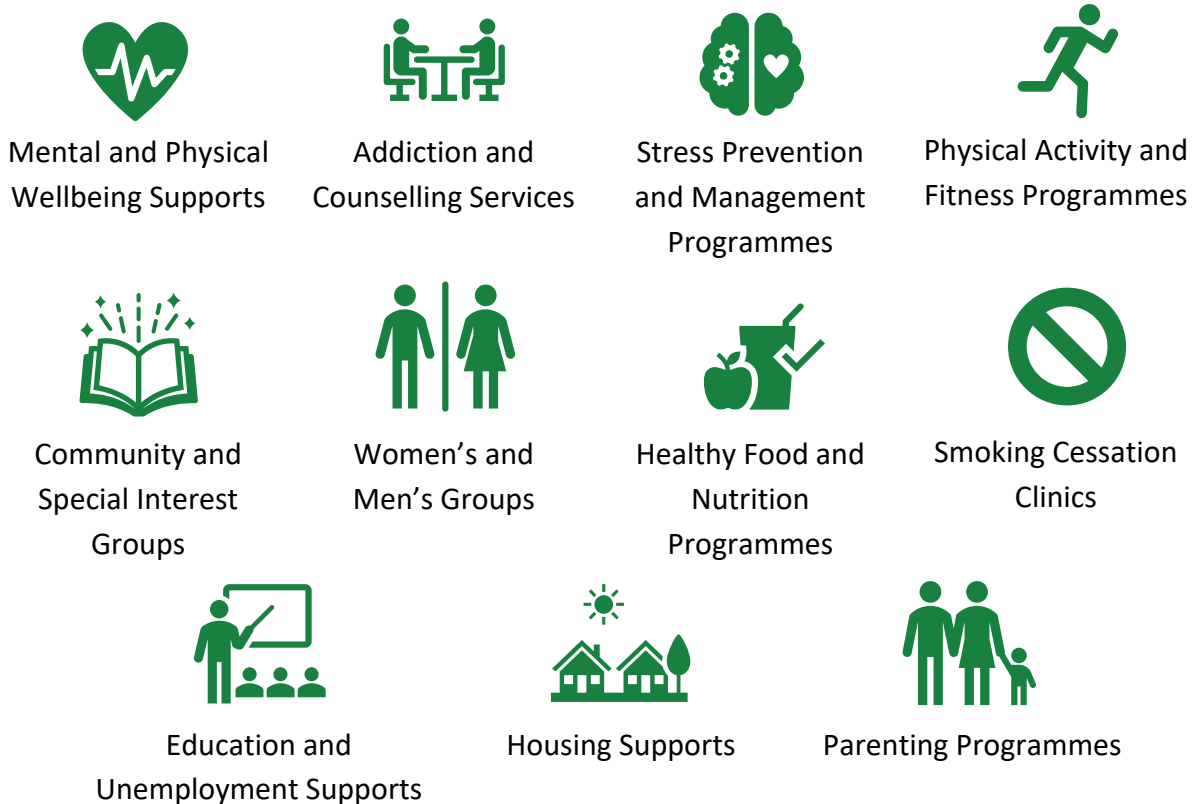
3.3.2. Connection with a Social Prescribing Link Worker

Following referral, a Social Prescribing Link Worker will contact a potential client to arrange an initial 1-to-1 consultation. This consultation involves an exploration of the person's needs, goals, what matters to them in their life, and the options available to them within their community to address these needs. Initial contacts also serve as an opportunity to complete mental health and wellbeing measurements. The Social Prescribing Link Worker explains the need for these measurements and supports clients to provide an accurate reflection of their current position.

3.3.3. Social Prescription

Following initial meetings, clients work in collaboration with their Social Prescribing Link Worker to address their needs and goals using a personalised coaching and co-production approach. A health and wellbeing plan is co-developed based on the needs and preferences of the client. The level of support provided by Social Prescribing Link Workers varies from client to client and can range from motivational support to practical support such as accompanying a client on the first

visit to their chosen activity/support. Social Prescribing Link Workers refer clients to a range of groups, supports and services in the Tallaght area, in line with their identified needs and interests. Akin to the establishment of inward referral relationships, the Tallaght Social Prescribing Team has also developed a range of community-based relationships which facilitate the onward referral of clients. Onward referral to internal SDCP programming is also facilitated. Examples of the supports and services to which clients are referred include:



Social Prescribing Link Workers remain engaged with their clients until the clients feel able to re-engage and reintegrate independently into the community, or until the health and wellbeing goals outlined in their plan have been achieved. The HSE sets a guideline for 6-8 intervention sessions per client but given the diverse and varying support needs of clients, clients in Tallaght frequently require longer periods of engagement.

3.3.4. Disengagement and Discharge

Once a client has successfully engaged with the groups or services identified, and achieved support goals, the client is discharged from the service with their consent. The mental health and wellbeing measurements administered during initial meetings are performed again to capture impact.

Section 4: Methodology

4.1. Introduction

In December 2024, SDCP commissioned S3 Solutions to conduct an independent and objective evaluation of the delivery of the Tallaght Social Prescribing Service between mid-2023 and mid-2024. The following outlines the methodology used to complete the evaluation.

4.2. Defining Success

As part of the evaluation process, a logic model was created to inform the indicators of success for the Tallaght Social Prescribing Service (Appendix 1). The logic model reflects the problem that the service sought to address, the inputs and activities which were used to address the problem, and the intended outputs and outcomes. These outcomes consider and reflect the HSE's *Minimum Data Outcomes Framework for Social Prescribing in Ireland* and include the "two critical outcomes central to social prescribing [...]: personal wellbeing and social connectedness."⁹

4.3. Data Collection

The evaluation adopted a mixed method approach to data collection and has been informed by the following activity:

- Desk review of SDCP documentation related to the implementation and delivery of the Tallaght Social Prescribing Service including:
 - Service Level Agreement and overview of the social prescribing service
 - Demographic client data
 - Client intervention data
 - Client outcomes data
 - Client evaluation outcomes data incl. SWEMWBS and MYCaW measurements
- 1 x online focus group with the Deputy Chief Executive Officer and Senior Health and Wellbeing Manager from SDCP
- 1 x online interview with a Tallaght Social Prescribing Link Worker
- 2 x online focus groups with representatives of the HSE (4 total participants)
- 2 x online interviews with referral organisations (2 total participants)
- 5 x phone interviews with clients of the Tallaght Social Prescribing Service
- 1 x online supplementary survey capturing the views of clients (19 responses)

⁹ HSE (2021) HSE Social Prescribing Framework. Available at: <https://www.hse.ie/eng/about/who/healthwellbeing/our-priority-programmes/mental-health-and-wellbeing/hse-social-prescribing-framework.pdf>

4.4. Data Analysis

Qualitative data analysis was conducted using both thematic and narrative approaches. Categories were developed, coded, and reduced. Survey data, researchers' observations and thematic data from consultations was cross referenced to identify emergent themes and issues and to explore the relationships between issues.

4.5. Limitations

Efforts have been made to enhance the reliability and validity of findings through multiple method consultation. However, we note the following limitations:

- As with any survey data, errors due to question non-responses may exist. The number of respondents who chose to respond to a survey question may be different from those who chose not to respond. Further, limited survey responses were achieved, likely due to the time passed between support completion and evaluation commencement.
- As with all consultations of this nature, consultations with individuals involved in the implementation and delivery of the Tallaght Social Prescribing Service may be subject to social desirability bias: the tendency for people to respond to research questions in a manner which they believe is socially acceptable or desirable, rather than providing truthful/accurate opinions.
- Collecting pre- and post-engagement mental health and wellbeing measurements presented practical challenges, particularly in securing follow-up responses after clients had completed their support journey. Despite these constraints, the evaluation successfully gathered a substantial body of data: 80 pre-engagement SWEMWBS scores and 78 pre-engagement MYCaW scores, alongside 23 post-engagement scores for each measure. Importantly, 22 clients provided both pre and post engagement scores, enabling meaningful comparative analysis of change over time. These results represent a strong foundation for understanding the service's impact, given the often transient and hard-to-reach nature of the client group. Future evaluations could build on this achievement by implementing additional strategies to maximise follow-up response rates and capture outcome data for a larger proportion of participants.

Section 5: Evaluation Findings

5.1. Introduction

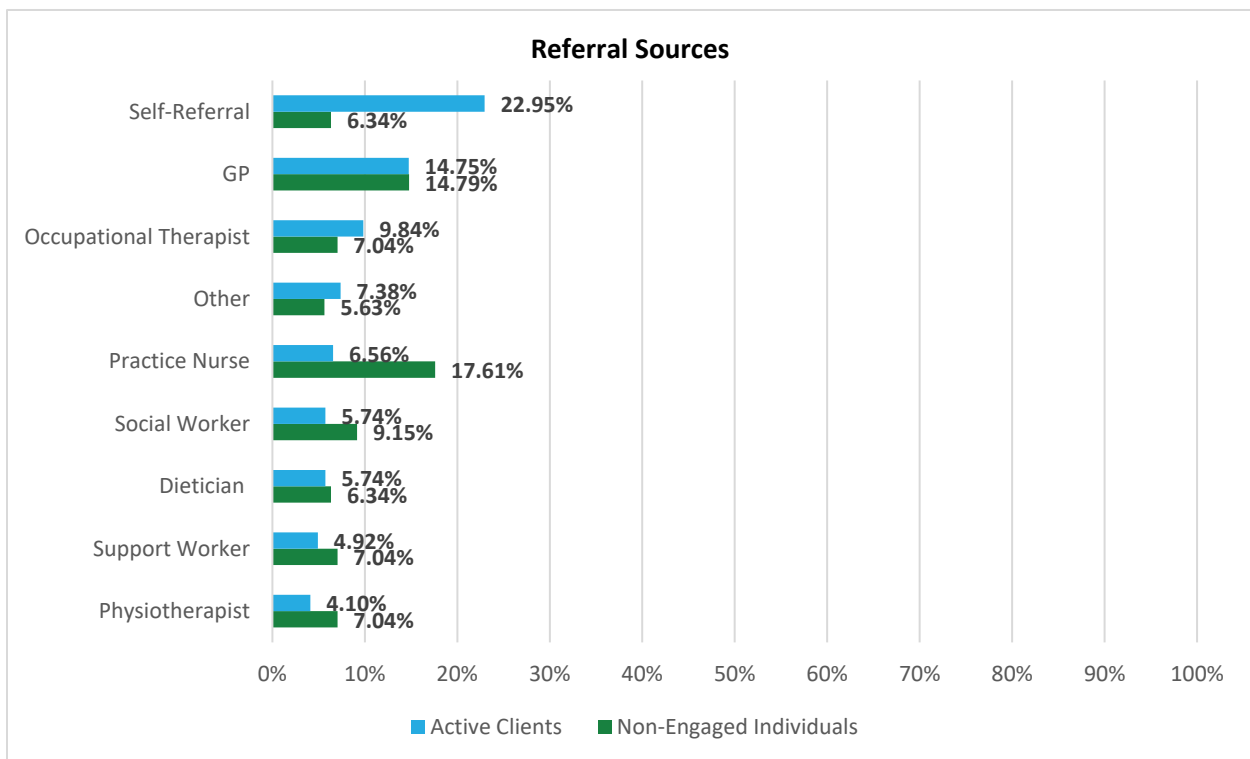
This section presents the findings of the evaluation process, including data collected by SDCP via Salesforce, survey findings, and the findings of qualitative consultation process.

5.2. Referral

A total of 264 individuals were referred to the Tallaght Social Prescribing Service between mid-2023 and mid-2024. Of this figure, 122 individuals (46%) progressed to the point of accessing social prescription and community support. The sub-sections below provide insight into the demographic breakdowns of these individuals (active clients), as well as individuals who did not progress to the point of engaging in community supports (non-engaged individuals).

5.2.1. Referral Sources

A total of 27 individual sources of referral were recorded. The most common sources of referral are illustrated in the graph below. Self-referral was the most common source of referral for individuals who progressed to active client status (23%) whilst referral by Practice Nurses was the most common source amongst non-engaged individuals (17.6%). GP referrals were common across both sets of individuals (14.8% respectively).

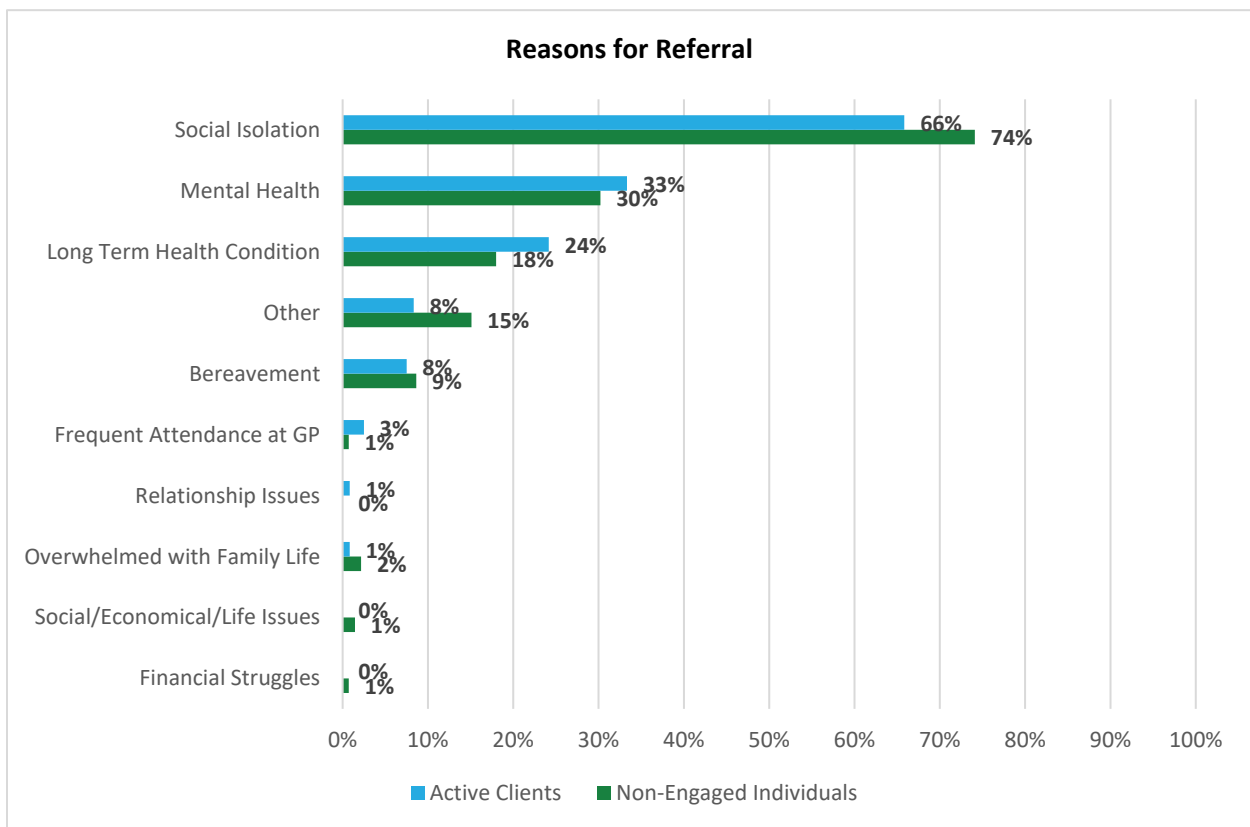


Graph 1: Referral Sources

5.2.2. Reasons for Referral

Information describing an individual’s need for social prescribing was collected at the point of referral. 67% of individuals who progressed to active client status and 63% of non-engaged individuals were referred for a single reason; 33% of individuals who progressed to active client status and 37% of non-engaged individuals had multiple reasons for referral.

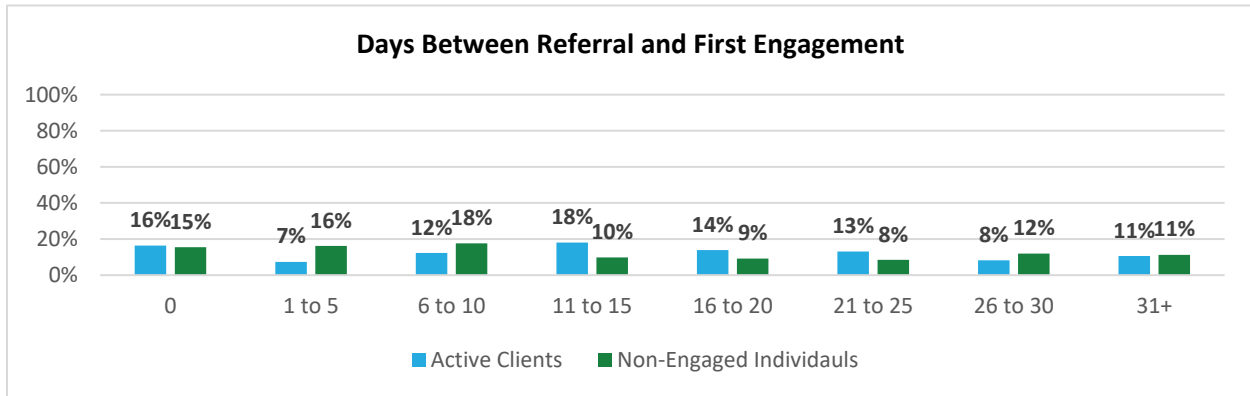
The graph below demonstrates that reasons for referral. Social isolation was the dominant reason for referral, with 66% of individuals who progressed to active client status and 74% of non-engaged individuals reported as experiencing social isolation. Mental health and long-term health conditions were also commonly reported reasons for referral across both groups.



Graph 2: Reasons for Referral

5.2.3. Time Lapse Between Referral and Engagement

The dates of referral to the Tallaght Social Prescribing Service and engagement were recorded. As is illustrated by the graph below, the time lapse before engagement is relatively similar for individuals who progressed to active client status and those who did not. 35% of individuals of who progressed to active client status were engaged within 10 days of referral, in comparison to 49% of non-engaged individuals.

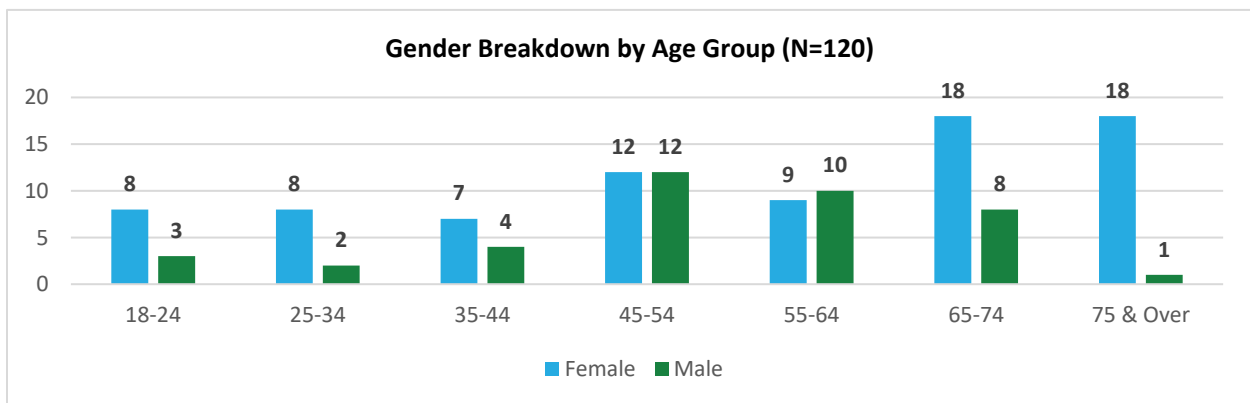


Graph 3: Comparison of Days Between Referral and First Engagement for Active Clients and Non-Engaged Individuals

5.3. Demographic Information for Active Clients

5.3.1. Demographics

122 individuals referred to the Tallaght Social Prescribing Service proceeded to active client status, progressing to the point of accessing social prescription and community support. 67% of clients engaged were female whilst 33% were male. Over half of clients engaged (53%) were aged 55 or older at the point of referral.¹⁰



Graph 4: Gender Breakdown of Active Clients by Age Group (N=120)

90%

Of clients were White Irish; 3% were of another White Background

66%

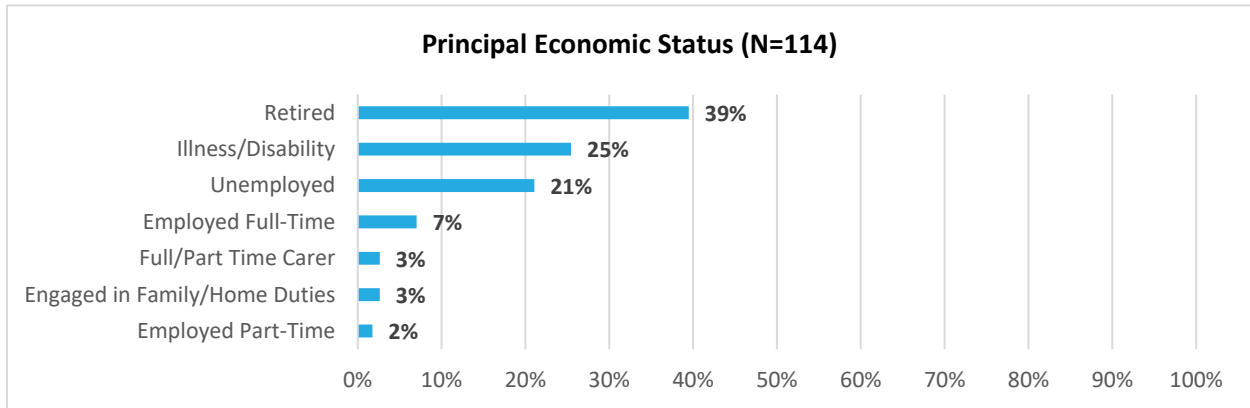
Of clients had not progressed past secondary-level education

14%

Of clients had a third level qualification or higher

¹⁰ The sex and ages of two clients were not included in Salesforce data and thus not included in figures displayed Graph 4.

The majority of clients were retired at the point of referral (39%), synergising with the high engagement rate of clients aged 55 or over. 9% of clients engaged were in employment at the point of referral (7% full-time and 2% part-time). 21% of clients were unemployed whilst 25% of clients reported that they were unable to work due to illness or disability.



Graph 5: Principal Economic Status of Active Clients (N=114)

36%

Of clients identified as having a disability; 64% did not

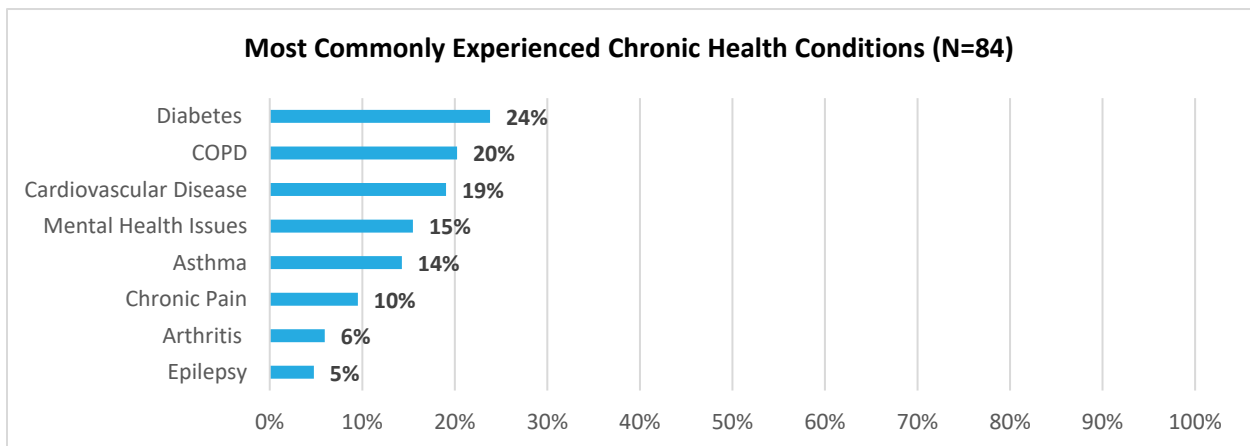
40%

Of clients reported having access needs including mobility, hearing, sight, literacy etc.

71%

Of clients identified as having a chronic health condition

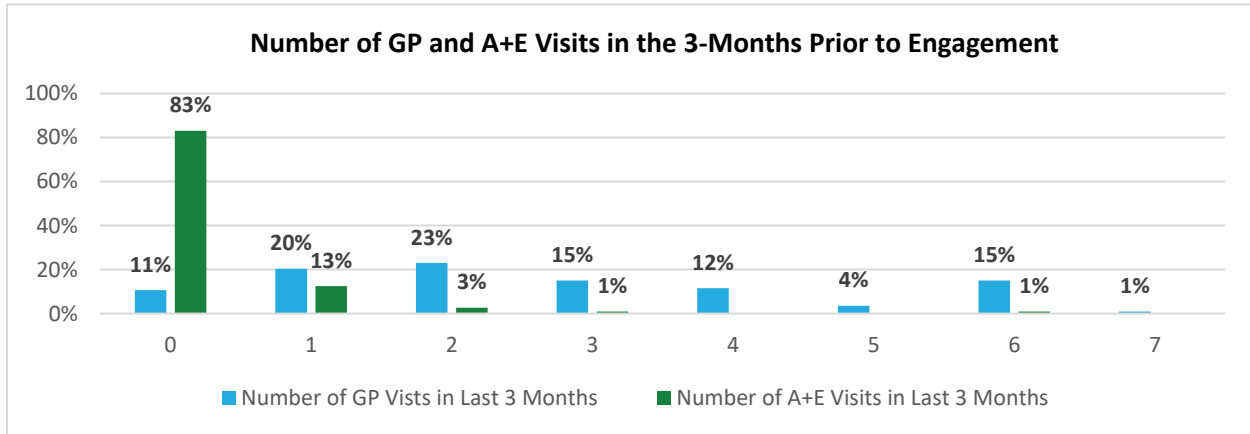
Of clients with a chronic health condition, 52% reported experiencing a singular chronic health condition, whilst 48% reported experiencing multiple chronic health conditions. The most common chronic health conditions cited included diabetes (24%), COPD (20%), and cardiovascular disease (19%). The most frequently cited chronic health conditions are displayed in the following graph. A full table is available in Appendix 2.



Graph 6: Chronic Health Conditions Most Commonly Experienced by Active Clients (N=84)

5.3.2. Visits to GP and A+E

Referrers reported on the number of GP and A+E visits individuals had in the 3-months prior to referral to the Tallaght Social Prescribing Service.



Graph 7: Number of GP and A+E Visits by Active Clients in the 3-Months Prior to Engagement

89%

Of clients had attended a GP in the previous 3 months; 11% had not

19%

Of clients attended a GP 5 or more times in the 3 months prior to referral

17%

Of clients had attended A+E in the previous 3 months; 83% had not

41%

Of clients who attended a GP 5 or more times in the 3 months prior to referral had also attended A+E at least once

89%

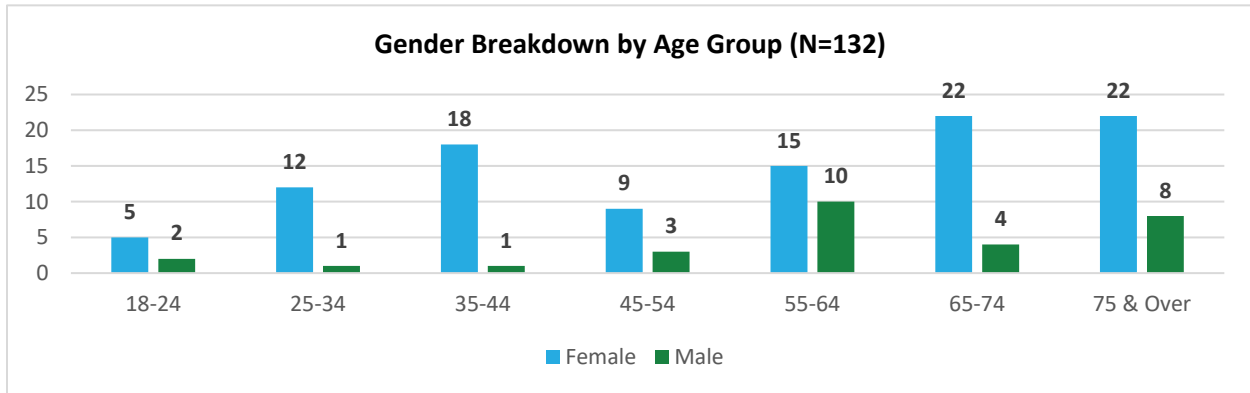
Of clients who had attended A+E in the 3 months prior to referral had also attended a GP

5.4. Demographic Information for Non-Engaged Individuals

5.4.1. Demographics

142 individuals referred to the Tallaght Social Prescribing Service did not progress to active client status as they did not progress to the point of receiving tangible outcomes or accessing community supports. 75% of these individuals were female whilst 25% were male. Three fifths of these individuals (61%) were aged 55 or older at the point of referral¹¹.

¹¹ The sex and ages of ten participants were not included in Salesforce data and thus not included in figures displayed Graph 8.



Graph 8: Gender Breakdown of Non-Engaged Individuals by Age Group (N=132)

7%

Of clients identified as having a disability¹¹

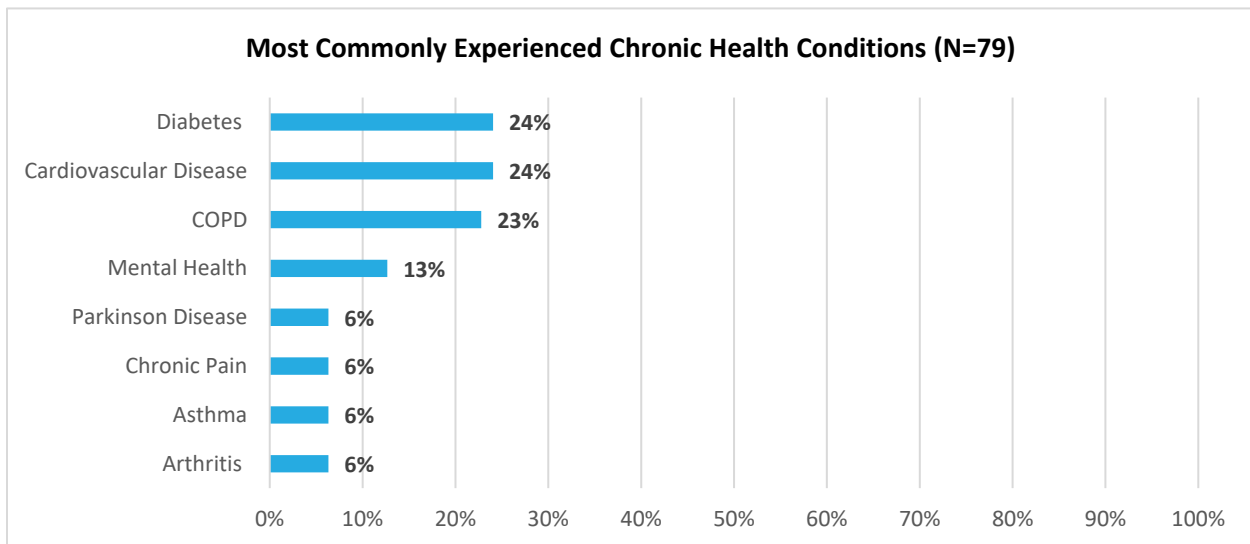
20%

Of individuals reported having access needs incl. mobility, sight, literacy, hearing and requiring an interpreter

63%

Of individuals identified as having a chronic health condition

Of individuals with a chronic health condition, 62% reported experiencing a singular chronic health condition, whilst 38% reported experiencing multiple chronic health conditions. The most common chronic health conditions cited included diabetes (24%), cardiovascular disease (24%) and COPD (23%). The most frequently cited chronic health conditions are displayed in the graph below. A full table is available in Appendix 2.

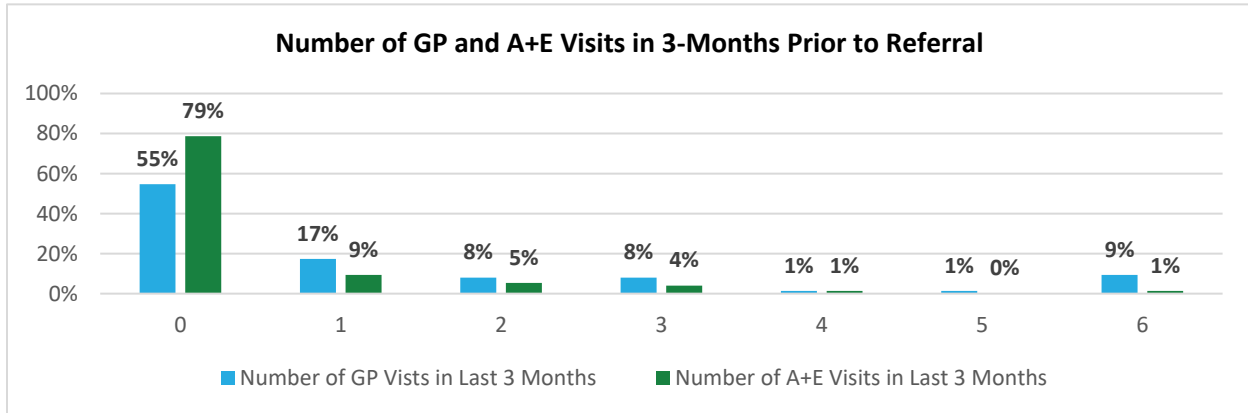


Graph 9: Chronic Health Conditions Most Commonly Experienced by Non-Engaged Individuals (N=79)

¹² Salesforce data on disabilities was limited; just 34 individuals had a recorded statement of whether they did or did not have a disability. It is assumed that individuals who did not have an entry related to disability do not identify as having a disability.

5.4.2. Visits to GP and A+E

Referrers reported on the number of GP and A+E visits individuals had in the 3-months prior to referral to the Tallaght Social Prescribing Service.



Graph 10: Number of GP and A+E Visits by Non-Engaged Individuals in the 3-Months Prior to Engagement

45%

Of individuals had attended a GP in the previous 3 months; 55% had not

11%

Of individuals attended a GP 5 or more times in the 3 months prior to referral

21%

Of individuals had attended A+E in the previous 3 months; 79% had not

38%

Of individuals who attended a GP 5 or more times in in the 3 months prior to referral had also attended A+E at least once

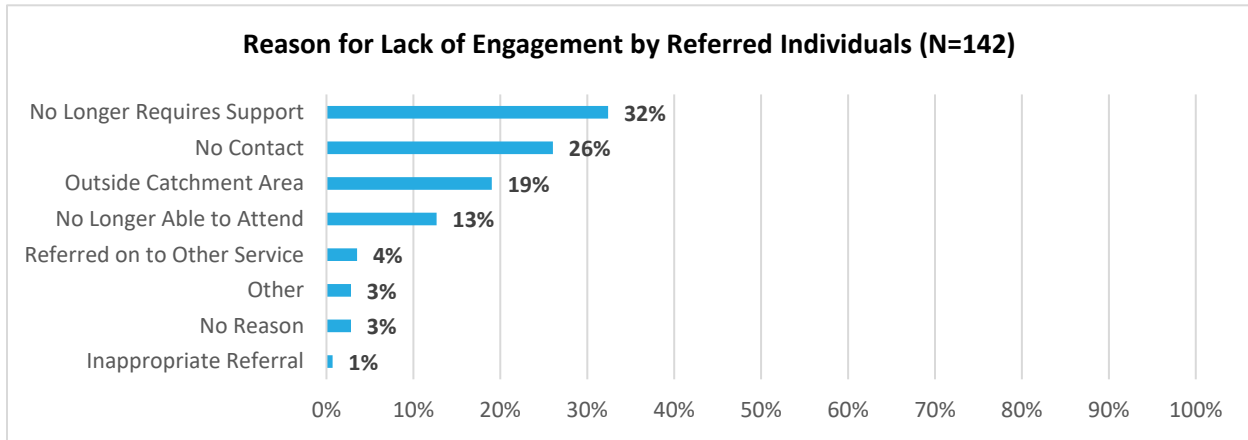
50%

Of individuals who had attended A+E in the 3 months prior to referral had also attended a GP

5.4.3. Reason for Lack of Engagement

Data was collected on the reason why 142 referred individuals did not progress to active client status with the Tallaght Social Prescribing Service. The most common reason for lack of engagement was feedback that referred individuals no longer required support (32%). 26% of non-engaged individuals were uncontactable and 19% lived outside of the project catchment area. Just 1% of these referrals were recorded as inappropriate referrals.¹³

¹³ Inappropriate referrals are those made for individuals who are not aged over 18, are not willing to consent to engagement, do not have the capacity to leave their home and engage with the community, and/or are currently in crisis and therefore require more specialised care than can be provided through social prescribing.



Graph 11: Reason for Lack of Engagement by Referred Individuals (N=142)

5.5. Client Journey

122 individuals referred to the Tallaght Social Prescribing Service proceeded to active client status. The following section details the journey of clients through the service, including interventions and outcomes resulting from client engagement, length of engagement and reasons for discharge from the service.

5.5.1. Interventions

Documentation provided to the evaluators by SDCP, which derives its information from the HSE Social Prescribing Framework, defines an intervention as ‘any interaction with, or on behalf of, or for the purpose of supporting a client.’¹⁴ **A total of 3,367 interventions were recorded across 263 individuals engaged during the evaluation period.** This is an average of 12.8 interventions per individual and 1683.5 interventions per Social Prescribing Link Worker. However, this figure included interventions for non-engaged individuals.

A total of 2,000 interventions¹⁵ were recorded by the Tallaght Social Prescribing Service team across the 122 clients who progressed to active client status. The number interventions recorded per client ranged from 1 to 59, with an average of 16.4 interventions per client. Calls were the most frequent intervention type recorded (40.05%), followed by texts (17.49%) and emails (17.19%). Just 13% of clients accessed 8 or fewer interventions.

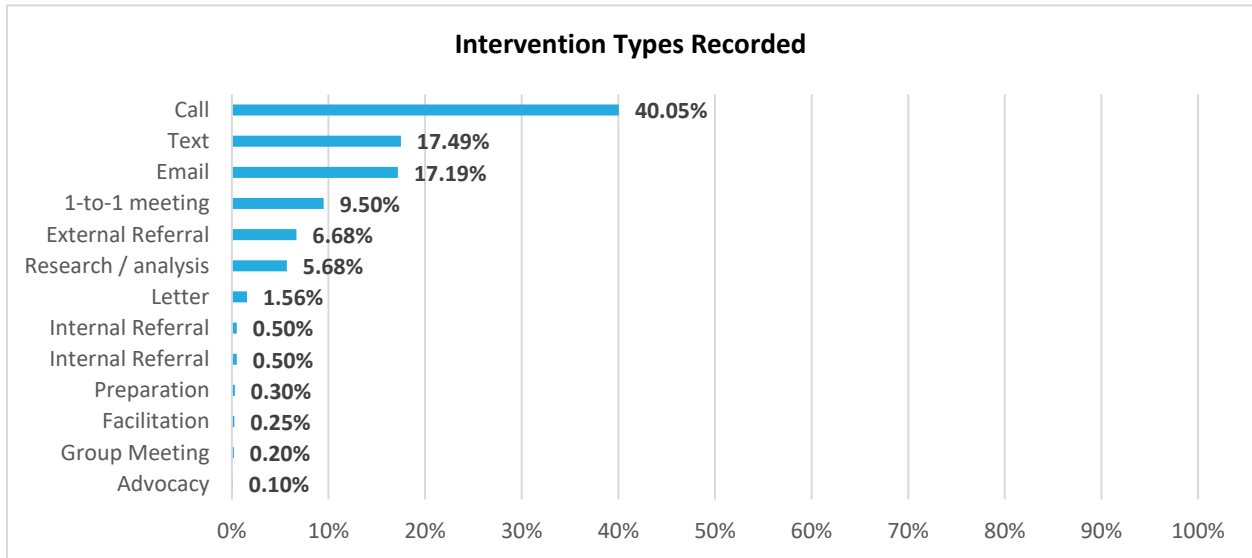


16.4

Average number of interventions per client

¹⁴ This definition is adapted from the narrative descriptions in the HSE Social Prescribing Framework (2023)

¹⁵ A number of interventions referred to unanswered phone calls. Efforts have been made by the evaluator to isolate intervention occurrences to those which involved interaction with the client, as per the HSE definition. This reduced the overall recorded number of interventions from 2,410 to 2,000. This suggests that the service interacts with a significantly higher volume of clients than become ‘active clients’, the administrative burden in facilitating phone calls and texts to clients who ultimately do not become active, is significant and impacts capacity.



Graph 12: Intervention Types Recorded

5.5.2. Outcomes of Interventions and Engagement

SDCP captured the outcomes of the Tallaght Social Prescribing Service for clients. Outcomes refer to the activities and services which clients engaged with as a result of referral by their Social Prescribing Link Worker. A total of 310 outcomes were recorded across 122 clients, ranging from 1 to 12 outcomes recorded per client. The average number of outcomes experienced by clients was 2.66.

2.66
Average number of outcomes per client

48%

Of clients engaged in Community, Social Activity, or Support Groups

34%

Of clients engaged in Physical Activity Groups

22%

Of clients engaged in Counselling Support (Mental Health)

20%

Of clients engaged in Mental Health/Wellbeing programmes

19%

Of clients engaged in activities to Learn New Skills

7%

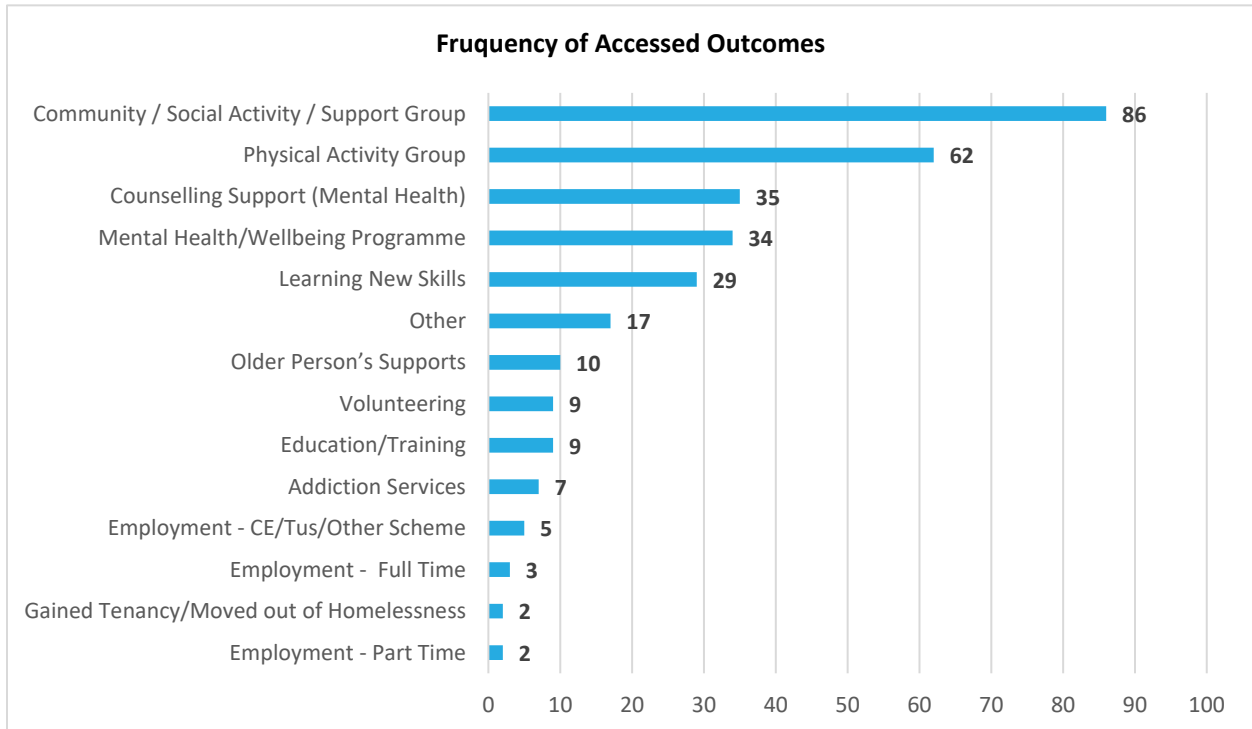
Of clients engaged in Older Person's Supports

6%

Of clients engaged in Volunteering

6%

Of clients engaged in Education / Training



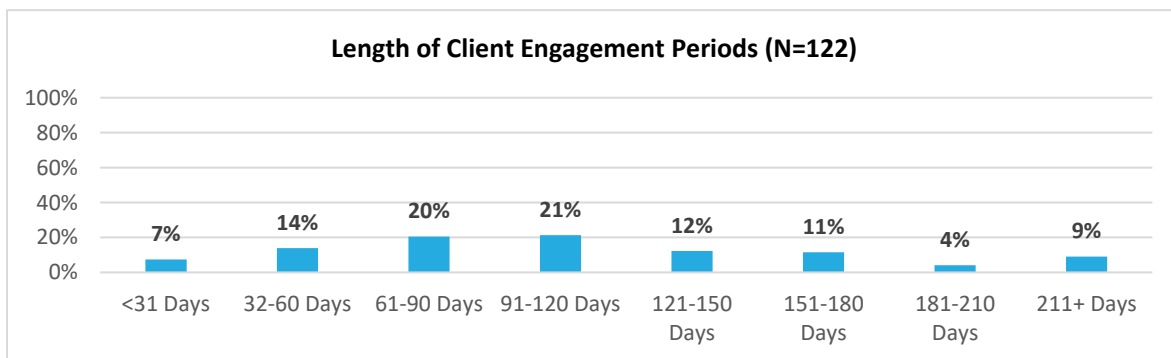
Graph 13: Frequency of Accessed Outcomes

5.5.3. Length of Engagement

The dates of first engagement and discharge from the Tallaght Social Prescribing Service were recorded. The majority of clients were engaged over a period of 2-4 months (41%). Just 7% of clients engaged for 1 month of less and just 9% engaged for 7 months or more. The average length of engagement for clients was 114 days. The relatively even spread of engagement likely reflects the diverse support needs of clients and demonstrates that clients engage for so long as they require, rather than for a specific window of time.



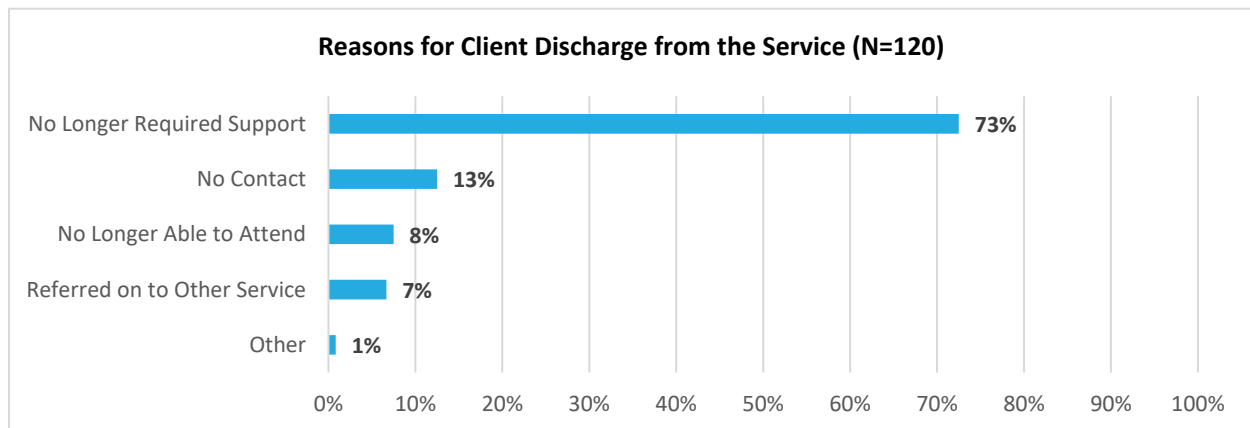
114 Days
Average length of client engagement



Graph 14: Length of Client Engagement Periods (N=122)

5.5.4. Reason for Discharge from Service

The graph below depicts a breakdown of the reasons why clients were discharged or exited the Tallaght Social Prescribing Service. 73% of clients were discharged as they no longer required support, suggesting that the majority of clients engaged with the service to a point of completion, in line with their needs. 13% of clients became uncontactable, 8% were no longer able to attend and 7% were referred onward to other services.



Graph 15: Reasons for Client Discharge from the Service (N=120)

5.6. Impact of the Service for Clients

SDCP employed two measures of client wellbeing to assess the impact of the Tallaght Social Prescribing Service on mental health, wellbeing and personal concerns:

- Shortened Warwick Edinburgh Mental Wellbeing Scale (SWEMWBS):** Clients responded to 7 wellbeing statements, providing scores of 1 (none of the time) to 5 (all of the time). The minimum score possible was 7 and highest was 35. Higher scores indicated better levels of wellbeing; increases in scores between pre- to post-engagement are defined as an improvement in wellbeing.¹⁶ Scores of 19.5 or lower are associated with low wellbeing, whilst scores of 27.5 or higher are associated with high wellbeing
- Measure Yourself Concerns and Wellbeing (MYCaW):** Clients provided scores for up to 2 personal concerns and their wellbeing on a scale of 0 (as good as it could be/no concern) to 6 (as bad as it could be). Higher scores indicated poorer levels of wellbeing; decreases in scores pre- to post-engaged are defined as an improvement in wellbeing.


¹⁶ Scores provided by clients were converted in line with the scoring instructions employed through the Shortened Warwick Edinburgh Mental Wellbeing Scale:

https://warwick.ac.uk/fac/sci/med/research/platform/wemwbs/using/howto/swemwbs_raw_score_to_metric_score_conversion_table.pdf

5.6.1. Shortened Warwick Edinburgh Mental Wellbeing Scale

80 pre-engagement SWEMWBS scores and 23 post-engagement SWEMWBS scores were available for individuals supported through the Tallaght Social Prescribing Service.¹⁷

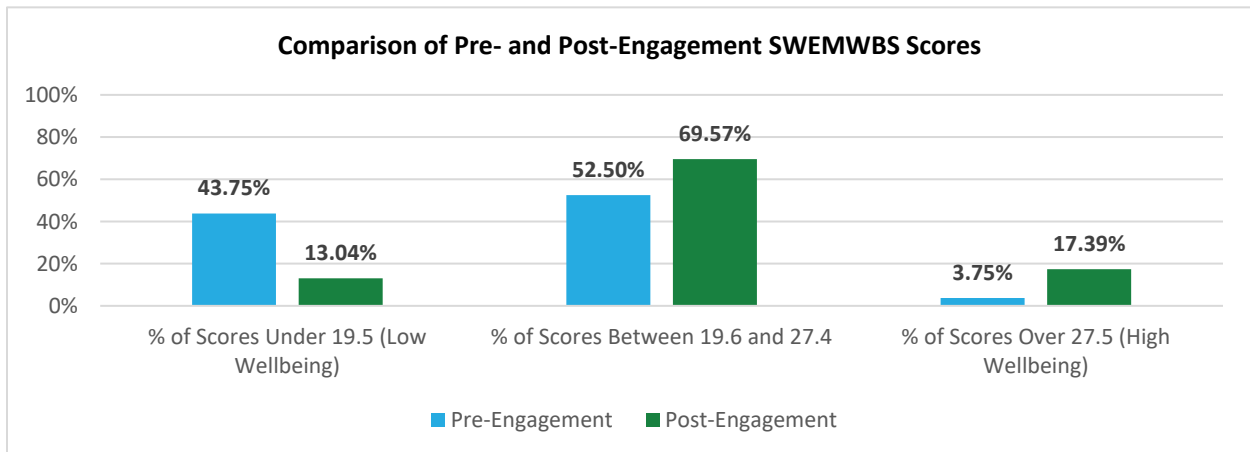
19.98	23.95	+19.87%
Average Pre-Engagement Score	Average Post-Engagement Score	Change in Average Client SWEMWBS Scores Between Pre- and Post-Engagement



87%

Of clients reported
medium-high
wellbeing post-
engagement

The average client SWEMWBS score increased by 19.87% between pre- and post-engagement measures. **This indicates an improvement in the average mental wellbeing of clients engaged.** Whilst 43.75% of clients reported scores indicating low wellbeing pre-engagement, just 13.04% of clients reported low wellbeing scores post-engagement. Further, just 3.75% of clients reported scores indicating high wellbeing pre-engagement, compared with 17.39% post-engagement. Post-engagement, 87% of clients reported medium-high wellbeing scores.



Graph 16: Comparison of Pre- and Post-Engagement SWEMWBS Scores

¹⁷ Scores included in the pre-engagement SWEMWBS include individuals who did not progress to full engagement with the Tallaght Social Prescribing Service. These scores have been included to provide a fuller picture of the level of need experienced by individuals referred to the service. All scores included in the post-engagement SWEMWBS reflect individuals who progressed to active client status.

Comparable SWEMWBS Scores

22 clients had SWEMWBS scores collected both pre- and post-engagement.

20.25

Average Pre-Engagement Score


24.51

Average Post-Engagement Score

+21.06%

Change in Average Client SWEMWBS Scores Between Pre- and Post-Engagement

The average client SWEMWBS score increased by 21.06% between pre- and post-engagement measures. Whilst 36% of clients with comparable pre- and post- measures reported scores indicating low wellbeing prior to engagement, just 9% of clients reported low wellbeing scores post-engagement. Further, whilst none of these clients reported scores indicating high wellbeing pre-engagement, 18% reported high wellbeing score post-engagement. Post-engagement, 91% of clients reported medium-high wellbeing scores.



91%
Of clients reported medium-high wellbeing post-engagement

86%

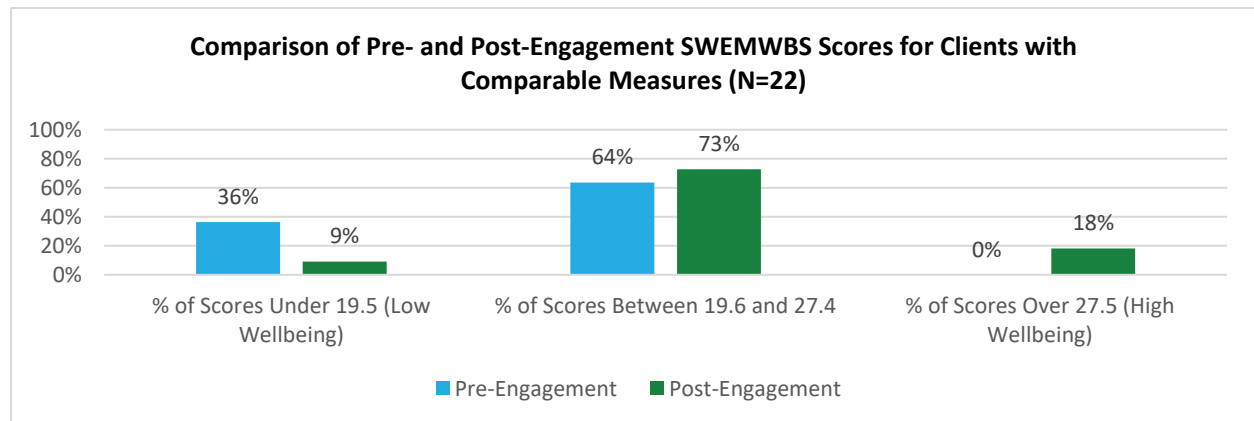
Of clients experienced an improvement in their wellbeing score

5%

Of clients maintained their wellbeing score (score remained in medium range)

9%

Of clients experienced a regression in their wellbeing score



Graph 17: Comparison of Pre- and Post-Engagement SWEMWBS Scores for Clients with Comparable Measures (N=22)

5.6.2. Measure Yourself Concerns and Wellbeing

78 pre-engagement MYCaW scores and 23 post-engagement MYCaW scores were available for individuals supported through the Tallaght Social Prescribing Service.¹⁸

5.14	2.32	-54.91%
Average Pre-Engagement Concern 1 Score	Average Post-Engagement Concern 1 Score	Change in Average Client Concern 1 Scores Between Pre- and Post Engagement
4.87	1.59	-67.37%
Average Pre-Engagement Concern 2 Score	Average Post-Engagement Concern 2 Score	Change in Average Client Concern 2 Scores Between Pre- and Post Engagement
3.63	2.69	-25.81%
Average Pre-Engagement Wellbeing Score	Average Post-Engagement Wellbeing Score	Change in Average Client Wellbeing Scores Between Pre- and Post Engagement

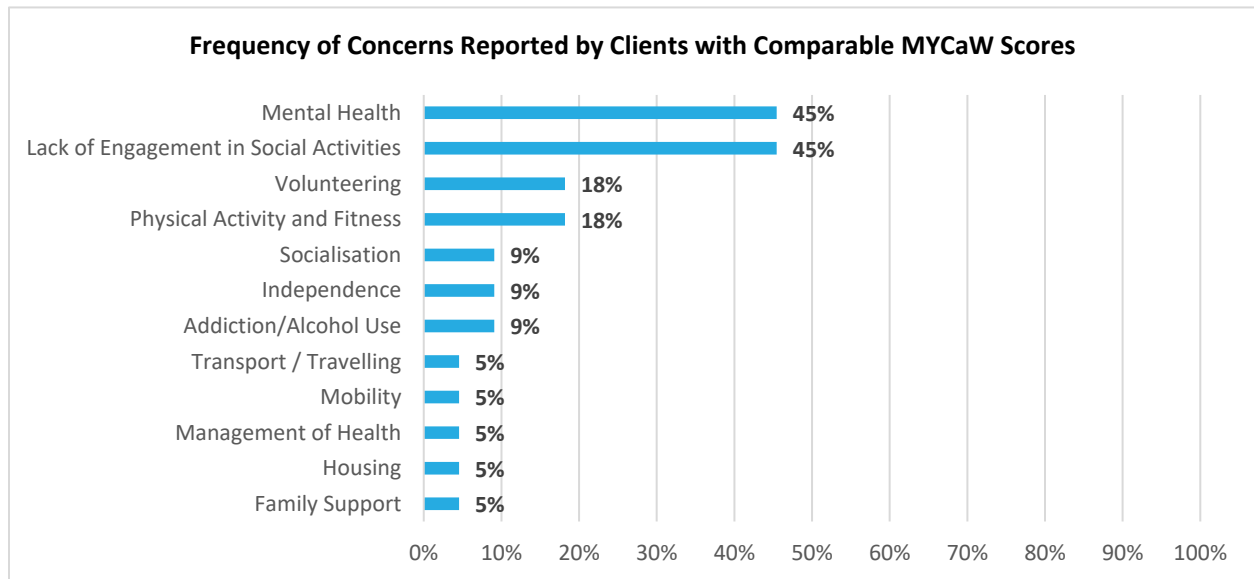
The most common concerns reported by clients were mental health, lack of engagement in social activities, socialisation and physical activity/fitness. A table displaying concerns experienced is available in Appendix 3. The average client score for Concern 1 decreased by 54.91% between pre- and post-engagement measures and the average score for Concern 2 decreased by 67.37%. Further, the average client wellbeing score improved by 25.81%. Taken together, this data indicates an improvement in the average wellbeing of clients engaged and a reduction in their level of concern about personal issues.

Comparable MYCaW Scores

22 clients had MYCaW scores collected both pre- and post-engagement. The most common concerns reported by clients included mental health (45%), lack of engagement in social activities (45%), a desire for volunteering (18%), and physical activity/fitness (18%).

¹⁸ Scores included in the pre-engagement MYCaW include individuals who did not progress to full engagement with the Tallaght Social Prescribing Service. These scores have been included to provide a fuller picture of the level of need experienced by individuals referred to the service. All scores included in the post-engagement MYCaW reflect individuals who progressed to active client status.

5.09	2.09	-58.93%
Average Pre-Engagement Concern 1 Score	Average Post-Engagement Concern 1 Score	Change in Average Client Concern 1 Scores Between Pre- and Post Engagement
4.85	1.59	-67.27%
Average Pre-Engagement Concern 2 Score	Average Post-Engagement Concern 2 Score	Change in Average Client Concern 2 Scores Between Pre- and Post Engagement
3.1	2.58	-16.81%
Average Pre-Engagement Wellbeing Score	Average Post-Engagement Wellbeing Score	Change in Average Client Wellbeing Scores Between Pre- and Post Engagement



Graph 18: Frequency of Concerns Reported by Clients with Comparable MYCaW Scores

The average client score for Concern 1 decreased by 58.93% between pre- and post-engagement measures and the average score for Concern 2 decreased by 67.27%. Further, the average client wellbeing score improved by 16.81%. Taken together, this data indicates an improvement in the average wellbeing of clients engaged and a reduction in their level of concern about personal issues.

91%	82%	71%	50%
Of clients experienced an improvement in their Concern 1 Score	Of clients experienced an improvement in their Concern 2 Score	Of clients experienced an improvement across both of their Concern Scores	Of clients experienced an improved in their MYCaW Wellbeing Score

91% of clients experienced an improvement in their Concern 1 score and 82% experienced an improvement in their Concern 2 score. No client experienced a regression in either of their concern scores. Given the range of concerns reported by clients, this suggests the ability of the Tallaght Social Prescribing Service to support a range of client needs.

5.7. Qualitative Consultation and Survey Findings

This sub-section presents the findings of the qualitative consultation conducted as part of the evaluation process, including feedback from SDCP, the HSE/Sláintecare Healthy Communities Team, referral organisations, and service clients. Findings from the client survey are also interspersed to provide a fuller picture of client experience.

5.7.1. Governance and Oversight of the Service

In discussing the governance and oversight of the Tallaght Social Prescribing Service, the HSE/Sláintecare Healthy Communities Team described SDCP as having a “well-structured Health and Wellbeing Department,” and cited the benefits of an organisation with “a network and web of on the ground contacts,” for the delivery of social prescribing. Regular meetings were noted where both teams “come together to look at solutions and agree approaches,” and reporting by SDCP to Sláintecare Healthy Communities was felt to be “really strong and thorough,” with reports always submitted on time.

SDCP similarly reported the regularity of contact and success of reporting to Sláintecare Healthy Communities but felt that specific engagements on key developments such as the creation of new referral forms or administrative requirements would be productive in supporting the sharing of knowledge from the operational to national level; ensuring key developments are reflective of on-the-ground experiences and learning. Additionally, greater clarity was sought on the definition of an intervention to support streamlined administrative processes and to ensure consistency across services, improving the comparability of cross-service evaluations.

SDCP also discussed the funding provision for social prescribing. It was noted that a standardised amount for each of the 20 SHC projects is provided across the country, despite this, the Tallaght Social Prescribing Service operates at a deficit and requires the input of additional financial resources from SDCP in order to meet delivery targets. The significant volume of time and insight required from senior management to support the Tallaght Social Prescribing Service was specifically cited, particularly at the time of establishment, despite the absence of funding for such contribution under the current funding model.

5.7.2. Operational and Team Management

SDCP reported that management of the service had been successful during the evaluation period, highlighting weekly team meetings where critical cases are discussed and reviewed collectively, and effective direct management to ensure Social Prescribing Link Workers access the support they need. This synergises with the description of management as “very supportive,” by a Tallaght Social Prescribing Link Worker. Reference was also made to the supportive relationships which have developed between Link Workers:

“It’s beneficial to work with other Social Prescribing Link Workers and we do make time for each other [...] We understand the role and you’re talking to someone who’s working in the same field.” – Social Prescribing Link Worker Feedback

The administrative processes utilised through the Tallaght Social Prescribing Service were felt to be a particular success. It was felt that the introduction of the Salesforce System was beneficial in reducing the time spent on administrative management and an effective method of both data collection and storage. Despite this, the practicalities of managing a service of this size, of keeping track of community supports, and meeting the funder’s reporting requirements necessitates a heavy burden of administration, with a Social Prescribing Link Worker estimating that “anywhere from 25-40% of [their] time goes into administration.” Whilst it was recognised that this is “part and parcel of the role,” SDCP discussed a need for administrative support in future, suggesting either funding for an administrative position or an increase in the number of Social Prescribing Link Workers to reduce individual case load and provide greater time for administration.

5.7.3. Delivery Model

This sub-section outlines discussion about the delivery of the Tallaght Social Prescribing Service, including elements which worked well and those which posed a challenge.

The delivery of the Tallaght Social Prescribing Service was described as successful overall. The Sláintecare Healthy Communities Team reported that:

“First and foremost, their model of delivery would be very much in line [with the ideals of Sláintecare Healthy Communities] and they are addressing the needs in their community.”

The model of delivery was described as being developed in collaborative approach with reference to the ‘top down national model’ (HSE Social Prescribing Framework) and bottom up community needs. SDCP characterised the service as a “strong support for the community,” and felt that the demand for the service and the number of word-of-mouth referrals received demonstrates how positively the service is perceived within Tallaght.

Referral Process

SDCP reflected positively on the referral process. The efforts of Social Prescribing Link Workers to expand referral pathways were noted and paralleled feedback from referral organisations who reported that they first learned about the Tallaght Social Prescribing Service through visits from Link Workers. These efforts have led to a growth in referrals and resulting, the service waiting list, with SDCP reportedly “pulling back,” promotional efforts as demand exceeds capacity.

“An email came to the practice manager and [a Tallaght Social Prescribing Link Worker] said she could come in and talk to us. We met for 20 minutes about the service and that’s when I started referring people in.” – Referral Organisation Representative

Whilst SDCP noted the benefits of the Salesforce system in streamlining the referral process, feedback from referral organisations was mixed. One organisation described the process as “very easy” and “straightforward,” highlighting the simplicity of the online form. Conversely, another referral organisation stated that referral is “not an easy process,” citing the incompatibility between Salesforce and the software used within GP surgeries in Ireland, and the additional time required to manually input client data. While stakeholders agreed that improved integration with GP systems could increase referral volumes, particularly if compatibility with the HSE’s HealthMail platform were established, it is important to recognise the significant administrative and developmental challenges involved. HealthMail is a secure, nationally governed system with strict compliance, security, and interoperability requirements, meaning that building a seamless interface with third-party platforms such as Salesforce would require substantial technical development, rigorous data governance processes, and national-level agreement. Referral organisations also expressed a desire for greater input from Social Prescribing Link Workers, suggesting that a regularly updated list of available activities would help them identify clients for referral, and that periodic updates on client progress would be welcomed.

Engagement Criteria

Of the clients consulted, two were referred by GPs, two self-referred, and one was referred by a counsellor. Clients cited mental health and wellbeing, long-term health conditions, addiction, and social isolation as the rationale for their referral. Paired with data highlighting that referred individuals classified as ‘inappropriate referrals’ or falling ‘outside the service catchment area’ were not engaged, **it is possible to conclude that the service is targeting appropriate clientele through appropriate referral avenues.** This is supported by feedback from SDCP who noted, *“there is a certain level of need that we can’t take. Those sorts of referrals now happen a lot less as our referral agencies understand.”* It should be noted that the launch of an online self referral system by SDCP significantly increased the number of self referrals from the community, which was considered a positive development by SDCP. In consultations, this was perceived to be a reflection of ‘word of mouth’ promotion, reflecting the positive reputation of the service. In addition, the increase in self referral has broadened the age range of participants, coinciding with an increase in 18-30 year olds accessing the service.

Role of Social Prescribing Link Workers

SDCP highlighted the centrality and importance of the Social Prescribing Link Worker role, identifying both “finding the right people,” for the Link Worker role and “relationship building,” with clients as key to success. The professional experience of Tallaght Social Prescribing Link Workers was referenced, with both having “worked in the community before,” and having previously “worked with people with complex needs.”

Paralleling feedback from SDCP, consulted clients pointed to the significance of the role of their Social Prescribing Link Worker in creating positive and impactful social prescribing experiences. Clients noted that link workers took time to “talk about what [their] needs were,” and felt they “wanted to understand.” Tallaght Social Prescribing Link Workers were described as “communicative,” “relaxed,” and “friendly,” with one client stating that they “created a safe environment.” Clients felt that their Social Prescribing Link Workers “provided enough support,” and, despite two clients reporting that they personally could have engaged more purposefully as clients, all clients consulted reported that their Link Worker connected them with supports and activities which matched their needs and interests.

“Giving someone the space to be listened to is key because a lot of the people that we work with haven’t had that for a while. Giving someone the space to talk can be very powerful and it builds trust, and they are more willing to engage.” – Social Prescribing Link Worker Feedback

“From the first meeting, the regularity with which she met me and the work and effort she put in to present me with available opportunities was fantastic.” – Client Feedback

“The supports I received were completely the sorts of supports which I needed as a person.” – Client Feedback

Positive feedback on the role of Social Prescribing Link Workers was also evident in the client survey. A summary of this feedback is provided below (N=19):

4.6/5	100%	95%
Average overall experience of support received from Social Prescribing Link Workers	Of respondents agreed that they felt listened to by their Social Prescribing Link Worker	Of respondents agreed that their Link Worker explained things in a way they could understand
90%	84%	84%
Of respondents agreed that their Link Worker helped to identify the support they needed	Of respondents agreed that their Link Worker was easy to communicate with	Of respondents agreed that they received enough support from their Link Worker

“She met with me regularly and showed a real concern for my wellbeing. We discussed many activities and events taking place locally. We found an activity that benefited me both physically and mentally. She checks in with me to see how things are going and updates me with anything new.” – Client Survey Feedback

Duration of Support

Current HSE guidelines for social prescribing highlight that clients should receive between 6-8 intervention sessions. However, a Tallaght Social Prescribing Link Worker reported that the “majority of people need more than 6-8 interventions,” and noted that “there should be an appreciation of the need for more support.” SDCP noted that they commonly support clients with a “high complexity,” of need; this was recognised by the HSE/Sláintecare Healthy Communities Team who pointed to the proximity of the Tallaght and Clondalkin Sláintecare Healthy Communities areas as recognition of the high level of complexity and deprivation which exists in the area. Complex needs reportedly necessitate longer intervention processes for clients, with a Tallaght Social Prescribing Link Worker reporting that “it can take a few phone calls to build the trust for people to be able to come and meet us.” This synergises with client feedback, as one client stated, “it took me a couple of meetings to be comfortable with the fact I wasn’t taking space from someone else or monopolising [the Link Worker’s] time.”

This mirrors findings in a 2024 evaluation of the Clondalkin Social Prescribing (SP) Project, highlighting a consistent pattern. The Clondalkin Evaluation found that Social Prescribers are frequently engaging with clients for longer durations and over more sessions than recommended by the HSE Social Prescribing Framework. This deviation was attributed primarily to the complex needs of the client cohort in the Clondalkin area, where social, health, and economic challenges are more acute than in some other regions. Despite being evaluated independently, the Clondalkin report and the findings in this evaluation converge on the conclusion that rigid adherence to the national framework's time parameters would undermine outcomes in these high-need contexts, and that a more flexible, needs-led approach is essential for effectiveness.

Future Development

Whilst it is evident that the current delivery model employed through the Tallaght Social Prescribing Service is achieving outcomes for clients and follows a structured system of governance, management and implementation, consultation discussion also focused on how the service could develop in future:

- **Developing Internal Referrals:** A Tallaght Social Prescribing Link Worker noted that internal referrals to SDCP programming could be developed through greater internal information sharing to promote cross-organisational knowledge about the range of opportunities available.
- **Identifying Impact on the Health Service:** A Tallaght Social Prescribing Link Worker highlighted that further monitoring of client healthcare engagement would support the identification of the *“impact of social prescribing on GP pressure, hospital admissions and presentations to A&E.”* This however would require significant inroad in terms of GP referral and is therefore a national approach and to be led by the HSE.
- **Client Categorisation:** The HSE CHO-7 Team suggested that consideration could be given to the introduction of a system to *“grade the complexity of clients.”* It was felt that such a system would support understanding of the need for greater levels of intervention. SDCP were open to this idea and referenced having considered classifying clients into two groups, one for those with lower needs requiring fewer interventions, and one for those with greater needs, requiring more comprehensive interventions. Whilst it was felt that such a system would be beneficial in balancing and supporting Social Prescriber case load, it was noted that a clear definition of interventions would be required before this could occur. In addition, creating a new categorisation of clients may move the service outside of the scope of the national framework and therefore would require consultation and engagement, led by the HSE, with other social prescribing services.
- **Innovative Ways of Tackling the Waiting List:** The HSE/Sláintecare Healthy Communities Team recognised that client waiting list evidenced high demand and suggested that future delivery could include mitigating activities which have worked well in other areas, such as

group activities for clients with lower levels of need while they wait for one-to-one support, or alternative methods which suit the service's clients. It should be noted that group based activities have been attempted previously with limited success. The HSE Framework also clearly sets out the personalised and individualised nature of the service which in contrary to the group based proposal. Several stakeholders referenced that a group based approach is an unrealistic alternative to providing the resources needed to address the need.

- **Specialising in Future:** Whilst the current format of the Tallaght Social Prescribing Service addresses adults over the age of 18, the HSE identified that there is a gap in provision for children and young people and noted that “exemplars and evidence of best practice,” are needed. It was suggested that an exploration of the viability/feasibility of a service for CYP should be considered, although acknowledgement that this would require resources and therefore collaboration and buy in from multiple agencies.

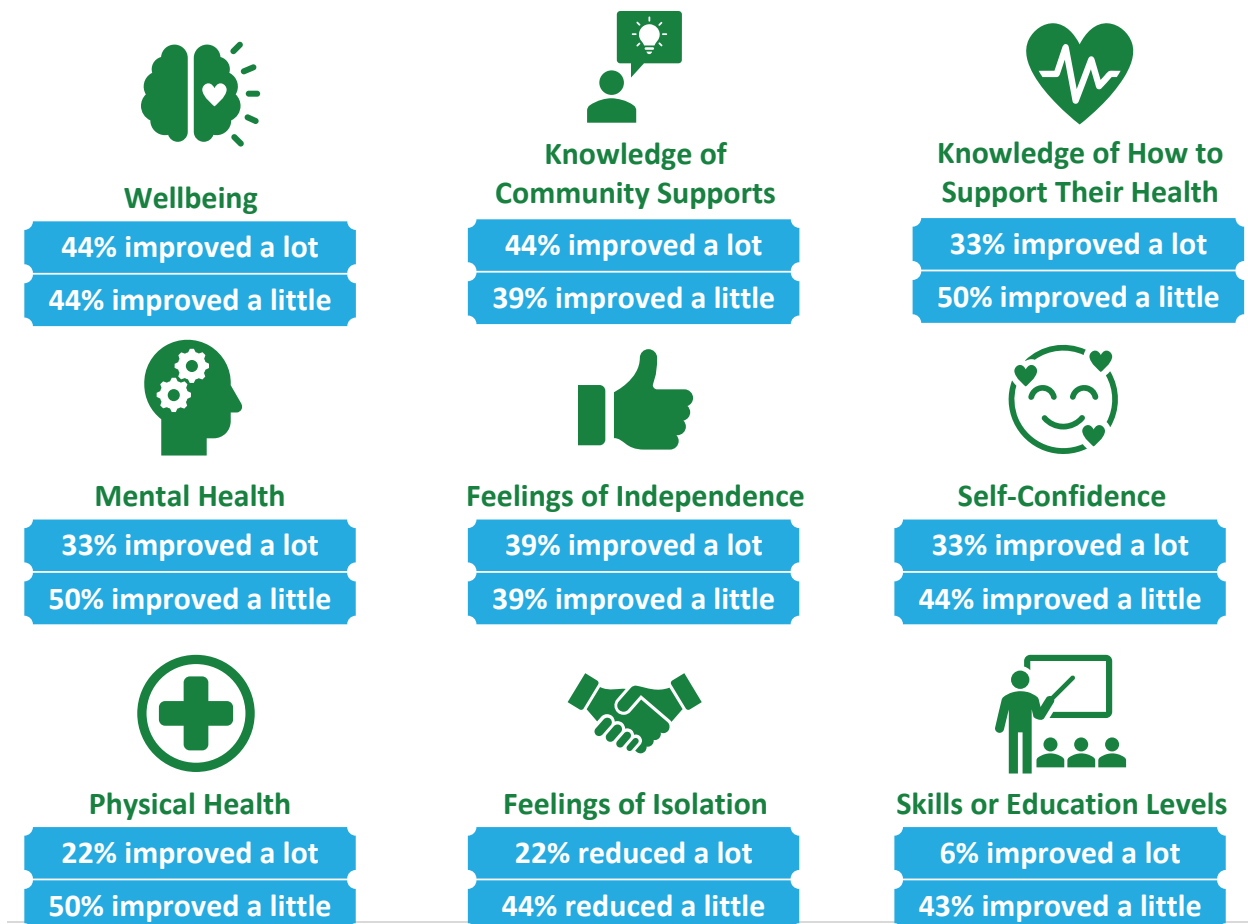
5.7.4. Impact of the Service

Clients reported experiencing positive outcomes as a result of the Tallaght Social Prescribing Service, citing positive impacts on their mental health and wellbeing, level of social interaction, physical health, and fitness.

“It’s made a huge change for me. I’m able to regulate my emotions better, my mental health is better and I’m able to socialise with people more.” – Client Feedback

“My mobility has certainly improved which improved my confidence and now means I can go out every now and again without the anxiety which I would normally have experienced. It’s been of an absolutely enormous benefit, and I couldn’t speak highly enough about the support I’ve received.” – Client Feedback

Reports of the impact of the Tallaght Social Prescribing Service were also provided through the client survey. Most commonly, respondents reported improvements for their wellbeing, their knowledge of available community supports, their mental health, and their knowledge about how to support their health.



Further, whilst referral organisations reported limited knowledge of the impact of the service, they referenced specific examples of how the service benefited individual clients:

“It does have some impact on the frequency of GP presentation. One of the first women I’d referred was coming into see me in the GP monthly and then I didn’t see her for another 6 months and she was a different woman. She said she’d accessed community services and got on great.” – Referral Organisation Feedback

“There is one woman who has come back to me singing about the service. She had an abusive partner at home and wanted some outlet, and they sent her to a dancing class and every time she comes in, she talks about it giving her a new lease of life.” – Referral Organisation Feedback

5.8. Case Studies

The following provides individual case studies of clients engaged by the Tallaght Social Prescribing Service. Data gathered on client through referral organisations and collected by SDCP is combined with qualitative interview findings collected directly by the client. Clients have been provided with pseudonyms to protect their identity.

5.8.1. Client A

Alex is aged between 18-24 and identifies as non-binary/gender non-conforming. Alex was referred to the Tallaght Social Prescribing Service by a GP who cited ‘mental health’ and ‘social isolation’ under the reasons for referral. Alex has a disability (identified in consultation as autism), chronic health condition (epilepsy) and access support needs. At the time of referral, it was reported that Alex had visited the GP six times in the previous three months.

Alex was invited to participate in an anonymous telephone interview to share their experience of the Tallaght Social Prescribing Service:

“My GP recommend me to the service a year or so ago. I was referred because of my mental health and my autism; I needed a bit of extra help and support. I met with my Social Prescribing Link Worker who made a plan which outlined who I was, what I enjoyed and my disabilities; we then looked at things which would help with my autism. I accessed counselling and [my Link Worker] placed me in a group called Walk for people with intellectual disabilities. I’m still with them. The activities I accessed were completely the sort of supports I needed as a person.

Everything was perfect about the service. [My Social Prescribing Link Worker] was really understanding and communicative and I felt safe around her. She created a safe environment. I do think I received enough support from her. The only thing which was difficult about the service was when I got rejected from some supports that we were looking at, but the supports I accessed in the end were what I needed.”

Alex accessed a total of 47 interventions over the course of 6 months of engagement with the Tallaght Social Prescribing Service. Through the service, Alex engaged in:



Creative Writing Course



Criminal Psychology Course



Counselling



WALK (Employment, Training, Social Support)

Regarding the impact of accessing the Tallaght Social Prescribing Service, Alex stated:

“The Tallaght Social Prescribing Service has made a huge change for me. I’m able to regulate my emotions better, my mental health is better and I’m able to socialise with people more.”

When first engaged, Alex’s pre-engagement MYCaW concern was a need to “link with day services.” Alex experienced a 100% reduction in their level of concern through engagement, providing this concern with a score of 0 post-engagement.

5

Pre-Engagement MYCaW Concern Score

0

Post-Engagement MYCaW Concern Score

-100%

Change in Concern Score

Alex also experienced a 10.28-point increase between their pre- and post-engagement SWEMWBS score, amounting to a 69.7% improvement. It is evident that Alex experienced a significant improvement in their wellbeing following engagement with the Tallaght Social Prescribing Service.

14.75

Pre-Engagement SWEMWBS Score

25.03

Post-Engagement SWEMWBS Score

+69.7%

Change in SWEMWBS Score

5.8.2. Client B

Barry is a 47 year old man who self-referred to the Tallaght Social Prescribing Service, citing ‘social isolation’ as the reason for referral. Barry learned about the service through a community programme which received a presentation visit from the Social Prescribing Link Workers. At the time of referral, Barry had visited the GP six times in the previous three months.

Barry was invited to participate in an anonymous telephone interview to share his experience of the Tallaght Social Prescribing Service:

“I was taking part in [a community programme] in the local community centre. [The Social Prescribing Link Workers] came in to give a talk and explain what social prescribing was. I’d never heard of social prescribing and had never availed of any services in my life until I linked in with SDCP. It’s one thing to know resources are available, a whole other thing to feel you’re worthy and deserving of them.

My Social Prescribing Link Worker helped me with filtering. I have ADHD and it was masked all my life by alcohol. I have been off alcohol for 2 years now and I struggle with categorising and get overwhelmed; she helped me with that. She asked me what was important and what we could do now. She was a very easy person to talk to because she didn’t just hear, she listened. It took me a couple of meetings to be comfortable with the fact I wasn’t taking space from someone else or monopolising her time. My Link Worker connected me with lots of things. She put me in touch with the COPD gentle exercise class, I did the Heads Up Programme three times, and she put me in touch with Living Well. I really enjoyed that.”

Barry accessed a total of 35 interventions over the course of nearly 4 months of engagement with the Tallaght Social Prescribing Service. Through the service, Barry engaged in:



Smoking
Cessation Services



Heads Up
Programme



Reflexology



Alcoholics
Anonymous



Volunteering

When first engaged, Barry’s pre-engagement MYCaW concerns were a need for “increased social interaction/engagement,” and a desire to “be of help/volunteer.” Barry experienced a 100% reduction in his Concern 1 score and a 60% reduction in his concern 2 score.

6	0	-100%
Pre-Engagement MYCaW Concern 1 Score	Post-Engagement MYCaW Concern 1 Score	Change in Concern 1 Score
5	2	-60%
Pre-Engagement MYCaW Concern 2 Score	Post-Engagement MYCaW Concern 2 Score	Change in Concern 2 Score
<p>Barry also experienced a 2.29-point increase in his SWEMWBS score, amounting to an 11.9% improvement. This evidences that Barry experienced an improvement in wellbeing following engagement with the Tallaght Social Prescribing Service.</p>		
19.25	21.54	+11.9%
Pre-Engagement SWEMWBS Score	Post-Engagement SWEMWBS Score	Change in SWEMWBS Score

Section 6: Discussion, Learning, and Analysis

6.1. Introduction

This section presents an analysis and discussion of the key learning for the Tallaght Social Prescribing Service. The section is framed under the following headings:

6.2. Themes in Client Demographics

6.2.1. Sex

Individuals identifying as female were more commonly referred to the Tallaght Social Prescribing Service than males. This may reflect gendered patterns in health-seeking behaviour. The World Health Organisation reports that men are “more likely to underutilise or delay the use of health services,” with men under the age of 70 in Ireland twice as likely to have had no consultation with a GP in the previous 12 months.¹⁹ However, whilst just 43% of females referred progressed to active client status, 53% of males referred progressed to active client status. Whilst precise conclusion cannot be made, this could suggest that referred males have higher levels of need or motivation as they have already overcome a higher barrier to seeking help in the first instance.

6.2.2. Age and Reasons for Referral

Older adults (55+) constitute the majority of referrals to the Tallaght Social Prescribing Service. The rate of progression to active client status is similar for individuals aged under 55 and 55+. Older adults more commonly reported social isolation (76%) and long-term health conditions (30%) among their reasons for referral than those under 55 (64% and 10%) respectively. This synergises with research suggesting that social isolation and poor health increase with age.²⁰ Comparatively, adults under 55 more commonly reported mental health as their reason for referral (46% vs. 20% of over 55s).

6.2.3. Chronic Health Conditions

67% of individuals referred to the Tallaght Social Prescribing Service reported experiencing a chronic health condition. Chronic health conditions were prevalent in both those who progressed to active client status and those who did not, with diabetes, COPD, and cardiovascular disease most frequently cited. Non-engaged individuals were less likely to have multiple chronic conditions, suggesting that those who progressed to active client status may have been

¹⁹ World Health Organisation (2018) *Ireland builds capacity to improve men’s health*. Available at: <https://www.who.int/europe/news/item/12-09-2018-ireland-builds-capacity-to-improve-men-s-health>

²⁰ The Irish Longitudinal Study on Ageing (2019) *Loneliness, social isolation, and their discordance among older adults*. Available at: https://tilda.tcd.ie/publications/reports/pdf/Report_Loneliness.pdf

experiencing greater health need and therefore may have had greater motivation for engagement.

6.2.4. Health Care Utilisation

89% of individuals who progressed to active client status and 45% of non-engaged individuals attended a GP in the three months prior to referral, with those who progressed to active client status having attended GPs more frequently. Individuals who attend their GP more often may have been more aware of their health and social needs and thus more receptive to further support, increasing the likelihood of progression to active engagement. Conversely, the lower rate of GP attendance among non-engaged individuals may highlight a larger barrier in terms of lower levels of engagement or sustained engagement with healthcare and support overall.

6.3. Impact of the Tallaght Social Prescribing Service

A logic model was created to inform the indicators of success for the Tallaght Social Prescribing Service. This model reflects the HSE's identification of personal wellbeing and social connectedness as critical outcomes for measurement and also incorporates further HSE measurement suggestions. The following section discusses the impact of the Tallaght Social Prescribing Service.

6.3.1. Impact on Personal Wellbeing

Two methods of monitoring the personal wellbeing of clients were employed by the Tallaght Social Prescribing Service: SWEMWBS and MYCaW:

- SWEMWBS data highlights that the average client SWEMWBS score increased by 19.87% between pre- and post-engagement measures, with 87% of clients reporting medium-high wellbeing scores post-engagement. These figures are greater for clients with comparable pre- and post-measures, with an increase in the average SWEMWBS score of 21.06% and 91% of clients reporting medium-high wellbeing scores post-engagement.
- MYCaW data highlights a similar trend. Clients displayed an average reduction in their concern scores of 54.91% for concern 1 and 67.37% for concern 2. For clients with comparable pre- and post-measures, 91% experienced an improvement in their concern 1 score, 82% experienced an improvement in their concern 2 score, and 71% experienced an improvement across both concerns.

Based on these measures, it is evident that the Tallaght Social Prescribing Service is positively impacting the personal wellbeing of clients. This is particularly significant given the level of deprivation evident in Tallaght, and the range and varying complexity of client need reported.

6.3.2. Impact on Social Connectedness

At the time of writing, no standardised measure of client social connectedness is recommended within the National Framework. Client survey data suggests that 66% of clients experienced a reduction in feelings of loneliness and social isolation (44% a little and 22% a lot). However, as just 18 clients provided data in this area, possible conclusions on the overall impact of the Tallaght Social Prescribing Service on social connectedness are limited.



66%

Of clients reported a reduction in feelings of loneliness and social isolation

6.3.3. Other Impacts

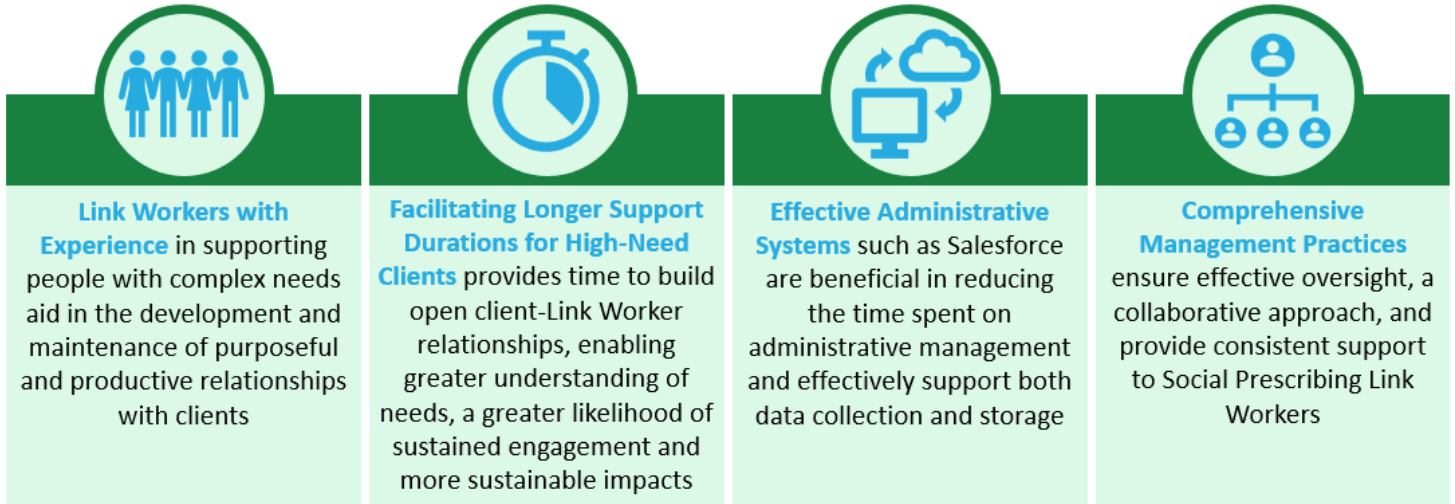
Beyond personal wellbeing and social connectedness, Tallaght Social Prescribing Service clients reported further positive outcomes and impacts as a result of engagement. This included improvements in their knowledge of available community support and how to support their own health, enhanced feelings of independence and self-confidence, improved physical health, and enhanced skills or education levels. This evidences the ability of social prescribing to have wide-ranging impact, and underlines the importance of client-focused support, with clients supported to engage in activities and supports which are relevant and of interest to them.

6.4. Delivery Model

6.4.1. Critical Success Factors and Areas for Development

This section draws on evaluation data to identify the critical success factors and potential areas for development within the current Tallaght Social Prescribing Service delivery model. Funding from the HSE is fundamental to the service and is implicit as a critical success factor.

Critical Success Factors



While the consultation meetings focused on the Tallaght service, several areas for development identified have national or broader relevance for social prescribing. These fall outside the direct scope of the Tallaght service but are included below for reference.

Areas for Development



6.4.2. Duration of Support and Engagement

The HSE Social Prescribing Framework sets a guideline for 6-8 intervention sessions per client. In practice, the diverse and high-level of need exhibited by referred clients often requires lengthier periods of support. 33% of individuals who progressed to active client status and 37% of non-engaged individuals were referred for multiple reasons. Of clients who actively engaged with the Tallaght Social Prescribing Service, 36% identified as having a disability; 40% identified as having

access needs; and 71% identified as having a chronic health condition. Of those with chronic health conditions, 48% reported experiencing multiple conditions. This illustrates the high level of need present in clients who accessed the Tallaght Social Prescribing Service.

When considering the number of interventions accessed, **just 13% of actively engaged clients received 8 or fewer interventions.** The average number of interventions per all individuals referred to the Tallaght Social Prescribing Service was 12.8 whilst the average number of interventions for clients who progressed to active status was 16.4. This is unsurprising given the above detailing of client need.

Comparing Durations of Support

Data on clients who did not exceed the HSE recommendation of eight interventions was analysed to provide commentary on the variations in intervention requirement. Clients who did not exceed eight interventions were consistent in age profile, principal economic status, and rates of disability, access needs and chronic health conditions. These clients were however more commonly female (80% vs. 67% of all clients) and noted lower rates of GP engagement in the 3 months prior to referral. Akin to the broader client pool, social isolation was also the most common reason for referral (50% vs. 66% of all clients), however just 7% of clients who did not exceed eight interventions had multiple reasons for referral, compared with 33% of all clients. **This suggests that clients who did not exceed eight interventions had less complex or lower levels of need, mirroring the findings in the Clondalkin report.**

Clients who did not exceed eight interventions advanced from referral to active engagement with the programme slightly quicker on average than the wider client pool, with 63% engaging in 15 days or fewer, compared with 54% of all clients. In terms of their engagement with the programme, 69% engaged for 60 days or less, compared with just 21% of the general client pool. The average number of days of engagement was 76.4 days, in comparison to 114 days for all clients. At the point of discharge, the majority of clients who did not exceed eight interventions reportedly no longer required support (81%), akin to the general client pool (73%). None of these clients were uncontactable at the point of discharge. **This again supports the conclusion that clients who did not exceed eight interventions had less complex or lower levels of need.**

Based on the above data, it appears that the recommendation for eight or fewer interventions as specified by the HSE Social Prescribing Framework may best suit clients with lower or less complex needs. Given the general complexity of need exhibited by Tallaght Social Prescribing Service clients, it is rational that additional interventions would be necessary.

Further, self-referral was the most common method of referral for both clients who did not exceed eight interventions (38%) and all clients who progressed to active engagement with the service (23%), whilst just 6.3% of individuals who did not proceed to active client status self-referred. **This suggests that the readiness of individuals to engage with support or make a change in their lives plays a role in their active engagement with the Tallaght Social Prescribing Service. Again, this may be simpler for clients with less complex needs.**

The 2024 evaluation of the Clondalkin Social Prescribing (SP) Project highlighted a consistent pattern: Social Prescribers were reported to have frequently engaged with clients for longer durations and over more sessions than recommended by the HSE Social Prescribing Framework. This deviation was attributed primarily to the complex needs of the client cohort in the Clondalkin area, where social, health, and economic challenges are more acute than in some other regions. The HSE’s national framework provides indicative guidelines for engagement, suggesting that “each participant would typically require no more than eight interventions” before moving into maintenance or community-based supports. These parameters are intended to ensure that the service remains short-term, focused on enabling connections and supporting self-management. In practice, the Clondalkin SP Project and the Tallaght SP Project delivery has exceeded this recommendation for a substantial proportion of clients. The Clondalkin evaluation records multiple perspectives underscoring this point:

“The HSE target is around eight interventions per client, but in Clondalkin we often double that before people are in a position to move on.” (Social Prescriber Clondalkin)

“Clients here have layers of need. If you closed the case after eight sessions, you’d be leaving people halfway through the process.” (Community partner Clondalkin)

“A rigid cut-off just doesn’t work with the people we’re seeing – they need trust, they need consistency, and that can’t be rushed.” (SP Project staff Clondalkin)

Data from both projects, supported by feedback from Social Prescribers and partner agencies, indicates that the average number of interventions is higher than the HSE benchmark, with several clients requiring intensive, prolonged support. This divergence is deliberate and stems from the complexity of presenting needs. Social Prescribers in both projects reported that clients often present with overlapping issues — including mental health difficulties, long-term unemployment, poverty, isolation, and sometimes housing or addiction-related challenges — which require extended rapport-building, multiple referrals, and sustained follow-up to achieve meaningful outcomes.

6.5. Strategic and Governance Level Challenges

Whilst feedback on the delivery of the Tallaght Social Prescribing Service indicates that the service is operating effectively and delivering outcomes for clients, there are several strategic and governance level challenges which should be addressed to allow for the further development of the service and its impact.

6.5.1. Definition of Interventions

The current definition of a social prescribing intervention as ‘any interaction with, or on behalf of, or for the purpose of supporting a client,’ does not account for the varying levels of time and resourcing which are required for different the forms of interaction. Under the current definition, activities which take minimal time such as individual text messages and short phone calls equate to activities which require longer planning and delivery timeframes, including 1-1 meetings with clients, research on specific onward referral opportunities, and the facilitation of access to community programming. This complicates conclusions on the proportion of clients who have accessed the recommended 6-8 interventions, as it is possible these individuals received greater time investment than those with longer periods of engagement. The lack of a comprehensive and specific definition of interventions also reduces the comparability of delivery across social prescribing services, as services may differ in their recording and categorisation of interventions.

While the development of a comprehensive national definition of social prescribing interventions sits within the remit of the HSE, the Tallaght service can play a constructive role in shaping this conversation. SDCP can strengthen its own monitoring by categorising interventions as short (<30 mins), medium (30–60 mins), or long (1+ hours). By analysing and sharing this data with the HSE Sláintecare Healthy Communities team, SDCP can provide practical, evidence-based insights from frontline delivery that help inform and influence the development of an agreed national definition.

6.5.2. High Demand and Client Waiting List

The high level of need in the Tallaght community, success in efforts to make referrer connections, and word-of-mouth recommendations by previous clients has culminated in high demand for the Tallaght Social Prescribing Service and the necessity of a client waiting list. Minimising the time between referral and support is likely to promote client engagement and increase positive outcomes. Reports from the World Health Organisation and the Organisation for Economic Co-operation and Development, cited by the Department of Health, highlight that reduced waiting times mitigate the risk of conditions worsening and leading to poorer health outcomes, and

improve patient satisfaction.²¹ Whilst this research refers to formal healthcare, it is likely that similar results would be evident in social prescribing as referrals to the service frequently cite physical health, mental health and wellbeing concerns.

The Tallaght Social Prescribing Service worked at capacity during the evaluation period mid 2023-mid 2024, necessitating the need for a client waiting list. While suggestions have been made to introduce group activities for clients with lower levels of need as they wait for one-to-one support, it should be noted that such activities have been trialed previously with limited success. Furthermore, the HSE Social Prescribing Framework emphasises the personalised and individualised nature of the service, which does not align closely with a group-based model. Several stakeholders also indicated that a group-based approach is not a realistic substitute for the resources required to meet current demand. Ultimately, the most effective way to address the client waiting list and expand the Tallaght Social Prescribing Team's capacity would be the addition of further Social Prescribing Link Workers, and the potential for this resourcing should be discussed and explored with the Sláintecare Healthy Communities Team.

6.6. Strategic Relevance

The purpose, delivery and outcomes of the Tallaght Social Prescribing Service are strategically relevant and linked to national and local policy priorities. Several pivotal policies are synthesised and reviewed in this section given their alignment to the context of the service and its impact.

6.6.1. National Social Prescribing Policy

The **HSE Social Prescribing Framework** was developed in 2020 to provide a common approach to the delivery of social prescribing. Social prescribing was first formally recognised in Irish government policy through the Stronger Together Mental Health Promotion Plan 2017 - 2022, calling for the integration of social prescribing across the HSE, community and voluntary sectors and highlighting this as a priority. It also features heavily in the HSE Mental Health Promotion Plan. The delivery of the Tallaght Social Prescribing Service is in line with the core principles of social prescribing outlined within the Framework and aligns with the delivery model described.

6.6.2. Draft Programme for Government: Securing Ireland's Future

In January 2025, the incoming Irish Government agreed on a **draft Programme for Government (PfG): Securing Ireland's Future 2025-2030**. Of these objectives, the focus on 'A Caring Society,' aligns most strongly with the Tallaght Social Prescribing Service through its priorities for building

²¹ Government of Ireland (2024) Minister for Health updates Cabinet on progress in relation to Acute Hospital Scheduled Care Waiting Times. Available at: <https://www.gov.ie/en/department-of-health/press-releases/minister-for-health-updates-cabinet-on-progress-in-relation-to-acute-hospital-scheduled-care-waiting-times/>

a healthier future, disability, mental health, and older people. The PfG makes commitments to supporting the voluntary and community sector working in mental health; supporting people with disabilities to live independently; focusing on exercise and wellbeing as preventative and rehabilitation measures; and supporting older people to live at home and in their own communities. These commitments align with the purpose and delivery of social prescribing, and evidence the synergy between the Tallaght Social Prescribing Programme and national priorities.

6.6.3. National Health Policy

Given the range of physical and mental health issues addressed through social prescribing, there is an innate synergy between the Tallaght Social Prescribing Service and national health policy. Firstly, the **HSE Health Services Healthy Ireland Implementation Plan 2023-2027** aims to support health behaviours throughout the life course and commits to further support for the continued integration and scaling of social prescribing across the health service. Secondly, the **Sláintecare Healthy Ireland Action Plan 2021-2025** seeks to create “A Healthy Ireland, where everyone can enjoy physical and mental health and wellbeing to their full potential, where wellbeing is valued and supported at every level of society and is everyone’s responsibility.” This synergises with the impact of the Tallaght Social Prescribing service as 88% of survey respondents report improved wellbeing, 83% report improved mental health, 83% report greater knowledge of how to support their health, and 72% report improved physical health, with consulted clients sharing similar outcomes. The Action Plan also aims to expand social prescribing, by integrating ‘non-clinical activities’ for mental health and to support the integration and expansion of social prescribing within at the local and national level, aligning with the purpose and delivery of the Tallaght Social Prescribing Service.

Third, **Sharing the Vision: A Mental Health Policy for Everyone** is a 10-year policy for mental health services in Ireland with a vision to “create a mental health system that addresses the needs of the population through a focus on the requirements of the individual.” Included in the Policy’s priorities for 2025-2027 is an expansion of social prescribing, with a commitment to promoting social prescribing nationally as an “effective means of linking those with mental health difficulties to community-based supports and interventions.” This synergises with the current and future delivery of the Tallaght Social Prescribing Service and reinforces the centrality of social prescribing to population health.

6.6.4. National Social Inclusion Policy

70% of the individuals referred to the Tallaght Social Prescribing Service between mid-2024 and mid-2024 report issues with social isolation; 66% of clients engaged and 74% of referred individuals who did not engage. The support provided to these individuals illustrates the

alignment and contribution of the Tallaght Social Prescribing Service to the priorities of the Department of Employment Affairs and Social Protection's **Roadmap for Social Inclusion 2020-2025**. The Roadmap includes priorities for targeted actions to empower communities to address social inclusion, including supporting community and voluntary in their work to enhance social inclusion. 66% of client survey respondents for the Tallaght Social Prescribing Service reported reductions in feeling of social isolation, with consulted clients also reporting enhanced socialisation, evidencing the contribution of the service to national priorities for social inclusion.

6.6.5. National Sport and Physical Activity Policy

Aligning with the support provided to clients to enhance their physical and mental health, the Tallaght Social Prescribing Service supported 62 individuals to access physical activity groups in their community. This illustrates the contribution of the service to national priorities for sport and physical activity. Healthy Ireland's **Get Ireland Active National Physical Activity Plan** outlines a mission to increase physical activity levels across Ireland, thereby improving the health and wellbeing of the population. While the plan does not explicitly reference social prescribing, its health-focused action area aligns closely with the purpose, delivery and outcomes of the Tallaght Social Prescribing Service.

6.6.6. Local Policy

Whilst contributing to the priorities of national policy, the Tallaght Social Prescribing Service also supports the achievement of local policy priorities. The **Active South Dublin: Local Sport and Physical Activity Plan** outlines a 5-year plan to promote the 'positive impact of regular participation in sport and physical activity. The Plan sets priorities for engaging low participation groups such as older people and people with chronic conditions in physical activity programmes, synergising directly with the client profile engaged by the Tallaght Social Prescribing Service and the enaction of onward referrals for clients to physical activity programming. The ambitions outlined in this Plan align with the delivery and outcomes of the Tallaght Social Prescribing Service.

Further, the **South County Dublin Local Economic and Community Plan (LECP)** outlines priorities for health and wellbeing, including the development of services targeting older people, physical activity, addiction, and mental health. Each of these priority areas are directly supported by the Tallaght Social Prescribing Service highlighting the synergy between the service's delivery and outcomes and the LECP.

6.6.7. Summary

The strategic alignment and relevance of the Tallaght Social Prescribing Service to a range of national and local policy priorities illustrates that the service represents an important investment for the Tallaght community, supporting their health and wellbeing across multiple avenues.

6.7. Continued Need and Relevancy of Social Prescribing Support

There is strong evidence to support the positive impact of the Tallaght Social Prescribing Service for clients and evident synergy between the outcomes of the service and both national and local level policy priorities. However, a long-term approach is required to address the level and impact of deprivation and the high complexity of need among members of the Tallaght population. The *Health Assets and Needs Assessment (HANA) 2025* identified rising mental health concerns and persistent issues with loneliness in the Tallaght community, as well as a continued prevalence of chronic illness, continued healthcare accessibility issues, and challenges with the financial cost of healthcare.²² It is clear that the need for the Tallaght Social Prescribing Service persists; this evaluation should be used to advocate for an expansion of the service to address the identified needs.

Section 7: Conclusions and Recommendations

7.1. Introduction

This section offers conclusions on the evaluation of the Tallaght Social Prescribing Service and provides recommendations for the future delivery of this service.

7.2. Conclusion

A primary objective of this evaluation was to ***analyse client journeys against national framework guidelines, identifying emerging themes in client demographics and social prescriptions.***

The HSE National Social Prescribing Framework sets out a standardised, person-centred model for delivering social prescribing services across Ireland, aimed at improving health and wellbeing through non-clinical, community-based supports. Core Components of the Delivery Model are referenced below, alongside an assessment of the Tallaght SP Service against each component.

²² Trinity College Dublin (2025) *Building a healthy Tallaght: new research launched.* Available at: https://www.tcd.ie/news_events/articles/2025/building-a-healthy-tallaght-new-report-launched/

Core Component	HSE National Framework Description	Alignment Assessment	
Referral Pathways	Participants can self-refer or be referred by GPs, health professionals, or community organisations.		<p>Tallaght receives referrals from a mix of GPs, health services, and community partners. The introduction of an online self-referral tool has significantly increased self-referrals and extended the age of clients, with greater uptake from 18-30 year olds.</p> <p>Referral pathways are functioning effectively. Some improvements were identified such as strengthening internal referrals, whilst broader challenge challenges remain (i.e. integration with GP systems) but this is considered as a national level challenge.</p>
Social Prescribing Link Worker Role	Link Worker meets clients, assesses needs, co-develops a personalised plan, and supports access to community supports.		Strong alignment. Link Workers in Tallaght provide personalised, needs-led support, invest significant time in rapport-building, and connect clients to relevant activities and services.
Number of Interventions	Typically no more than eight structured interventions per client; flexibility permitted for complex needs.		Not aligned. Tallaght frequently exceeds eight interventions due to clients' complex, multi-layered needs. Average sessions per client are significantly above the HSE benchmark. This is consistent with findings from a 2024 evaluation of the Clondalkin Social Prescribing Service.
Types of Support	Information provision, encouragement, facilitated introductions, follow-ups, and coordination with community organisations.		Fully aligned. Tallaght delivers a broad range of support types, including emotional support, signposting, and active liaison with community organisations.
Outcome Focus	Improve mental, physical, and social wellbeing; strengthen community connectedness; promote self-management.		<p>Aligned. Evaluation evidence shows improvements in wellbeing measures for those with both pre- and post-data, and qualitative feedback demonstrates enhanced social engagement and confidence.</p> <p>At the time of writing, no social connectedness tool is mandated/recommended for collection within the National Framework, offering an area of further development.</p>

Monitoring and Evaluation	Collect baseline and follow-up data (e.g., wellbeing scores) to evidence impact.		Partially aligned. Tallaght collects substantial baseline data (80 SWEMWBS, 78 MYCaW pre-scores), but follow-up data capture is lower (23 post-scores for each). Data collected still provides a valuable evidence base given follow-up challenges. The administrative burden in collecting follow up data is challenging, compounded by the higher level of support required for individual clients, whilst striving to meet recommended caseloads for social prescribing link workers in line with national recommendations
Integration with Health and Community Systems	Partnership between HSE, community/voluntary sector, and local networks.		Aligned in community integration, strong collaboration with local agencies and positive references to collaboration in both the development of the delivery model and ongoing engagement regarding service improvement.

The Tallaght Social Prescribing Service demonstrates strong compatibility with the majority of the HSE National Framework’s delivery model components, with notable strengths in personalised support, breadth of interventions offered, and community integration.

Referral pathways are well established, with a healthy mix of health service, community organisation and self referrals. While integration with GP systems via HealthMail remains a challenge, reflecting national-level technical and governance barriers — the Tallaght service has maintained effective referrals through other channels, enhanced significantly by the introduction of its online self referral portal which has extended and enhanced the reach of the service.

The Social Prescribing Link Worker role is fully embedded, offering tailored, person-centred support that mirrors the HSE Framework’s description. Clients consistently reported feeling heard, supported, and encouraged to engage with new activities and services. Types of support delivered align closely with HSE expectations, encompassing information provision, encouragement and motivational support, introductions, and follow-up contacts. Evaluation quotes reflect the value of this holistic approach, for example:

“She didn’t just give me a leaflet — she called ahead, made sure they were expecting me, and checked in after.” (Client)

Outcome focus is evident, with improvements captured both quantitatively (for those with complete data sets) and qualitatively. The 22 matched pre and post evaluation scores indicate positive shifts in wellbeing and community participation by participants.

Where Tallaght diverges from the HSE Framework is in the number of interventions. While the Framework suggests a limit of around eight structured sessions per client, Tallaght frequently exceeds this, often doubling the benchmark. This mirrors findings from the independent Clondalkin evaluation, which identified similar patterns due to the complex and multi-faceted needs of local clients. The Independent evaluations of the Clondalkin and Tallaght Social Prescribing services, carried out by different consultants, reveal a consistent theme in how the model operates on the ground. In both cases, exceeding the benchmark reflects intentional, needs-led adaptation rather than inefficiency. As one Link Worker in Tallaght described:

“You can’t move someone on after eight sessions if they’re only just starting to trust you.”

In both areas, Social Prescribers regularly work with clients for longer periods than the HSE Social Prescribing Framework’s guideline of around eight interventions. This reflects the reality that many clients present with complex, intersecting needs that demand more time for trust-building, sustained encouragement, and carefully coordinated referrals before they can confidently engage with community based supports. The Tallaght report highlights that support *“often extends well beyond the HSE’s recommended timeframe”* because of the high prevalence of mental health issues, social isolation, and socio-economic challenges — a finding closely mirrored in Clondalkin, where *“we often double [the HSE target] before people are in a position to move on.”* Although prepared independently, both evaluations reach the same conclusion: in contexts marked by high levels of disadvantage, strict limits on the number of interventions risk undermining progress, and a flexible, needs-led approach is vital to achieving sustainable outcomes. This perhaps challenges the viability of the currently national KPI framework for caseloads.

Given the socio-economic profile of the Tallaght client base, with high rates of mental health challenges, social isolation, and financial hardship, this flexible approach is not only justified but appears to be essential to achieving sustainable outcomes.

Monitoring and evaluation processes are in place, with robust baseline data capture. Follow-up data collection remains challenging due to difficulties in maintaining post-engagement contact and the administrative challenge of collecting follow up data, a common issue in community based services. Nonetheless, the quantity and quality of data gathered represent a strong evidence base.

Finally, integration with community systems is a clear strength, underpinned by strong local partnerships. While technical integration with GP HealthMail systems is outside the local

project's direct control, the Tallaght service contributes constructively to discussions at the HSE level on improving collaboration and connection.

7.3. Recommendations

Several recommendations are proposed, both at a local service level as well as those at a national level which may be more relevant for the HSE and other partners.

7.3.1. Tallaght SP Service Recommendation 1: Advocacy for Additional Resources

The evaluation provides evidence of the Tallaght Social Prescribing Service's positive impact on clients, with clear alignment between its outcomes and both national and local policy priorities. Demand for the service remains high, yet current resourcing levels are insufficient to meet need, resulting in a persistent waiting list. This situation is compounded by the depth of deprivation and the high complexity of needs within the Tallaght population, which require sustained, intensive support from Social Prescribing Link Workers, beyond the recommended number of interventions in the national framework. It is therefore recommended that SDCP use this evaluation to present a case for additional resources for the service. This should include a review of the current funding allocation to ensure it reflects the scale of service delivery, covering both frontline Social Prescribing Link Worker capacity and required administrative support. Expanding resources would enable the service to reduce waiting times, extend its reach, enhance its monitoring and evaluation capacity and strengthen its impact on clients.

7.3.2. Tallaght SP Service Recommendation 2: Internal Referral Pathways

It is recommended that SDCP and the Tallaght Social Prescribing team review and enhance internal referral pathways. This could involve: Establishing a clear, documented internal referral protocol across all SDCP service areas, providing periodic training and awareness sessions for staff to ensure they understand the purpose, scope, and benefits of the social prescribing service, introducing or promoting a simple internal referral form or digital process to streamline information sharing between programmes and scheduling regular check-ins between programme leads and the Social Prescribing Link Workers to identify potential referrals.

Strengthening these pathways would ensure that opportunities to connect clients with personalised, non-clinical support are maximised, leading to improved outcomes and better integration of SDCP's service offer.

7.3.3. Tallaght Service Recommendation 3: Introducing Social Connectedness Measurements

A range of data was collected on individuals referred to the Tallaght Social Prescribing Service, with significant efforts made to gather pre and post engagement measures for personal wellbeing, in line with the National Framework. At the time of writing no standardised measure of client social connectedness identified in the HSE National Framework and therefore not in use within the service. It is recognised that the HSE may have since considered such as measure, for example the Social Connectedness Scale. If this is the case, it is recommended that SDCP integrate the selected measure into future delivery. In doing so, consideration should be given to the administrative burden on Link Workers and the need to balance comprehensive data collection with service capacity and the needs of the clients. Where additional measures are adopted, adequate resourcing and practical processes will be essential to ensure that the data collected is both consistent and meaningful without detracting from client engagement time.

7.3.4. Tallaght Service Recommendation 4: Exploration of CYP Service

It is recommended that SDCP, in partnership with the HSE and other relevant statutory and community stakeholders, explore the feasibility of developing a dedicated social prescribing service for children and young people in the Tallaght area. This exploratory work should include: assessing local need and demand, drawing on demographic data, service usage trends, and stakeholder insights, reviewing best practice models for youth-focused social prescribing in Ireland and internationally, identifying potential referral pathways from schools, youth services, health professionals, and community organisations, considering appropriate outcome measures and safeguarding protocols specific to younger age groups and exploring potential funding streams and resource requirements for sustainable delivery. A feasibility study of this nature would establish whether a children and young people's social prescribing service could complement existing supports, address identified service gaps, and improve health and wellbeing outcomes for younger residents in the area.

7.3.5. HSE Recommendation 1: Delivery Model

This evaluation has identified a range of critical success factors and areas for potential enhancement within the Tallaght Social Prescribing delivery model. Importantly, the findings, consistent with those from the independently conducted Clondalkin evaluation, indicate that the current HSE benchmark for the number of interventions does not fully reflect the realities of working with populations experiencing high levels of deprivation and complex needs.

It is therefore recommended that the HSE consider these emerging findings from both areas when reviewing and potentially redefining the national intervention parameters. Incorporating this evidence into future iterations of the Social Prescribing Framework would ensure that delivery models remain flexible, needs-led, and capable of achieving meaningful, sustainable outcomes in disadvantaged communities.

7.3.6. HSE Recommendation 2: Supporting a Definition of Intervention

There is an emerging need (based on the Clondalkin and Tallaght evaluation) to consider a national definition of social prescribing interventions to ensure consistency across services and enable accurate reporting. While the authority to create such a definition rests with the HSE, the Tallaght service can play an important role in informing and shaping it. It is recommended that SDCP work collaboratively with HSE colleagues in the national office to advocate for this development, using Tallaght's service data as a practical evidence base. As part of this, SDCP could consider categorising interventions into short (<30 mins), medium (30–60 mins), and long (1+ hours) to illustrate the range and intensity of work being undertaken. Presenting these insights to the HSE Sláintecare Healthy Communities team would help ensure that any agreed national definition reflects frontline realities, particularly in communities with high levels of complexity and need.

7.3.7. HSE Recommendation 3: KPIs


Findings from both the Tallaght and Clondalkin Social Prescribing evaluations demonstrate that Social Prescribers in areas of high socio-economic disadvantage consistently work with clients for longer periods than the HSE Social Prescribing Framework's indicative guideline of approximately eight interventions. This extended engagement reflects the complex, multi-layered needs of clients, many of whom require sustained support, trust-building, and multiple coordinated referrals before achieving lasting change.

It is therefore recommended that the HSE, in consultation with local delivery partners such as SDCP, review the current national KPI framework for social prescribing caseloads and intervention volumes. Consideration should be given to introducing flexibility or adjusted benchmarks for services operating in areas of significant deprivation. Such an approach would better reflect the realities of frontline delivery, support more accurate performance measurement, and ensure that services are not penalised for adopting the needs-led, person-centred approaches that are essential to achieving meaningful and sustainable outcomes.


Appendix 1: Service Logic Model

The Problem

Social isolation, fear, loneliness and associated inactivity have negative consequences for health and particularly impact individuals who are at risk or already experience social exclusion and health inequality in Tallaght. Specific examples include older age groups, those with chronic health problems, people with mental health difficulties and psychosocial needs, carers, single parents, migrants, immigrant and minority ethnic groups. Despite the range of individuals affected and the need which exists, the health service in Tallaght does not have the capacity to deliver dedicated supports. The Tallaght Social Prescribing service addresses this gap.



Inputs

- Funding from Sláintecare Healthy Communities
 - Quarterly governance and strategic planning meetings with Sláintecare Healthy Communities
 - Sláintecare Healthy Communities peer support network
 - HSeLand Training
 - South Dublin County Partnership Health and Wellbeing Team
 - Monthly management meetings of South Dublin County Partnership Health and Wellbeing Team
 - Internal South Dublin County Partnership policies and governance procedures
 - Essential skills training course for Social Prescribing Link Workers
 - Salesforce Software incl. centralised online referral form for all referral sources
 - Promotion and awareness raising activities for healthcare professionals
 - Knowledge and experience of South Dublin County Partnership Health and Wellbeing Team garnered from a history of support provided for the Tallaght Community
- 

Activities

- Referrals from healthcare professionals
- Self-referrals
- 1-1 consultations at point of referral to explore needs, goals and options, including baseline MYCAW and SWEMWBS assessments
- Development of individualised health and wellbeing plans
- Personalised referrals by Social Prescribing Link Worker to needs-led support options

- Referral to internal and external community groups, supports and services as needed, including:
 - Education and training
 - Employment supports
 - Volunteering opportunities
 - Community / social activities / support groups
 - Counselling support
 - Mental health and wellbeing programmes
 - Older person's supports
 - Physical activity groups
 - Addiction services
 - Housing supports
 - Other supports
- Continual engagement with Social Prescribing Link Worker throughout journey
- Discharge meetings following achievement of support goals, including post-engagement MYCAW and SWEMWBS assessments



Outputs

- 264 referrals received:
 - Healthcare professionals (150)
 - Self-referrals (37)
 - Social workers (20)
 - Other referrals (17)
 - Support workers (16)
 - Mental healthcare professionals (16)
 - Friends/family (4)
 - Health Promotion officer (1)
 - Migrant Employment Officer (1)
 - Child and Family Support Network Co-ordinator (1)
 - Community Drugs Education and Intervention Worker (1)
- 122 referrals resulting in client participation
- 122 x 1-1 consultations at point of referral to explore needs, goals and options.
- 310 Personalised referrals by Social Prescribing Link Worker to need-led support options which were acted upon by clients, including referrals to:
 - Education and Training (9)
 - Employment Support (5)
 - Volunteering Opportunities (9)
 - Counselling Supports (35)
 - Older Person's Support (10)
 - Mental Health and Wellbeing Programmes (34)
 - Physical Activity Groups (62)
 - Addiction Services (7)
 - Housing Supports (2)
 - Community / social activities / support groups (86)
 - Other Supports (17)



Outcomes

- Client experience improved personal wellbeing (must measure)
- Clients experience enhanced social connectedness (must measure)
- Clients experience improved mental health
- Clients experience improved physical health
- Clients adopt positive health behaviours
- Clients increase levels of community engagement
- Clients experience enhanced skills and qualifications
- Clients experience enhanced self-confidence
- Clients feel more independent

Appendix 2: Chronic Health Conditions of Actively Engaged Clients

Chronic Health Condition	% Chronic Health Conditions Experienced by Actively Engaged Clients (N=84)	% of Chronic Health Conditions Experienced by Non-Engaged Individuals (N=84)
Acquired Brain / Skull Injury	2%	1%
Addiction	0%	3%
ADHD	2%	3%
Alzheimer's	1%	0%
Anemia	1%	1%
Arthritis	6%	6%
ASD	4%	1%
Asthma	14%	6%
Atrial Fibrillation	0%	1%
Breathing Difficulties	0%	1%
Cancer	2%	1%
Cardiovascular Disease	19%	24%
Cauda Equina Syndrome	0%	1%
Cellulitis	0%	1%
Cerebral Amyloid Angiopathy	0%	1%
Chronic Pain	10%	6%
Congestive Cardiac Failure	0%	1%
Crohn's Disease	1%	1%
COPD	20%	23%
Dementia	4%	0%
Diabetes	24%	24%
Epilepsy	5%	3%
Fibromyalgia	1%	3%
Glaucoma	1%	0%
Hearing Loss	1%	0%
Heart Disease	0%	1%
Hepatitis B	1%	0%
Hepatitis C	0%	1%
Hereditary Spastic Paraplegia	0%	1%
Hidradenitis Suppurativa	1%	0%
High Blood Pressure	4%	1%
Hyperlipidaemia	0%	1%
Hypertension	2%	4%

Hypotension	1%	0%
Irritable Bowel Syndrome	0%	3%
Intellectual / Learning Disability	2%	1%
Kidney Disease	2%	0%
Leg Ulcers	0%	1%
Mental Health Issues	15%	13%
Migraines	0%	1%
Multiple Sclerosis	0%	1%
Myeloma	1%	0%
Neuropathy	1%	1%
Obesity	0%	1%
Organ Transplant	1%	0%
Osteoarthritis	1%	0%
Osteoporosis	1%	3%
Other	2%	1%
Pancreatitis	0%	1%
Parkinson's Disease	4%	6%
Peripheral Vascular Disease	0%	3%
Pre-Diabetic	0%	3%
Previous Stroke	4%	4%
Protein C Deficiency	1%	0%
Psoriasis	0%	1%
Raynaud's Syndrome	1%	0%
Recurrent UTIs	0%	1%
Sleep Apnoea	0%	1%
Spinal Issues	1%	0%
Tourette's Syndrome	1%	0%
Ulcerative Colitis	0%	3%
Vision impaired	0%	1%

Appendix 3: Concerns Reported through MYCaW

Column1	Concerns Reported (Pre)	Concerns Reported (Post)
Addiction/Alcohol Use	5%	9%
Confidence	8%	4%
Domestic Abuse	1%	0%
Education / Learning	6%	0%
Employment	4%	0%
Family Support	5%	4%
Hobbies	1%	4%
Housing	4%	4%
Independence	1%	4%
Lack of Engagement in Social Activities	28%	13%
Management of Health	3%	4%
Medical Card	1%	0%
Mental Health	44%	61%
Mobility	4%	9%
Physical Activity and Fitness	18%	17%
Socialisation	21%	13%
Time for Self	1%	0%
Transport / Travelling	3%	0%
Volunteering	6%	9%