

## **Social Prescribing Feasibility Study**

Includes:

Final Report

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Completed for: 360 Nurse Practitioner Led Clinic

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Course Code: BIOL 4890Y

Course Name: Community-Based Research Project (Sc)

Completion Date: 4/1/2024

Project ID: 6104



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Social Prescribing at the 360 Degree Nurse Practitioner-Led Clinic

Final Findings and Potential Paths Forward

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April 5, 2024

## **Executive Summary**

### What is Social Prescribing?

Social prescribing is a new healthcare initiative. Social prescribing starts with a health care provider identifying a need in a patients' social determinates of health. The healthcare provider then writes a prescription relevant to this need. It can include anything from walking groups, legal aid clinics, anxiety support groups, going to the theater, or a meals-on-wheels program to name a few. Social prescription provides a framework for making these kinds of changes in one's life, and it can help encourage patients since they are getting support from their health care team. Ideally, financial barriers would be removed from obtaining this kind of support, just as there is support for individuals in need of pharmaceutical medications.

### Research Questions

1. Is there a need for social prescribing at the 360 Degree Nurse Practitioner-Led Clinic (360 NPLC)?
2. What is the capacity for social prescribing at the 360 NPLC?
3. Should any available social prescribing resources be focused on those with mental health issues?

### The 360 Degree Nurse Practitioner Led Clinic—Current Insights

- Most patients seen each day have high rates of food and housing insecurity, mental health issues, and a higher-than-average number of patients have mobility problems or chronic diseases.
- Unofficial social prescriptions take the form of shower and laundry services, the Safer Supply Program, occasional community gardening, and assistance filling out paperwork to help patients gain access to transportation and funding to go to the YMCA, as well as referrals to shelters in the community, Elizabeth Fry Society, and 12-Step programs.
- The clinic does not have procedures in place to determine if patients have needs that could be met by social prescriptions. Operation at the clinic is generally on a tight schedule and often there is no time or opportunity to address multiple concerns in one appointment.
- There is no feedback system to assess patient satisfaction with the current social prescription practices.

### Structure of Social Prescribing

Social prescribing differs from the current practice of simply telling patients that they should get more exercise or access some kind of food/housing support. The official framework has systems in place to *assist* in accessing these services. The “prescription” legitimizes the claim that the patient's life needs to change. Tracking and following up on social prescriptions helps provide a body of evidence to justify government spending on this kind of social assistance.

Having an official framework can also provide guidelines and recommendations based on specific patient markers. This helps reduce decision fatigue from already overburdened healthcare workers. There are two main models of implementation, internal and external.

#### Internal Framework

- Prescription items occur within the clinic that offers prescribing.
- Greater staff numbers (and possibly volunteers) required to run prescription programming.
- Greater control over the quality of prescriptions that are offered, however it takes up more resources in terms of money, staffing, time, and space.

#### External Framework

- Prescriptions are created in the clinic but occur outside the clinic in the community.
- Less staffing, money, time, and space required, but prescriptions will rely on community services being robust and able to handle an influx of people accessing them.
- Often rely on link workers to help connect patients with community organizations where they will access the prescriptions given to them from their health care provider. Link workers also work with patients to overcome barriers they may face in accessing their prescription (such as transportation or funding issues).

#### Implementation Considerations and Concerns

Before deciding on the overall model (internal vs external) and the specifics of how to implement social prescribing in each setting there are several considerations to be made.

These include:

- **Funding:** How much funding will be obtained? Will there be continued funding, or is only a one-time payment guaranteed?
- **Physical Space:** Is there funding for the organization to grow physically? Or will current space need to be reorganized if choosing internal prescriptions? Is there an ability to reorganize space for social prescriptions at all? Is there somewhere for a link worker to meet with patients?
- **Staffing:** Could current staff job responsibilities change to incorporate social prescribing into their job duties, or will new staff be required?
- **Creating Plans:** how will referrals be made to community organizations? Which patients will be recommended what services? Will there be written guidelines for staff to follow in recommending services?

- Clientele of the Clinic: due to the specific vulnerable status of some patients who access the 360 NPLC, they will face additional barriers to accessing social prescriptions. Just as some patients struggle to show up for appointments, take pharmaceutical prescriptions, and attend other recommended services, these individuals will similarly struggle to access social prescriptions. What support/things will be put in place to help these individuals with their unique challenges?

### Recommended Paths Forward

Guidelines outlining what patient profiles (as in health conditions and/or social factors) qualify for which support will be a necessary part of either prescription pathway. Staff need clear boundaries (with some flexibility) to best support patients and to ensure they do not have to spend a significant amount of time matching patient presentations with relevant prescriptions.

#### Internal

- Dietician and nutrition related programming.
- Increased access to shower and laundry services.
- Support groups (including those geared towards mental health and wellbeing, urban indigenous, managing common chronic illnesses such as diabetes or heart disease, and more).
- Tickets for entertainment including art spaces, theater and cinema, and other events.

#### External

- Hire link worker to:
  - Connect with and maintain communication with community organizations.
  - Help patients overcome barriers related to accessing their prescription(s) (including accessing funding, helping them create a buddy system to overcome anxieties, sending reminders, and providing ongoing support).
  - Maintain patient records and track social prescription program.
- Start a network of not-for-profit and other community organizations that could brainstorm and figure out solutions to problems by meeting up regularly to discuss challenges and share resources.

## **Acronyms**

360 NPLC – 360 Degree Nurse Practitioner Led Clinic

AA – Alcoholics Anonymous

CHC—Community Health Centre

CMHA – Canadian Mental Health Association

CTS – Consumption and Treatment Services (typically refers to the location on Simcoe Street in Peterborough).

GSP—Green Social Prescribing

HCP—Health Care Provider

LW—Link Worker (could also be a community navigator, community connector or several other titles)

NA – Narcotics Anonymous

NFP—Not for Profit

NP—Nurse Practitioner

OA – Overeaters Anonymous

ODSP – Ontario Disability Support Program

OW – Ontario Works

PRHC – Peterborough Regional Health Center

RN – Registered Nurse

SDH—Social Determinants of Health

SP—Social Prescription

SSP – Safer Supply Program

SW – Social Work(er)

WHO—World Health Organization

YMCA – Government association also referred to as “the Y.”

## **Table of Contents**

### **Introduction**

Goals of the Project

Research Questions

### **Context of the Study**

### **Literature Review**

Common Themes in Social Prescribing

*Autonomy*

*The Power of Prescription*

Green Social Prescribing

Connections Between Socioeconomic Status, Mental and Physical Health

Isolation and Loneliness

*Demographics with Increased Likelihood of Loneliness*

Specific Health Conditions

*Mental Health (Anxiety and Depression)*

*Diabetes*

Challenges in Social Prescribing Literature

### **Organizational Structure of Social Prescription (People, Models, and More)**

Eligibility and Referrals

Staff Organization and Role

Examples of Existing Social Prescription Models

*A Menu for Health*

*ARC (Assistance and Referral Center)*

*Red Cross Friendly Call Program*

Potential Organization

Final Note on Implementation Strategies

### **Methodology**

Summary

Additional Information on Staff Interviews

## **Results—Synthesizing Informational Interviews**

Primary Care and the Safer Supply Program

The Demographics of the 360 NPLC

How the 360 NPLC Currently Partakes in Social Prescribing

Services Offered

Links in the Community

Feedback on Services

Going Forward with Social Prescribing

Different Perspectives between Professionals

## **Discussion**

Challenges of Implementation

Potential Paths Forward

*Internal Prescriptions*

*External Prescriptions*

## **Recommendations**

Internal Model Recommendations

External Model Recommendations

## **Appendices**

Appendix A—Potential Social Prescriptions and their Benefits

Appendix B—Staff Interview Questions

Appendix C—Summary Chart of Staff Interviews

Appendix D—Transcriptions of Staff Interviews

Appendix E—Example Organizations in the Peterborough Community

## **References**

## **Introduction**

Social Prescribing is a relatively new term and concept for healthcare that focuses on connecting individuals with social support(s) in their community and other non-traditional forms of healthcare. It typically focuses these resources on marginalized groups or those who experience health inequity. Social prescriptions can include anything from yoga, volunteering, adopting a puppy or art therapy to accessing housing services, group counselling or meals-on-wheels (Please see appendix A for a list of potential SPs). Starting in the mid 2000's and into the 2010's, the term "social prescribing" started taking off in science and social science journals. The general concept of linking medical and community organizations seems to have begun earlier than that, with some papers referencing the general concept in the 1980's and 1990's. During and since the COVID-19 pandemic, there has been an explosion in work on providing evidence for SP, including pilot projects in Canada, the United States of America, Australia, United Kingdom, and more.

Social prescribing is the act of an individual visiting the HCP with their complainant issue(s) and their HCP prescribing them the most relevant non-medical resources they believe would help improve the patient's condition (Golden et al., 2023). By using the system, the patient/individual then gains access to a link worker (Cole et al., 2020). This link worker helps the patient work out the logistics to access the prescription provided by the primary HCP (Cole et al., 2020). This could include linking the patient to relevant community organizations, helping them find funding to access paid services, and looking into other potential barriers that the patient may face that could decrease adherence to their prescription (Cole et al., 2020). The patient then accesses these social prescriptions and can continue to access the link worker for logistical help, and typically follows up with their HCP to track how well their treatment is working.

Robust literature providing solid evidence for the benefits of social prescribing is currently being built up. In recent years some small (and large scale in the case of NHS) pilot projects have been launched, so the literature is growing. During (and since) the COVID-19 pandemic occurred, a spotlight has been put on the SDH and the vast effects they have on our mental and physical health (Vidovik et al., 2021). This includes the negative impact of isolation, and the positive impacts of interacting and being part of a community (Vidovik et al., 2021).

### Goals of the Project

This project worked to explore how social prescribing might help those who attend the 360 NPLC, how implementation might occur and how social prescriptions might help their specific patients. This study is necessary as there is a limited amount of clear literature about how to implement social prescribing in various clinical settings. Thus, for any future funding to have the biggest impact possible, having a plan in place based on information set out in this report will help them achieve their goals faster and more efficiently. The 360 NPLC needs a plan specific to them and their patients' needs, they need knowledge of what other social programming is in the Peterborough area that they could link with. They need suggestions for how to track this programming's effectiveness and follow up with improvements. A project such as this one may even provide other smaller city clinics with tips on improving their own services and utilizing the social services in their communities to assist patients in need.

### Research Questions

This project originally posed 3 key research questions to explore. These questions were a starting point to get the general scope/idea of the project across and had many potential ways to explore

answers that could then be used by the clinic to inform plans and requests for funds at this not-for-profit health care clinic.

- Is there a need for social prescribing in the Peterborough area, and specifically at the 360 NPLC?
- What is the capacity for social prescribing services within the 360 NPLC?
- Should resources for social prescribing at the 360 NPLC be used for all patients at the clinic or only offered to those experiencing mental health issues?

### **Context of study**

The Peterborough community has a lack of healthcare infrastructure. Many people in the Peterborough community struggle to find a family doctor, with wait lists for many practices being an estimated 5-10 years. The 360 NPLC currently has a waitlist of over 400 people, and they are not currently accepting new referrals for their waitlist (Peterborough 360 Degree Nurse Practitioner Led Clinic, 2024). The 360 NPLC serves Peterborough's most vulnerable populations and focuses on accepting patients into the practice that fall low on the SDH scale. They run programs such as the Safer Supply Program, have internal shower and laundry services to be used by their patients, and much more. Their vision is to provide "collaborative and accessible primary health care for all", with a mission to "meet the needs of individuals and groups by striving for and providing primary health care that is equitable, person centered and widely accessible" (Peterborough 360 Degree Nurse Practitioner Led Clinic, 2024)). This project aims to shed light on how social prescribing will help the core mission and vision of the 360 NPLC.

From the 2023-2026 strategic plan, the clinic serves 2471 patients with an additional 271 individuals supported at the CTS and via outreach programs. From self-disclosure surveys 44% of the patients seen are food insecure, 40.2% report having a mental illness, 77.6% have at least one disability, 15.8% report being homeless, 35% are prescribed 5+ medications, and 7.2% are indigenous (while only 3.2% of Peterborough's population is indigenous). Upon talking to the staff in November 2023, it seems the situation of who is typically seen on a day-to-day basis at the 360 NPLC is struggling and experiencing more mental illness, and food and housing insecurity than the previously mentioned statistics imply.

The staff at the 360 NPLC currently refer to resources within the Peterborough community, however, they do not have a directory, recommendations are made based off the knowledge each individual staff member may have of the community. Interviews with the staff revealed that some of the most common referrals/recommendations they make for their patients to access other NFP's or organizations in the community include the YMCA, the Elizabeth Fry Society, shelters, and warming rooms such as those offered by One City Peterborough.

## **Literature review**

### Common Themes in Social Prescribing

One common theme seen in social prescribing is access to community resources. These resources are often not-for-profit agencies that provide a service, such as a community garden or a food bank (Golden et al., 2023). They could also include paid services such as a healthy food delivery service (Golden et al., 2023). These services could also be in the form of community clubs, like a book club or recreational sports league. Access to these services (such as transportation) can

sometimes be a concern, but these are issues that a link worker would hopefully have additional resources to address (Golden et al., 2023).

Community based social prescribing would work differently in different communities, as each community has its own agencies, struggles, and areas that thrive. SP also functions partially off the backs of volunteer organizations, which could pose an issue if SP were to be rolled out immediately on a large-scale basis, as opposed to on a smaller scale, which is currently being done. SP will look different in communities based on their size, resources, funding, and patient demographics.

Social prescribing is meant to help both the community and the individual thrive, while simultaneously helping to alleviate burdens on the traditional health care system (Vidovik et al., 2021). Link workers will be vital in assisting patients in making real changes, as one study demonstrated by giving both the control and treatment group verbal and written knowledge of resources available (Lindou et al., 2019). The treatment group received a written “prescription” but were not assisted in accessing said prescription (Lindou et al., 2019). Those in the treatment group did report greater confidence in accessing services, but no beneficial health and well-being outcomes were detected with this model (Lindou et al., 2019). For SP to work and be effective in communities, the system will require several working parts; link workers, community resources, and funding to help the clients/patients overcome barriers to access their prescriptions.

Single elements/activities can be prescribed, and this can be great for pilot projects looking to measure the direct effects of a specific intervention. However, in an ideal approach, the HCP would look at their patients’ needs and prescribe *several* relevant interventions for the link worker to help the patient access immediately. It may include a social group that meets outdoors, like a walking group or birding club as well as a meal delivery service. In a real-world approach

to SP, many prescriptions may be laid out for the patient, and the patient would choose one (or possibly two) that fit in their life immediately, then as these lifestyle changes become habit, they may meet with their link worker to add more prescriptions into their life as they see fit.

Throughout this process the patient would be the one in control of what is most relevant and/or important to them.

### *Autonomy*

Social prescribing allows patients to be empowered to take control of their own health (Golden et al., 2023). Through SP, patients have a very active role to play in increasing their health and wellbeing. Unlike traditional medicine where you just take a pill every day and hope to feel better, with SP you get to have a say in what realistically works in your life, then put forth the initiative to improve your own health. If the individual finds their treatment is not working, they can reconnect with their link worker and look for solutions to logistical issues stopping them from their prescription (maybe they need transit, or access to childcare), or to find a SP that better fits their needs. For example, perhaps a patient finds that the social interaction at an art class is the most beneficial aspect of that group. They would ask the link worker to find them a different group that allows for more time spent talking between members, such as a walking group where they can spend time in nature while building a social connection with fellow hikers.

SP also considers a holistic picture of the patients' life, which could be vital for finding the correct prescription of care (Golden et al., 2023). SP recognizes the financial, social, and intrapersonal struggles that individuals may face in accessing a SP and works with the patient to overcome these barriers to care (Golden et al., 2023). It can also just be helpful for patients to be heard and have someone who is really listening to their day-to-day struggles. Modern doctor's offices in North America are driven to see a large volume of patients in a short period of time,

which can leave care feeling impersonal and rushed (Hogan, S., 2023). With SP you get a primary HCP who will prescribe, but then you receive access to a link worker who will have longer appointments with the patient, listening to their needs and struggles in accessing care. This follow-up may be an important distinction between SP and traditional healthcare models. Another important distinction between typical healthcare models and SP is that it is multifaceted, and more time is spent listening to and problem solving with patients. This can be especially important for helping individuals with their mental and social needs.

### *The Power of Prescription*

Mental and social health are areas that medication has a hard time effectively treating (Kirsch, I., 2019). Studies have shown that much of the effectiveness of mental health medication is due to the placebo effect (Kirsch, I., 2019). These medications often come with a slew of side effects, many of which can have a negative impact on the patient's life (Kirsch, I., 2019). Social prescriptions may decrease the need for antidepressants and antipsychotic medications, giving patients new lifestyle factors and someone (a link worker) who is really listening to them about what logistically makes sense in their life. This link worker will also listen to the patients' social story, which can be vital for a patient's well-being by allowing them to be heard, and by addressing possible practical solutions that may work in the patient's life. One advantage to SP over traditional prescription medications is the lack of negative side effects. For instance, a walking group might not cure a patient's depression, but it certainly won't harm their quality of life.

As mentioned previously, part of the appeal of SP from the patients' point of view, is the ability to have autonomy over their healthcare through having a say in what SP may work best in their life. It may not necessarily be the placebo effect that makes the change, but the new positive

lifestyle factors that are being introduced coupled with the empowerment of making their own health a priority. In a study evaluating whether the manipulation of expectations of improved health and wellbeing could affect how much exercise impacted well-being and mental health, it was found that the only meaningful effects were between the no exercise group and the two groups that did aerobic exercise. (Arbinga et al., 2018). There was no difference between the exercise group with added manipulation/suggestion of outcome expectations and the group that just exercised with no other intervention (Arbinga et al., 2018). This demonstrates that the actual lifestyle factors, like the addition of exercise, arts, and community support is likely the aspect of a SP that makes a meaningful impact on the patient.

Another aspect of social prescribing that impacts both the healthcare workers and the patient is the term “prescription” itself. The word “prescription” has power behind it, as only certain medical professionals have the scope and allowance to prescribe. This poses a concern for SP, as it may be done by social workers, psychotherapists, RN’s or RPN’s among other medical professionals, who do not have the power to prescribe prescription medications. Consequently, there is debate surrounding whether SP should be initiated only by HCPs who can already prescribe medications, or whether SP should be initiated by a broad range of HCP and mental health professionals. There is no current regulation or common practices around writing SPs, so it can technically be done by anyone. However, some medical and mental health practitioners who are not permitted to write pharmaceutical prescriptions may be hesitant to start “prescribing” SPs. Some say the word “prescription” is used because it brings social interventions to the forefront of patient care and helps remind doctors who often practice from a pharmacy-based lens to look at the patient more holistically and bring the SDH into a greater light. This provides SP with legitimacy as a medication-based prescription in the eyes of a

patient. Another reason why it may be referred to as a “prescription” is that it follows the same prescribing format as pharmaceutical medications. It is specific to the patient and their needs, it follows a daily frequency, occurs for a preset duration, and if the issue persists, the prescription may be renewed (Martino et al., 2015). Despite some scholars using these criteria as justification for labeling it “prescription”, some SP literature uses other formats with different criteria. Many organizations offering SP simply link patients with community-based programs and leave it at that.

### Green Social Prescribing

As social prescribing becomes a hot topic, specific branches of it are emerging in the literature. One form of social prescription that is beginning to emerge is green social prescribing (GSP). Much of the literature that specifically references it as GSP has come out in the last year or two, although nature-based prescriptions started being discussed frequently post COVID-19 pandemic and has been mentioned since the conception of social prescribing. GSP involves prescriptions that help the environment, such as garbage clean up or conservation groups, and prescriptions that take place in nature, such as forest bathing or joining a birding club (Makanjuola et al., 2023).

Green Social Prescribing may be a helpful kind of prescription, as often its activities include several elements which may make improvements to physical, spiritual, sociological and community well-being. Gardening for example, can allow a person to be social (in the case of a community plot or garden), while getting some physical activity, and often also includes mindfulness, as the individual doing the gardening must pay attention to what the plant needs

(Howarth et al., 2020). In a meta-analysis done on gardening, the 77 studies included showed promising beneficial results to both personal gardening, community gardening, and horticulture therapy, which was gardening being done with a therapist's guidance (Howarth et al., 2020).

As the NHS and the UK government promote GSP in communities, one study sought to address the current effectiveness and impact of GSP in Walsall, UK (Sun et al., 2023). A specific example found GSP to be highly beneficial to a 40-year-old male in the study, demonstrating how important scaling social prescription can be (Sun et al., 2023). This individual suffered from mental health disorders and was a survivor of domestic abuse (Sun et al., 2023). He was also living in social housing and was flagged as being at high risk of social isolation, so he was prescribed a nature-based walking group that greatly changed his outlook on life for the better (Sun et al., 2023). In Walsall “the range of activities are diverse including range of activities is diverse, including, for example, walks on the canal, picnics, after-school clubs, radio-controlled cars, kayaking with the Canals Trust, paddle boating, and high tree-top climbing” (Sun et al., 2023). The listed activities of Walsall exemplify the wide range of activities that would also be possible for the town of Peterborough, ON.

A project in Barcelona, Spain focused on creating a Nature-Based Social Prescription menu (in the form of a brochure) specifically for socioeconomically deprived neighbourhoods, and focused on GSP that was accessible and would get people out into green spaces interacting with each other (Santos-Tapia et al., 2023). It worked by finding an array of activities and laying them out on a map, so individuals would have options based on their specific accessibility situation (Santos-Tapia et al., 2023). The “menu” included sections for citizen science, guided tours and workshops, community gardens, and exercise/relaxation (Santos-Tapia et al., 2023). Various

community organizations came together to create the written “menu” and delivered it to the public, the public delivered positive feedback in general (Santos-Tapia et al., 2023).

Green social prescribing initiatives have clearly been shown to improve overall physical, mental, and social health of the individuals who get involved (Makanjuola et al., 2023). GSP has the potential to enhance the community and could be an area of focus in social prescribing that occurs in Peterborough, Ontario. Peterborough has lots of green space (such as parks, walking trails, and sports fields), it also has lots of water activity potential such as kayaking, paddleboarding and canoeing. Churches and other organizations in the city have community gardens, and there are environmental groups and other clubs/groups that take place outdoors.

#### Connections between Socioeconomic Status, Mental and Physical Health

Psychosocial factors have an enormous impact on physical and mental health. The location you live in and grew up in is the biggest predictor of your health struggles and socioeconomic status. People in lower socioeconomic classes often face compounding challenges that worsen their physical and mental health over time (Johnson & Gomez, 2023). These individuals often do not have the money to alleviate certain challenges in their life that would allow them a greater amount of time to take part in activities that increase wellbeing. They often face greater stressors related to transportation and childcare, which decreases the time they have for things such as healthy meals and exercise, both of which help the physical and mental health of the individual and their family.

Both the location and quality of housing can impact air pollution that individuals are exposed to. Affordable housing often comes with health risks, such as mold, poor ventilation, being located

closer to factories or motorways, or being in a more densely populated area of town (Kivimäki et al., 2020). If a low-income family owns their home and they find mold in it, they often cannot pay to fix it, and black mold is notoriously difficult to eliminate. Living in moldy housing can be unhealthy for anyone, it can cause especially negative consequences for children living in the home, as their respiratory system, immune system and other body systems are still developing (Mariarasan and Hüls, 2021). Children living in homes with mold are at far greater risk for hospitalization due to acute respiratory infections (Ingham et al., 2019). This is just one example of how being in a low socioeconomic class can impact your health and well-being.

Being of low socioeconomic status often comes with additional risk factors for developing or progressing diseases, such as malnutrition or a lack of access to preventative healthcare (Kivimäki et al., 2020). Additionally, these individuals often also face greater social barriers, such as discrimination, being chronically stressed, or having a less stable social support system (Kivimäki et al., 2020). In a Finnish prospective cohort study, they found that those of low socioeconomic status are more likely to progress through an illness cascade that starts with psychiatric disorders, substance abuse and self-harm, which later in life develops into certain cancers, liver, and renal failures, as well as other diseases (Kivimäki et al., 2020).

Since people of low socioeconomic status face additional stressors in their life, such as living paycheck to paycheck, not having secure housing, facing un(der)employment, and struggling to keep up with transportation costs (whether it be paying for the bus, or maintaining a car), these individuals are prone to having chronic stress. Chronic stress can lead people to cope in unhealthy ways, such as consuming too many calories, smoking, or drinking instead of using more healthy coping methods such as exercise (Bird et al., 2020). Although stress is adaptive, it allows us to survive by providing a boost of adrenaline to escape predators. Today, these stress

hormones being released in everyday situations cannot help us outrun our problems. Chronic stress has become maladaptive, leading to a constant state of flight-or-fright for some individuals that can lead to chronic diseases.

Both the cortisol released by increased stress and the unhealthy coping mechanisms utilized by individuals can increase inflammation in the body (Bird et al., 2020). Inflammation in the body is linked to the development and/or the worsening of diseases (Bird et al., 2020). In Bird's (2020) study they highlighted "the 3 P's to create resilience; People, Purpose, and Place". All three of these P's can begin to be addressed through SP. SPs can increase our social network, helping to create connections between people, and it can help people find a purpose while giving them autonomy over their own health. GSP can help people reconnect with nature, or help the individual find a better housing situation. These smaller, less expensive prescriptions can make a difference in a person's life, especially if they have the time and resources to make long-term changes to their lifestyle. Social prescriptions related to housing would also make a huge difference on an individual's health, however it would be one of the most cost prohibitive social prescriptions.

Even with housing, social activities, and nutrition, an individual may still struggle in certain areas. Health and well-being are complex and multifaceted that often making changes to one area does not always have a large effect on the other. This is why even people who are privileged to have stable income, be in a high socioeconomic class, or not have to worry about money because they are receiving a pension may still suffer in other ways, such as being lonely. This is also part of the reason why SP may be applicable to everyone, as it may provide a social cure for loneliness by providing a community of connections for the individual (Wakefield et al., 2022).

## Isolation and Loneliness

During the COVID-19 pandemic, many people throughout the globe found their mental (as well as physical) health declining (Ellyatt, H., 2022). This was attributed to isolation from social circles, with physical distancing and small social bubbles being two of the most common coronavirus procedures taken on in Canada. When people were told to stay in their homes, they found themselves getting restless and feeling isolated. Luckily for those effected by the lockdowns of the COVID-19 pandemic, the restrictions did not stay in place forever. Some people were not so lucky and their feelings of loneliness and/or isolation have not been, or maybe never were, tied to the coronavirus pandemic.

Community involvement can not only help the community thrive, but also improve the lives of individuals within the community (Wakefield et al., 2022). Isolated individuals do not have a community, whether that be through their geographic area, friendships, or family, leading to poor health. Isolated people are prone to developing depression, as well as worsening conditions that may flare up due to stress, such as gastrointestinal diseases or joint-related diseases like arthritis. When conducting brain imaging, studies show that people who experience suicidal ideation are more sensitive to social disconnect and do not seem to get better with antidepressants (Courtet, P., 2022). Thus, providing these individuals with a social prescription and a community may be the alleviation they need from their psychological pain (Courtet, P., 2022).

A study conducted in Queensland Australia sought to find whether SP could decrease loneliness in adults, since approximately 1 in 3 adults in Australia and New Zealand report feeling lonely and isolated (Dingle et al., 2022). When compared to the control group that did not do any SP community interventions, those who did social based SPs reported being significantly less lonely and had increased self-reported social trust after just 8 weeks (Dingle et al., 2022). It is also

notable to mention that these individuals had a variety of activities to choose from (or get prescribed) including some activities that were art based, physical, and educational. At the 8-week mark when follow-up took place, just under 80% of those in the treatment group were still attending their SP. This demonstrates how palatable SP's may be and that, given the proper prescription, people may adhere to their prescription if they get direct beneficial results (Dingle et al., 2022). This means that a variety of SP's may work for isolated/lonely individuals if they foster connection between the individuals attending.

### *Demographics with Increased Likelihood of Loneliness/Isolation*

There are several specific demographics that seem to be more prone to isolation than others. This includes the elderly/older individuals, who may have integrated into a long-term care or retirement homes at the same time they may be losing lifelong friends or partners. Isolation is also common in middle aged white men as this demographic often feels a heavy financial burden, has problems with their intimate partners, and are more likely to commit suicide since stigma around seeking support stops them from getting the care they need (SSM Health, 2019). Another generation that is increasingly reporting loneliness and is getting diagnosed with more mental health disorders than any previous generation is young people (currently roughly ages 16-25) who were raised in the era of cell phones and internet (Daniyal et al., 2022). While cell phones and the internet increase capacity for connection, it seems to decrease meaningful social connections (Daniyal et al., 2022).

A meta-analysis conducted on SPs that have the potential to help older adults combat their loneliness had promising results, with a variety of activities decreasing the amount of isolation felt and increasing the mental health and wellbeing of patients (Paquet et al., 2023). Group recreational activities appeared to be the best way to reduce loneliness in this subgroup, but

increased social interaction in almost any capacity had an effect (Paquet et al., 2023). Other programming that had a positive benefit on this demographic includes promoting mental and physical health and providing them with home and/or community care (Paquet et al., 2023). These supports, especially those that increase social interaction while focusing on physical and mental wellbeing would likely be adequate for other demographics suffering from loneliness and isolation.

Being lonely and isolated can lead to depression, however a study conducted on the preventative effects of hobbies on development of depression had promising results (Fancourt et al., 2019). Individuals who did not have depression or hobbies at the beginning of the study and kept up with hobbies had a reduced incidence of depression compared to those who did not carry on with a hobby (Fancourt et al., 2019). Those who had mild or moderate depression (no one with severe depression was included in the study) saw a decrease in depressive symptoms (Fancourt, et al., 2019). The results held true for both men and women in the study, but the study did not differentiate if social hobbies had a different effect than non-social hobbies, which was highlighted as an area for further research (Fancourt et al., 2019). Studying effects on other health conditions is also required, as currently there is limited research studying the direct effects of various SPs on different highlighted diseases.

### Specific Health Conditions

There is a wide range of conditions that social prescribing can provide aid for. Since aspects of health are interconnected, direct effects of helping one issue may help lessen the burden of the other ailment/issue. Many people with one health problem experience comorbidities, or other

health problems alongside it. Often these ailments exacerbate each other, as the body has a harder time dampening the effects of multiple diseases/illnesses.

As mentioned previously, chronic stress can lead to a myriad of problems. Stress itself can increase cortisol levels leading to increased inflammation in the body. People also deal with stress by leaning on coping mechanisms. These coping mechanisms may be healthy like exercise or deep breathing techniques, or unhealthy such as binge eating, smoking, drinking or substance abuse. Obesity may be one outcome of binge eating that occurs due to chronic stress, and it is one of the most prevalent chronic diseases of today's society (Jayasinghe et al., 2023). SP may be the ideal type of treatment for these (often) lifestyle-related diseases (Jayasinghe et al., 2023). Jayasinghe (2023) and their colleagues argue that medicine must move away from the traditional "biomedical approach to care" into a "biopsychosocial model" of care. This model of care will likely be necessary as traditional treatments and medications continue to have inadequate effects, often come with negative side effects, and are costly to develop and produce (Jayasinghe et al., 2023).

Other health conditions that are related to inflammation in the body and are often comorbid with diseases such as obesity would likely benefit from SP. Examples of these conditions include heart disease, arthritis, diabetes, autoimmune disorders, and mental health problems. Mental health conditions may have the widest application related to social interventions that can be provided by social prescribing and are currently the most widely studied (Fancourt et al., 2019).

### *Mental Health (Anxiety and Depression)*

The most studied area of social prescribing seems to be its potential benefits to mental health (Fancourt et al., 2019). Mental health is complex, and socioeconomic factors in an individual's

life have significant impact on stress levels. These factors can often be intermingled, and it can be difficult to pinpoint what area of a person's life is causing the most negative impact, or what part of a SP has the greatest positive impact since most SPs are multifaceted (Stickley, T., & Hui, A., 2012). In a 2012 study done in the UK, researchers found an overall positive benefit to mental health in participants who were part of a community-based art class, in which all the participants were currently accessing or had accessed mental health services in the past (Stickley, T., and Hui, A., 2012). Arts and culture are vital for people to express themselves, assist in a positive mindset and increase engagement in communities (Fancourt, D., & Finn, S., 2019).

With more and more studies coming out about the arts and their benefit to health, there is a consistent message that is emerging, and that is that arts are good at increasing positive health metrics (Fancourt, D., & Steptoe, A., 2019). They help increase health advocacy and may encourage people to be more likely to engage in exercise or stop unhealthy habits (Fancourt, D., & Steptoe, A., 2019). Partaking in the arts can reduce psychological stress and stress hormones, as well as decreasing inflammatory responses (Fancourt, D., & Steptoe, A., 2019).

A yoga-based social prescription may be a good option for those facing mental health struggles, as one study found that over the course of 3 months practicing yoga increased confidence of self-management of health, and gave participants practical skills for how to destress, such as breathwork (Cheshire et al., 2022). Yoga may also be a highly applicable SP for other health conditions with its de-stressing breathwork and gentle form of exercise (Cheshire et al., 2022). Yoga could be a viable option, as all that is needed to teach a class is a mat for each participant and an instructor to guide them.

## *Diabetes*

Diabetes can be genetic or developmentally related to lifestyle choices. Social prescription will have a greater impact on those with Type II diabetes, but SP may help those with type I diabetes in other areas of their life. For those with pre-diabetes or type II diabetes it can be beneficial to have a tailored plan to help manage symptoms or stop a patient from becoming diabetic (Herbert et al., 2015). One on one appointments and working with the patient may be two of the biggest factors in making sure a type II or pre-diabetic sticks with their action plan (Herbert et al., 2015). An action plan may be in the form of a SP, since so much of managing diabetes has to do with diet, exercise, and stress, it is an excellent candidate for a SP focus (Fitzpatrick, S. L., 2023). Prediabetics would be excellent candidates to focus SP efforts on, as preventing type II diabetes would be beneficial to the individuals whose health is at stake, the community, the healthcare system and the government (Fitzpatrick, S. L., 2023).

A 2017 scoping review of the literature on SP use for diabetes turned up some positive results, but they highlighted that much research is still needed to provide a sounder bed of evidence (Pilkington et al., 2017). Although this study is nearly 6 years old, it highlights the need in SP to continue to provide focused trials, as well as roll out more broad pilot projects to continue seeing the results that SP can have on the individual and the community.

## Challenges of Social Prescribing Literature

While there is currently a boom happening in SP literature and studies, each study is quantifiable itself, however it can be difficult to relate studies to each other (Husk et al., 2019). Since outcome measures such as well-being, happiness and mental health have a multitude of different

scales and tests, it can be hard to make a meta-analysis that accurately portrays the full picture and offers a comparison of different SP methods. Ideally there will eventually be studies outlining how a wide range of different SPs work for many different diseases. Since there are so many different conditions and diseases SP may provide a benefit for and so many different SPs, literature is currently lacking in this area.

If a SP does not work out for a specific patient in a study of a given disease, ideally a follow-up and investigation would be done into the factors that caused it to have no impact, once again there are very few or no mentions about this in studies at the current time. Approaches for different populations and demographics would also be important to know for HCPs (Husk et al., 2019). Understanding diversity both in what communities can offer and what patient demographic they may need to utilize the system would greatly impact where any funding should be spent (Husk et al., 2019).

If widescale policy is to be adapted in Canada to make a major shift in our current healthcare model, strong evidence will be needed to provide evidence and justification for the change. This is why it is so important for studies to continue to be conducted, even if they are on a small scale, like at one clinic, or in one small town.

There are lots of case studies, but not a lot of large quantitative studies. However, projects such as The SingWell Project are aiming to change that. This study is ongoing over the course of 7 years, in which new choirs may pop up at different times, but they will all tracking identical outcome measures and gathering the same patient information (The SingWell Project, n.d). So far, they have found that choral singing increases mood, social connections, and pain thresholds, while decreasing stress of participants (The SingWell Project, n.d). In this study they are measuring the stress hormone cortisol and a social bonding (among other things) hormone,

oxytocin in the patient's saliva. Projects like The SingWell Project are beginning to bridge the gap between the literature and what we vaguely know about the benefits of SP. Arts, culture, and nature seem to be vital to human health and wellbeing (Golden et al., 2023).

### **Organizational Structure of Social Prescribing (People, Models, and More)**

Social prescribing has a broad scope with many potential ways to implement it, and this implementation depends on organization planning, the community resources available, the eligible demographic, as well as several other factors. The World Health Organization put out a rough step by step process on how to implement social prescribing, which goes through items such as assembling a core team, developing a workplan, and how to monitor and evaluate the program once it is implemented (*A Toolkit for...*, 2022). However, the document also brings up a very important point, which is that social prescribing is just the pathway to getting patients assistance with their SDH. The prescriptions only work as well as the community organizations that offer what is being prescribed. That is why it is essential to do a situational analysis to determine if the geographic area where the prescriptions are being offered is prepared to handle the extra clientele that will come with social prescriptions (*A Toolkit for...*, 2022).

Social prescriptions also require someone to lead the program, someone who can check in with the people who are receiving services, see what is working, recommend new services as needed, and help assist clients in overcoming any barriers that are getting in the way of them accessing their prescription. Follow up, follow through and tracking are what makes SP work (Sandhu et al., 2022). This tracking and follow-up can supply evidence that social benefits can have a wider impact on health, helping to give justification for health care dollars spent in this domain and

helping ensure that those accessing the services are able to do so (Scarpetti et al., 2024). SP is an area that can be used in both preventative healthcare and in treatment-based healthcare. SP addresses needs that will help build-up people to be more mentally and financially sound, as well as help patients who are already struggling to access support that may decrease the burden of their disease (Fitzpatrick, S. L., 2023).

Many HCP's already offer social prescriptions in an unofficial capacity by encouraging clients to access various social supports, both those in the community and through helping them access funding that often requires a doctor or NP to sign off on. By implementing social prescribing in an official framework, it may help alleviate stress on primary care teams and hospitals, and provide the funding needed for patients to get access to the care they deserve.

### Eligibility and Referrals

When creating a SP framework, there is much background work that needs to be done to help the program run smoothly. Decisions must be made to determine who can access SPs. Some SP programs allow anyone who seems to have a need for non-medical assistance to access services (Scarpetti et al., 2024). Other SP programs want to focus resources on those who will experience the largest impact, including SPs focused on high-risk populations such as those with chronic diseases, comorbidities, those who experience mental health problems, or the elderly (Oster et al., 2023). Other SP programs do not focus on the previously listed markers for determining eligibility for their program, but instead focus on more non-clinical factors such as socioeconomic status, which allows people experiencing poverty, homelessness, or food insecurity access to programming (Oster et al., 2023). For example, one doctor in Toronto

recognized his patients' need for money, as poverty was having a negative impact on their mental and physical health (Porter, 2015). This doctor began finding ways to get funding directly to these patients and started a primary health care doctor-led SP pilot project (Porter, 2015).

Another decision that needs to be made when implementing any SP project is how referrals into the program will be handled. In other words, who can access the services and how can they access the program? Many SP's need a doctor or other primary HCP to refer into the program before a SP can be given to the patient. Sometimes the doctor, NP or other primary HCP is also the one that does follow up and follow through, while in other examples the primary HCP just refers to the social prescription program, and then the patient sees a link worker about the details of their prescription (Oster et al., 2023). Some programs push even more for patient autonomy and personal health decision-making, quoting self-determination theory in why they allow clients to self-refer into the program (Morse et al., 2022). Through patient self-referral the organizations offering SP say it is more likely the patient will have a positive experience and get something out of the SP, as they are choosing to partake entirely themselves. Other SP programs require a referral, but then allow for patient autonomy and self-determination by laying out the options of SPs for the patient and allowing them to choose which one(s) they will partake in (Grand River Community Health Centre..., 2023).

In Ontario, several CHCs participate in a SP framework, trying to offer those who attend access to further health education, support groups, nutrition services and more (Alliance for Healthier Communities, n.d). Many of them do not have any specific referral process, instead allowing clients who come to the CHC to get involved in their SP framework. At the Grand River Community Health Centre, they have a supportive environment with staff who develop rapport with those coming into the CHC, and these staff and volunteers help encourage those attending

to improve their health and wellbeing through various internal programs they run. In turn, some of those who attended and saw their mental and physical wellbeing improve became volunteers at the facility to help newcomers with similar SP initiatives (Grand River Community Health Centre..., 2023).

As for the self-referral CHC model shown above, the patient would only get access to support if they continued accessing the facility and showing up for services. If the client's mental health worsened, there would be no one to notice it, as they do not schedule specific follow-up with patients. In a model with a focus on follow-up and follow through, they would likely set a check in point with a patient for a month (or several months) later to see if the service is working and if there are any accessibility issues that were not recognized at the start of the care plan.

### Services Offered

Social prescription services are only as strong as the specific services that make them up. No matter how good staff encouragement, accessibility, or follow-through is, if the services themselves are unsatisfactory or lacking, then a SP program cannot thrive (*A Toolkit for...*, 2022). That is why one step of the WHO's toolkit includes assessing whether services are adequate, meeting minimum quality standards, and making sure that the quality of these services can withstand a greater number of individuals accessing them (*A Toolkit for...*, 2022). Once you have a focus demographic (or a broad all-encompassing demographic), decisions need to be made about what kinds of patient presentations will be recommended for which kinds of social prescriptions (Oster et al., 2023).

Some social prescription models offer internal prescriptions, where the organization doing the prescribing offers all the potential support in house. Another model is for a health care service to offer social prescriptions, and have those prescriptions be services available in the community, run and organized by other groups. Often these external program focused SP models have link workers that help clients overcome any barriers they may be facing to access their SP (Sandhu et al., 2022). Link workers may also help clients get SPs related to food security and housing, helping them access services and funds specifically for these necessities (Sandhu et al., 2022).

An example of the internal SP model is the Life Rooms Model that was developed for two facilities in the UK, both of which were in communities with a large percentage of disadvantaged individuals, including individuals with poor mental health and suffering from poverty (Hassan et al., 2020). This model allowed patients to self-refer, with no input from a HCP, and once in the facility they were able to co-create a SP plan for themselves (Hassan et al., 2020). The facilities themselves acted like a community center, but with a larger focus on support groups, housing support, food/dietary support and learning based sessions related to mental health, finances, or wellbeing (Hassan et al., 2020). Those running the facility consisted of link workers with training on housing and financial support, staff with mental health training, and volunteers who had training as well as lived experience with a range of mental health issues (Hassan et al., 2020). Patients partaking in this model appreciated being treated “like a person not a patient”, and overall were satisfied with the program, from the skills learned, the support they received from staff, and relationships formed with other clients of the Life Room (Hassan et al., 2020).

Staff Organization and Role

To make a SP program work, staff are required to run it. There needs to be at least one staff member leading the project who, in a smaller organization, may be the only person working solely on the project. In larger organizations, this individual would ideally be the leader for a larger team made up of link workers or those in more specified roles (such as social workers, counsellors, nurses, etc.) that can also partake in offering social prescriptions and perform the follow-up and follow through ensuring patients are receiving their prescriptions (Sandhu et al., 2022).

For organizations that are doing an external-based model of SP, it is important that part of the role of some staff (be it link workers, a lead organizer, or an administrator) are responsible for keeping in contact with community organizations and any places that they offer SPs to (Pescheny et al., 2018). This way if a group or organization is reaching capacity, or facing struggles with keeping their doors open, the team offering SP to this service can make an informed decision about whether to refer clients there. This is one of the biggest challenges with an external model, the SP service can only be as good as the services currently offered in the community, and those who are actively offering prescriptions cannot know if in some time a service will become unavailable (Pescheny et al., 2018). It is also the responsibility of the staff to help identify any potential barriers the patient may face in accessing the recommended social prescription(s) and working on solutions to overcome those barriers (Sandhu et al., 2021).

There can be some barriers that make it more difficult for staff to feel confident and able to participate in SP, one being that some organizations looking to implement SP are already understaffed, and if they cannot hire anyone new to spearhead the project, it can be difficult to rejig existing job duties to make it work (Pescheny et al., 2018). Another important factor is that

staff need adequate training to feel comfortable and often want guidelines as to what kind of patient presentations would lead them to specific SPs (Pescheny et al., 2018).

The duties of staff need to be defined, and sometimes this means switching up what existing staff are doing or creating entirely new roles on the team and hiring new people, such as link workers, or someone to lead the new SP initiative at an existing facility (Morse et al., 2022). When hiring someone to lead the initiative, there are three different types of background an organization could look for. The specific qualifications will heavily depend on the plan for how the organization will implement social prescribing. An organization may look for someone who will understand the medical aspects of what patients need, such as a doctor, NP, or RN. They may look for someone who has a larger understanding of mental health, such as a social worker or counsellor who has worked in a community-based role. The final type of person who may be a good fit to lead a SP initiative is someone who has an administrative background, ideally someone with organizational skills who has been a part of a community group or non-profit that already has connections in the community. Any person who is hired to spearhead the project should have strong leadership abilities, as it is likely they will be leading an already existing or new staff in the realm of SP (Sandhu et al., 2021).

To support the main staff, a volunteer base may be a good fit for some social prescription models. The volunteers can run programming in community, help those attending develop further social bonds, and may even be pre-linked with a particular patient as a way for a socially isolated and anxious patient to attend an event they otherwise would not (Sandhu et al., 2021). There are many ways volunteers can be utilized, and in some models the people who receive the SPs eventually start helping others, which continues to help themselves while furthering the scope and reach of the project (Sandhu et al., 2021).

## Examples of Existing Social Prescription Models

### *A Menu for Health*

In Barcelona, Spain a menu (brochure) of care for residents in a socioeconomically deprived area was created, with a focus on green spaces, in hope of increasing both the physical and mental health of people in the community (Santos-Tapia et al., 2023). The activities on the menu encouraged access to green spaces, joining walking groups (which increased social connectivity), and offered other items that were locally present. The menu was developed by a collective of community organizations, as well as community members who were asked for input (Santos-Tapia et al., 2023). In the end they increased awareness of social programming and spaces in the area, assisting everyone who lived in the community. This is an example of a hands-off approach to SP.

### *ARC (Assistance and Referral Center)*

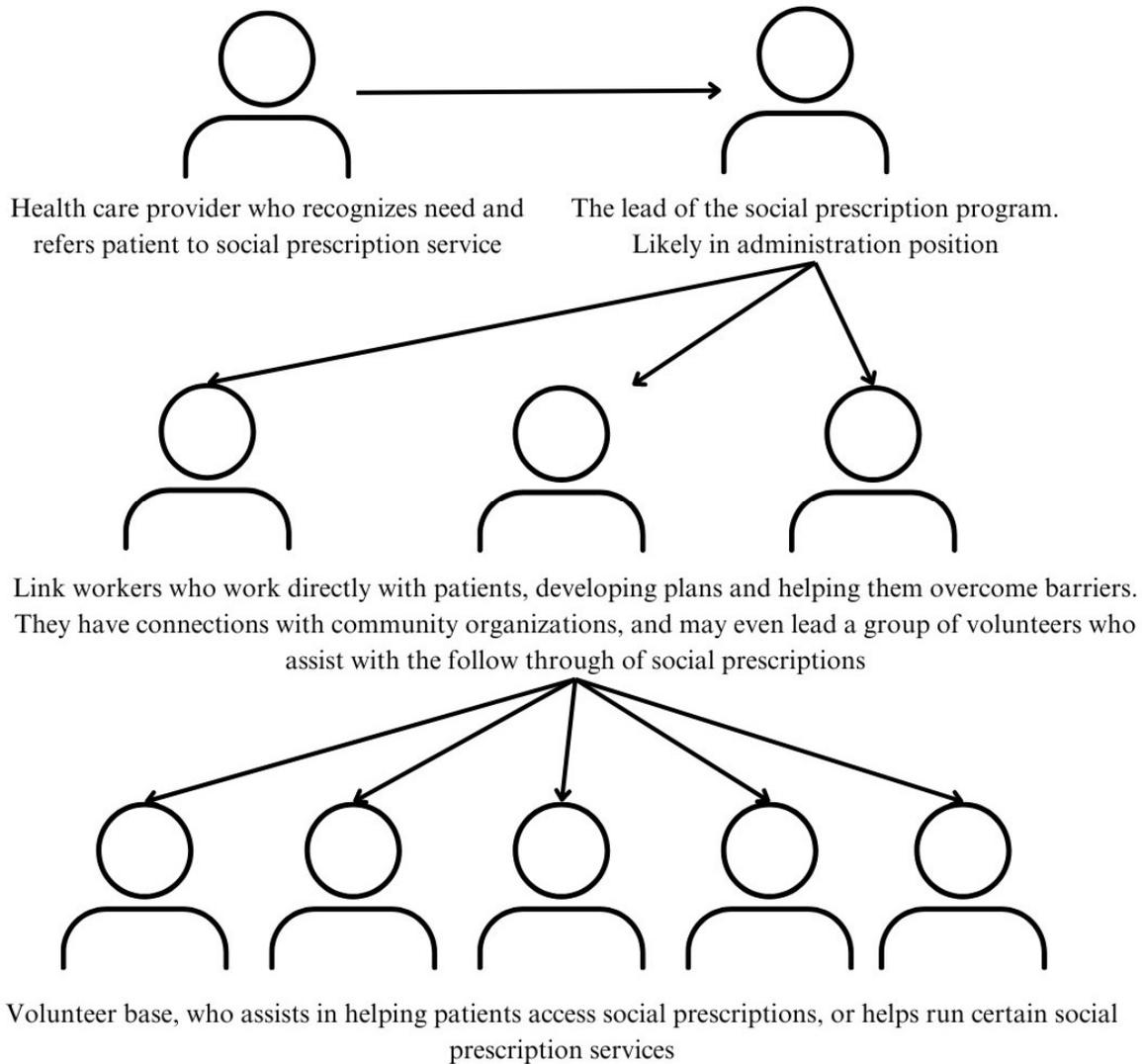
In a region of Quebec there are paid community outreach coordinators (link workers), that help organize and keep their network linked with various community organizations they can refer individuals to. Volunteers deliver services, like conversation clubs, walking groups, and seniors' wellness groups. People accessing the services reported back that they really appreciate the relationship they have with their community outreach coordinator. Each coordinator handles approximately 10 patients at a time; however, they are looking to become more efficient. Patients call in and get linked with a coordinator who works with them to recommend groups and help bridge accessibility related gaps, such as transit or funds. These connectors frequently check in with the clients they are working with, as well as the volunteers in the community who run much of the programming they prescribe. Some of the coordinators specialize in certain sectors,

addressing the needs of specific clients, with some focusing specifically on employment, the elderly, housing, or helping those in caregiving positions (Arc., 2024). These coordinators are organized by a program director, but there are lots of other administrative type positions in the ARC network to make it work.

### *Red Cross Friendly Call Program*

The Canadian Institute for Social Prescribing (2023) recognized the services that the Red Cross Friendly Calls Program brings to Canadians. The service offers weekly phone calls to those who need someone to talk to. The volunteers on the other end of the line receive training and then give a listening ear. They help their buddy make plans to attend services that would support their health and wellbeing or do breathing exercises right there on the phone with them. The service focuses on social connections to decrease loneliness, while also adding building blocks for assisting the individual accessing the program to start developing healthy habits. This program focuses on holistic care, with volunteers helping the client think about all aspects of their health.

## Potential Organization



## Final Note on Implementation Strategies

It is important to note that there is no current standard or best way to implement social prescribing (Scarpetti et al., 2024). There are no pre-established prescriptions that should be offered, ways for referrals into the program to be done, or ways for the organizations offering SP

to be set up. There are a variety of examples, and many of them have received feedback from clients accessing SP, but there have not been formal studies done and quantitative data gathered on how it may *best* be done. Quantitative data would be difficult to standardize, as the SP environment is so dependent on sources of funding, the community it operates in, and the demographic it focuses on (Morse et al., 2022). It will likely continue this way for some time, as it would be a hinderance to use only a single strategy, as each community and individual is unique. It gives flexibility to the program to not have pre-defined boundaries and unnecessary prerequisites to access funding. Until more quantitative analysis has been done on the best practices of SP, it is best to use a broad approach specific to individual communities.

## **Methodology**

### Summary of Methodology

1. Conduct a broad literature review on what social prescribing is, how it works, and who it can help. This literature review was conducted using both peer-reviewed original research and reviews, and grey literature taken from government and organization websites.
2. Meet with staff at the 360 NPLC and explore the current set-up, workload, and capacity of the clinic and how it would be possible to move forward. These interviews were conducted in person with a predetermined set of questions, most of which were open-ended to allow the staff to fully flesh out their thoughts.
3. Research different structures/models of social prescribing and how they could be applied to the clinic.

### Additional information on Staff Interviews

Staff interviews were conducted with a preset collection of questions (see appendix C), most of which were open-ended. Verbal interviews were conducted both for ease of getting them done during the staff's workday and so they could fully elaborate on their answers without the confines of a text box. Research shows that open ended questions allow for more spontaneity and for more meaningful answers to be provided (Popping, 2015). The interview questions were aimed at seeing what staff knew about SP, what they would like to see going forward at the clinic and in the wider community, and to get some insights about how the clinic runs. Participants were selected based on availability on the of the interviews, and when one interview was complete, the interviewee would usually recommend another staff member who was likely free for the interview. In the end two NP's, two nurses (unclear whether they were RN's or RPN's), two SW's and one medical office administrator made up the seven staff members who participated in the interviewing process. All interviews were recorded on an audio device and then transcribed after the fact. After the interviews had been transcribed, they were summarized into a chart and analyzed for common themes and other information that may be useful.

### **Results—Synthesizing Informational Interviews**

\*Please see appendix C for a summary table of interviews and appendix D for the full transcriptions of the interviews.

Primary Care and Safer Supply Program

The 360 NPLC building is split into 3 sections. One section is where backend staff work, where staff take breaks and eat lunch, and has a large conference room for when the entire team meets weekly. There are two patient facing sections of the building, one section has traditional clinic rooms common in doctor's offices, which serves as the location of primary care. In this area the building has a waiting room and administration at a front desk to check people in. This is also where the laundry and shower services the 360 NPLC offers reside. The final section of their owned space is currently being used for the SSP, in which they offer tools and prescriptions for drug use and teach people about the safest ways to manage their addiction. This area is an open space, and they also offer art drop-in sessions, and they always have snacks and small art projects for people to work on. Individuals do not need to be associated with the clinic to access the SSP.

### The Demographics of the 360 NPLC

The 360 NPLC focuses on providing health services to vulnerable populations in the Peterborough community that otherwise would not get the care they deserve. Most of the patients at the 360 Degree NPLC are those who are experiencing homelessness, have little to no access to food, are under the poverty line, have a substance abuse issue, do not have a family doctor in the community, or a combination of those things. There may be other groups, but those listed make up the vast majority of those who are seen at the 360 NPLC.

When asked about some specifics of those who they see on a typical day, it became apparent that virtually every individual seen by the 360 NPLC experiences mental health problems, most interviewees indicated 90%+ of those they see have mental health problems. Their life

circumstances may contribute to their mental health problems, or their mental health problems may have led to their difficult life circumstances.

When asked about food insecurity, every interviewee indicated that at least 50% of those they see are food insecure, the average answer came out to 81% of the individuals accessing the clinic struggling to afford food. As for housing insecurity, answers on the primary care side were lower than on the SSP side, the averaged answer from those who work in the primary care side was indicative that 38% of the patients seen on a given day experience homelessness or are housing insecure.

When asked about mobility problems, answers varied widely, likely because some interviewees were thinking about more than obvious physical problems, like using a walker or cane, and were additionally talking about people who have respiratory or cardiovascular related mobility problems. Interviewee answers indicated on average 37% of patients experience mobility problems. As for diabetes, answers were more uniform ranging from 25-40%, with an average of 30% of individuals having some form of diabetes.

Clearly, patients who use the services offered by the 360 NPLC experience higher rates of mental health problems, mobility problems, diabetes and food and housing insecurity than the average citizen. The individuals who access the clinic are much more vulnerable on average and are generally experiencing lower social and mental health than the average Peterborough citizen.

#### How the 360 NPLC Currently Partakes in Social Prescribing

Although there is no formal process, the 360 NPLC currently has several ways in which they assist patients with their Social Determinants of Health. Patients have no written intake form

questions that would directly inform staff as to if they are experiencing mental health problems or having issues relating to food insecurity or housing.

No paperwork is required prior to being seen at their appointment, so individuals who have already completed their clinic intake simply book an appointment and arrive at their scheduled appointment time. The clinic also focuses on getting people in quickly, offering next or same day appointments frequently. This assists their disorganized and often severely mentally ill patients who are then more likely to make it to an appointment and get help.

Staff at the clinic help lots of individuals fill out forms for ODSP and OW, as individuals who are deserving and apply for these supports often have no family physician to access to fill out the sections that must be completed by a HCP.

### Services Offered

The clinic offers a range of services that could be considered social prescriptions. This includes access to shower and laundry services, which are very commonly used. Some individuals book weekly showers, and some individuals book in as needed. Staff can give out bus passes for Peterborough transit, and they help fill out OW and ODSP forms for patients who cannot take the bus to get funding for taxi services for trips to locations deemed necessary.

The 360 NPLC has a relationship with the YMCA in Peterborough, and if the NPs or SWs deem it necessary or helpful for the patient, they can give them a free 60- or 90-day pass (that could be renewed if needed). NPs divulged that these passes not only help patients get access to the facility for physical health needs, but also can be an avenue to help with mental health, by helping some patients with social anxiety or who are experiencing isolation get out of the house.

The SWs at the clinic can do individual therapy sessions with clients, and in those sessions, they often give patients recommendations for other programming they can access in the community that might help them with their mental health or help them with the situation they are in that impacts their mental health negatively.

For patients experiencing isolation, RNs and NPs at the clinic do hour-long home visits, however this is only able to happen every other month for each patient who needs it, as staffing capacity restricts more visits.

On the SSP side they primarily supply tool kits related to safer drug use (including needles, naloxone kits, and gloves, among other supplies). Other than that, they offer art programming and a safe place for people to go to get out of the elements. They also have had a community garden in the Spring/Summer months and shared the food with any clientele who needed or wanted some. Through this gardening program they were also able to offer any urban indigenous client's access to traditional medicines and herbs. They offer sage and tobacco kits year-round for those who want further connection to their traditional ceremonies but otherwise would not have the means to.

### Links in the Community

Talking to staff, they indicated that communication with other organizations in the community can be difficult and has gotten worse since the COVID-19 pandemic. However, there were a few organizations throughout Peterborough that the staff commonly said they link patients too, including shelters, food services (like the Salvation Army), the Elizabeth Fry Society, and the

CMHA. One of the SWs also indicated they often help clients start attending one of the 12 step programs, like OA, NA, or AA.

### Feedback on Services

In general staff members do not get much feedback on either internal or external programming.

In general, if someone wants to use a service again, that is how they hear about how it is working. Clients are generally happy with shower and laundry services, and the art programming on the SSP side. However, sometimes staff get complaints about how Peterborough Transit routes are not helpful to them, as they only service certain parts of town and bus transfers can be difficult, especially for those with mobility problems, or the elderly who cannot wait out in the cold too long.

It was noted that Peterborough (like many other communities) has many gaps in what services it offers to the public. The top three that were discussed were housing, food, and mental health services. On the day of interviewing, many interviewees brought up the fact that One Roof was closing their hot lunch service the following day, leaving Peterborough residents with just one hot meal option a day that they can access for free.

### Going Forward with Social Prescriptions

Staff were excited about the prospect of getting funding to further help those coming into the clinic with their social determinants of health. They gave suggestions for what they would like to see internally and externally, based not on what was realistic, but based on what they would like

to see if funding was not a constraint. Within the clinic the most common want was to bring back the dietician and the food programming that dietician would run. This would include getting groups together to make meals, learning how to make nutritious foods on a budget, and would allow people to bring home the food that had been made in the workshop. Group therapy and support groups were the other most noted programs that staff would like to see done within the clinic. Many staff noted that they would like to see programming that is multidisciplinary, meaning that they would like to see support put in place that help patients with more than one aspect of health at a time. An example would be in a support group for mental health, a patient would be in a group setting (social), while getting to learn how to better care for their mental health or just giving them a healthy place to vent about their struggles with others who understand them.

Some staff thought external programming might be more realistic, as they currently do not have the physical space or staffing to run much more out of the clinic they are working out of. Lots of staff talked about helping patients afford programming they would not otherwise have, such as helping them go out to the movies, to art galleries, or to plays at the theatre. Linking to a greater number of community centers and gyms could also be helpful, as then clients would be able to select one that is more physically accessible for them.

As for support needed going forward, staff noted that support would look different depending on if they were focusing on external or internal programming. For either one the greatest need would be funding to support it. Aside from money, staff highlighted that they would likely require additional staffing to help patients access further supports, especially if there was more internal programming, but could even be necessary with external programming, they also brought up how helpful building up a volunteer base would be, as they could be paired with

clients who are socially anxious or isolated and attend programming with them. Physical space may be needed to implement internal programming, as the community kitchen program used to be run in the area that currently operates the SSP. Staff noted that more community partners would also be great and a way to easily communicate with them would be helpful. Finally, one staff member noted how helpful it would be to have clear guidelines for eligibility of different SPs, so that time was not wasted in appointments critically thinking about each individuals' circumstances and what they could access.

Staff were asked if there was anything aside from funding the Government (either provincial or federal) could do to help with the implementation of SP. Multiple interviewees said it would be helpful is the Government could help with public awareness of SP and have them promote SP as a viable option of health promotion. Some interviewees also noted that they wish the work being done at the clinic was recognized by the provincial government as healthcare so they could get funding provincially. Currently funding comes primarily from federal grants. Staff had legitimate concerns about how SP would be done at the 360 NPLC, however, they are on board if they can obtain funding to launch the project.

Overall staff interviews and general research indicate that SP would be a great new resource to bring into the clinic. Interventions that focus on the SDH should be brought to the forefront of medical care. Research has shown how important social, education, and basic needs are for health outcomes, and these are things that cannot be helped with prescription medication.

Brining in SP interventions is a way to address social issues in healthcare and is an excellent way to spend on preventative healthcare, as the saying goes an ounce of prevention is worth a pound of cure, so healthcare spending would be much better spent on preventing people from getting diseases and keeping our population healthy long-term. This will save healthcare money in the

long run, although would likely be heavy spending up front.

In the 360 NPLC they are funded primarily by federal government grants, so to implement SP on top of their currently run programs, more funding would be required. Interventions that may be most important in this clinical setting would likely be helping the 360 NPLC's vulnerable patients get some of their basic needs met, this could include money for food programming, housing support, and supplies to help them live day to day more comfortably.

### Different Perspectives between Professionals

Individuals of similar professions had some commonalities in their answers to interview questions. Both SWs interviewed focused on isolation in their description of SP. These SWs also noted that SP was at the core of what they do, since they focus on the external factors in a client's life that affect their mental health, and what community resources they might use to help them with these issues. The SWs noted that people in Peterborough need access to shelter, whether that be temporary escape from the elements, or just better access to affordable housing. All the nurses (RN, RPN, and NP) noted that one of the most impactful things they do that could be considered a SP is get patients gym memberships to help with isolation, mental and physical health. Both NPs also noted that they commonly help those on ODSP fill out paperwork to gain access to transportation, and they noted that they refer people externally to shelters in Peterborough quite often. All staff responded that food programming would be helpful in terms of moving forward with SP. Both NPs as well as some of the other interviewees noted that support groups might also work at the 360 NPLC. As for obstacles to getting a SP program running, resources were commonly quoted as the biggest factor that will affect implementation, including everything from money, time, space, staff and even case management.

## **Discussion**

### Challenges of implementation

Throughout a review of current SP programs taking place across Canada, scientific literature assessing pilot projects, and discussion from the staff of the 360 NPLC, many challenges of implementing social prescription became apparent that should be considered prior to moving forward with any such program. First and foremost is funding; any new program will need some kind of funding. For NFPs, funding is not often guaranteed on an ongoing basis and instead is allotted yearly through applications and getting approved for specific programs. Not knowing whether funding will continue year to year may have an impact on what kind of SP model the 360 NPLC should take on. In an ideal world, the best SP for the 360 NPLC's vulnerable demographics would be necessities like food and shelter. However, providing these specific supports consistently would cost a lot of money, and given limited funding, would not be possible. Looking at cost-effective ways to make a difference in an individual's other SDH, such as improving mental health through social interaction, is also important and may be possible on a more limited budget.

Staffing is another big concern. During interviews it became apparent that staff wish they could do more for current patients, or support more patients, but they are already functioning at capacity. Healthcare in general is currently an area where nurses and other HCPs are feeling overworked and struggle to keep up with their day-to-day load. Some SP schemes propose repurposing staff, giving them new job duties that would allow them to tackle this new initiative. At the 360 NPLC, as in most primary healthcare settings, staff are already doing vitally

important work. Therefore, it would not be a good idea to repurpose their role to allow for SP as it may result in other important elements of healthcare being overlooked. In their interviews, several staff members mentioned that even just one more staff member would be vital to starting a SP initiative at the clinic. To have a link worker, or case manager, focused on either internal case management or maintaining connections in the community would be an essential step forward in the process. Since providing ongoing services and support for patients relies on follow-up, tracking and assessing services, it would be too much for current staff at the clinic to take on. Some SP models and pilot projects utilize volunteers to help with running SP programming. This can come with its own issues since volunteers can be difficult to come by in a society where people must work >40 hours a week to meet their needs, and retirees must come out of retirement to make ends meet. So, relying on volunteers to run SP makes it more difficult to ensure consistency.

For staff (current or new), it would be important to have clear guidelines and policies surrounding which patients can access SP and the specific prescriptions they would qualify for. Having clear guidelines takes away some of the burden on staff who will be responsible for initiating SP, as they can spend less time on standard cases and more time on patients with unique circumstances. If selecting an external model, having something as simple as a list of community organizations and their respective activities, accompanied by guidelines for which individuals who would benefit most from the organizations based on their SDH factors, would be beneficial. If offering an internal model with support groups, or dietician access, having guidelines for which patient profiles would warrant access to those programs would make SP easier on staff.

When choosing an internal method, additional physical space is a concern. Currently the 360 NPLC operates out of a small facility and does not have much extra space. The SSP side of the clinic has a little extra space that may allow for small support groups or cooking classes.

However, scheduling drop-ins and support groups around their current clinic programming would need to be considered. If the clinic obtains significant funding, extra space for social prescriptions may be a good way to spend some of the funds. With news of a community health center being approved that is working alongside the 360 NPLC, it may be possible to increase programming for both the CHC and the 360 NPLC by carefully planning which facility offers specific services.

Finally, the patients themselves need to be considered. There should be plans in place for how LWs might help patients overcome common barriers to accessing SPs. There should also be considerations regarding the specific nature of the problems facing some of the patients at the 360 NPLC. The most common barriers to accessing SPs in literature were funding and transportation. Some SP models did not supply participants with funding to obtain their SP. For example, if a walking group was recommended, and attending that group came with a cost, some models had no policies or funding for patients who could not afford it. When helping patients of low socioeconomic status, it is important to have ways to help them access care financially. Just as there is government funding to help some individuals with pharmaceutical medication, there should be funding in place either from the government or the clinic participating in SP to assist patients financially. This funding can be linked to the prescription itself (e.g. the group therapy cost, or cost of yoga classes), or to helping the patient access the prescription (e.g. helping them

afford transportation or childcare). One NP at the 360 NPLC pointed out that the mental state of some vulnerable clients may make it harder for these individuals to access SPs. Some individuals have disorganized mental states, in which they have trouble keeping appointments or holding on to medications prescribed by medical staff at the clinic. These individuals would have trouble tending to their recommended SP as well. Thus, additional ways to overcome these barriers should be addressed.

Potential Paths forward

### *Internal Prescriptions*

When exploring internal prescription options, it is advisable to initially assess possibilities with the space already available. A viable starting point could involve monitoring and tracking the usage and benefits of the supports already provided to patients by the 360 NPLC and ensure that staff follow up about the services used. Reworking current procedures and relabeling SSP, YMCA passes, shower, and laundry services as SPs on patient files could begin providing data on how many clinic patients use these services.

Identifying the need for SPs is another step that could be taken. Sometimes staff are only going to have time to address the patient's primary complaint, but if there is time for staff to ask about the patients SDH it could help them identify need. This would help shed light on whether a patient might benefit from something the clinic currently offers or if there might be something in the community they can recommend (which may be considered an external SP). Another way to identify patients who might have a need for SP would be to put a whiteboard in either the examination rooms or the waiting room (or both). So, while a patient is waiting for their appointment to start, they could identify SDH factors relevant to them based on indicators

printed on a whiteboard. An example could be having a handheld whiteboard in each examination room with questions such as “would you like to discuss your mental health today?”, “do you feel you have had enough to eat in the last 24 hours?”, or “are you feeling lonely?”. The patient could either tick boxes or write “yes” or “no” on the question(s) displayed or ignore it completely. Then if the HCP sees one of the boxes indicating social need, they can find time to address it during their appointment or at least give the patient some additional resources.

The next area to look at would be whether the 360 NPLC can offer additional laundry and shower services, either by scheduling more clients with the stations already available or adding more laundry or shower services in the clinic space where possible. Staff indicated during interviews that these services are helpful for a variety of reasons, both by helping general hygiene and even improving wound care outcomes. Community gardening was also offered in the past, in conjunction with a nearby church. Continuing and/or expanding this program could be an additional SP to offer in the warm months.

If adding new programming is possible, a dietician may be a great addition to the team. The 360 NPLC used to have a dietician and current staff indicated that it would be a great service to some of their patients to bring one back. Previously the dietician only worked one day a week, which can make retention difficult, but with the right funding it may be possible to hire a full-time dietician, or one who works 2-3 days a week. The dietician could bring multifaceted programming to the clinic, in which they provide education and free food in a social environment. Bringing in a dietician and food programming in this capacity would require the use of a full kitchen and would take place in the SSP area of the clinic. The dietician could meet one-on-one with patients to offer individual support for managing chronic illnesses, weight loss, or how to ensure a balanced diet for patients partaking in non-traditional diets (such as ketogenic

diet, vegan, or vegetarian). The dietician could also offer group support for helping patients manage more common diseases (such as diabetes, high cholesterol, or heart disease) by using diet to manage their symptoms and general health. Other group classes a dietician could offer include general healthy eating information, how to eat well on a limited budget, and more. They could also offer cooking classes to teach people accessing this SP how to cook nutritious food with limited kitchen equipment, or on a limited budget. This kind of programming would touch on several of the SDH.

Another possibility for internal SPs would be to repurpose part of the current SWs job, or to hire a new SW to run support groups. Just as the SSP offers art therapy and art sessions with a professional, they could also offer a variety of support groups based on what is likely to help the greatest number of patients. Drop-in support groups would allow for patients who have more unpredictable schedules to attend programming, increasing accessibility. Potential support groups could cover topics such as mental health (this could go in depth on certain conditions like living with anxiety or depression, or cover more broad helpful topics week to week like self-care, sleep, wellbeing, meditation, and mindfulness), healthy eating, substance use, grief/bereavement, being a caregiver, or being indigenous in an urban environment (which may be relevant since the 360 NPLC supports a higher than average number of indigenous individuals). Volunteers with lived experience and training may be able to help run support groups, like they do in other SP models, such as the life rooms model (Hassan et al., 2020).

Another way to offer help to patients may be through a SP bursary program, this would meld internal and external prescriptions, as all the funding would be provided through the clinic, but the support would not happen at the clinic itself. People who are struggling to pay for food or shelter could apply and get some relief. If there was less funding in this area, the bursary could

cover other items that may make an impact on a patient's mental health, like paying for therapy, exercise classes, or even art-related events like attending movies or theatre performances.

### *External Prescriptions*

The same tracking and identification initiatives as mentioned above would still be relevant to taking on an external model of SP, as you still need to identify the need to recommend and connect patients with support relevant to them.

Hiring a link worker would be essential to offering external SPs. The qualifications of a link worker would be something to consider, as it needs to be someone with knowledge of the community, communication skills, and active and empathetic listening skills, as well as the ability to handle confidential information. A link worker could be a SW, but it could also be someone with no official credentials if they had the right knowledge set. LWs are essential for spending extra time with the patient that nurses and NPs at the clinic do not have. They are needed to work out the logistics and plan of action for how a patient will access the SPs identified by the primary care team. This LW could develop a feedback system to get data on SPs offered in the community and help patients tackle any problems that arise and refer them back to the primary care team if needed. This LW would develop and maintain relationships with various community organizations where the patients would access the SPs. They could also potentially help a network of NFPs and other organizations have contact with each other, to help spread awareness of various support across the community, work together to overcome challenges, and streamline services.

With or without a LW, a volunteer base could be used to help patients access support in the community. In an internal model, volunteers may be used to help run support groups and other programming. In an external model they can be used in a variety of ways. Volunteers could help

remind patients of their SPs, helping patients who have memory problems or who are generally forgetful. SWs brought up that volunteers could also be used as a buddy system to attend walking groups, or other programming with socially anxious or isolated individuals in need of a safe person with whom to access other services.

With or without a LW it may be helpful for the 360 NPLC to create a referral directory for different community organizations and what they offer (see appendix E for some potential connecting organizations). This could be utilized by the SWs or other staff during appointments. Staff at the clinic mentioned that it can be difficult to get in touch with certain NFPs and organizations, and that they cannot guarantee to patients that an organization will remain open. Maintaining an updated directory containing contact information would prove beneficial. This directory should also include referral details for various programs and organizations. This approach ensures that if a formal referral from a primary HCP is necessary, clinic staff can readily assist the patient. Additionally, it empowers patients by providing clarity on whether a self-referral process is available.

### **Recommendations**

For either prescription pathway, guidelines for what patients will receive which support will be necessary. Staff need clear boundaries (with some flexibility) to best support patients and to ensure they do not have to spend a significant amount of time matching patient presentations with relevant prescriptions. Regardless of the chosen model, the 360 NPLC will need to establish an identification, tracking, and feedback system. This system is essential to identify the need for SPs, monitor their implementation—both for patient benefit and data collection purposes—and

gather feedback. Additionally, following up with patients regarding their SP is imperative, just like it is with doctors or NPs for prescription medications.

#### Internal Model Recommendations

- 1) Hire a dietician to run food related support groups, cooking classes and one-on-one sessions with patients who need it.
- 2) Schedule or find physical space for additional shower and laundry services.
- 3) Hire another SW to run support groups.

#### External Model Recommendations

- 1) Hire a LW to develop plans of action to access SPs in the community, help patients identify and overcome barriers to care, and maintain patient files in the EMR.
- 2) Develop a directory of NFPs and organizations that would offer SPs in the community.
- 3) Get volunteers to help remind patients of SPs that they are supposed to attend, or even offer phone calls to reduce loneliness and isolation like the Red Cross Friendly Calls Program.

## Appendices

### Appendix A—Potential Social Prescriptions and their Potential Benefits

Note: 3=large benefit, 2=moderate benefit, 1=low benefit

\*All numbers are subjective and not based on any scientific study

<b>Social Prescription</b>	<b>Economic Benefit</b>	<b>Community Benefit</b>	<b>Mental Health Benefit</b>	<b>Physical Health Benefit</b>
<b>Primarily Economic Benefit</b>				
Food Bank	3	1	2	1
Housing Services (grants, finding safe housing)	3	2	3	3
Childcare Subsidy	3	1	2	1
Food Subscription Service (meals on wheels)	3		2	3
Transit Pass	3	1	1	
Dietician Services	3		2	3
Employment Services	3	2	2	1
Legal advice (community legal center)	3	1	2	
Clothing Programs (for winter, for interviews, etc.)	3		2	
Literacy Groups	3	1	3	
<b>Primarily Physical Benefit</b>				
Exercise Classes	1		2	3
Self Defense Classes	1	1	2	3
Addiction Resources	2	2	3	3
Safe Supply Programs	2	2	2	3
Breakfast Program	1	1	2	3
Communal Dining	1	2	2	3
Dance Classes	1		3	3
<b>Primarily Mental Benefit</b>				
Choir		2	3	1
Book Club		1	2	
Forest Bathing		1	3	1
Art Therapy or Classes		1	3	
Knitting Club		1	3	1
Sexual violence support			3	
Indigenous Supports/Services		1	2	

Home Gardening	1		3	2
Sexual Violence Support/Helpline/Groups		2	3	
LGBTQIA+ Support groups/helpline		1	3	
Social Calls (phone a friend services)		2	3	
Grief Support groups/counselling		2	3	
Counselling	1	1	3	
Parenting groups		2	3	
Caregiver Supports	1	1	3	
<b>Primarily Community Benefit</b>				
Eco-Volunteer Group	1	3	2	2
Community Gardening	1	3	2	2
Volunteering Roles		3	1	1

## Appendix B—Staff Interview Questions

1. What is your role at the clinic?
2. What does social prescribing mean to you? (if you are unfamiliar with the concept, your best guess is fine)
3. With the knowledge of what social prescribing is, how would you say you provide social prescriptions to the patients that you see?
4. What is the most common internal social prescription that you currently offer/suggest to patients you see?
5. What is the most common external social prescription you offer (and what organization offers this)?
6. What social (or mental or physical) issue do these patients face that leads you to recommend said service?
7. When you first see a patient, do you do anything to identify their biopsychosocial needs?
8. Do patients fill out forms asking about their social needs before they are seen?
9. When you recommend a service to a patient do you ever get feedback about it? Is it usually positive or negative?
10. What do you think you or the clinic could do to improve access to social prescriptions?
11. Where do you feel programming could be expanded within the clinic?
12. Do you foresee any obstacles arising from the expansion of social prescription?
13. What kind of support (staffing, room, money, organizational flow, etc.) do you believe the clinic needs to implement a more official social prescribing framework?
14. On a daily basis roughly what percentage of the patients you see struggle with or have one of the following:
  - Mental Health Illnesses
  - Diabetes
  - Unstable or no housing
  - Food insecurity
  - Mobility issues
15. Aside from additional funding, is there anything that the Government could do that would assist the clinic in implementing social prescribing?
16. Do you have any other questions for me or general comments?

## Appendix C—Summary Chart of Staff Interviews

	<b>Interviewee 1</b>	<b>Interviewee 2</b>	<b>Interviewee 3</b>	<b>Interviewee 4</b>	<b>Interviewee 5</b>	<b>Interviewee 6</b>	<b>Interviewee 7</b>
<b>Role at the clinic</b>	RN. Splitting time in primary care and the CTS.	Social worker. I do mostly therapy and some case management.	Nurse. My role will be on the SSP side and the practice side as well.	Medical Office Administrator and administrative assistant for the SSP.	NP	Social worker.	NP, I do mostly primary care.
<b>Time in that role</b>	Almost 6 months	2 years	This is my second day here.	14 months	3.5 years	2.5 years	Since October 2021. Just over 2 years
<b>Time in that field</b>	Since 2021	In the shelter system as a PSW for 5 years while I was in school, then I started to work here.	13 years as a nurse.	I worked as an admin in a dental office before my role here.	Been a NP since 2018. About 5.5 years.	Since 2005. So about 18 years.	NP since 2019. Worked as a Nurse for 2.5 years before becoming an NP.
<b>What does social prescribing mean to you?</b>	First heard about it today. It's like a formalized "prescription" to help someone with social events.	Getting people actively involved in the community in ways that will help their own life. Especially helpful for people experiencing isolation or social anxiety.	It is a way to connect patients of social situations and help raise awareness of support in the community.	I first heard of the term this morning. Linking people in terms of building community, which is a big part of what we do here.	It helps people who are isolated. This can be especially prevalent for elderly, but isolation and loneliness are something that everyone felt during COVID.	First heard the term this morning. It's HCP's recommended activities for people experiencing isolation or poor mental health.	It's something to help people with both their mental and physical health.
<b>How would you say you practice SP in your role?</b>	We give out gym memberships. The SSP side hosts art drop ins.	Recommending ways for people to volunteer in the community in ways it will help		Here at SSP we offer art drop ins, and we always have art for people to do. We also	We have YMCA passes, which sometimes I give out just to get people out of the house.	As a SW it is in the fabric of the profession. I connect people with lots of resources in	I give out gym memberships and connect people with social workers. Sometimes we also give out meal vouchers.

		<p>their own mental health. Fostering positive connections for people experiencing loneliness.</p>		<p>of course offer safe injection kits, naloxone kits and more for people who need them. We offer survival gear and clothing. We offer snacks. We had a community garden.</p>		<p>the community, and always keep in mind any barriers my client may face.</p>	
<p><b>Do patients fill out forms related to mental or social health before they are seen?</b></p>	<p>Not that I'm aware of.</p>	<p>I don't do a formal assessment</p>	<p>I would imagine there is, but I wouldn't know.</p>		<p>We used to do demographic forms during initial intakes. It is less formal now.</p>	<p>No. I feel like we are fortunate our clients don't have to fill out any screening or assessments before seeing them.</p>	<p>No. We do non-traditional patient hand-over. Patients here can be chaotic and disorganized, so we try to help them address their issue ASAP.</p>
<p><b>Do you have questions for patients when you first see them to help identify their social or mental health needs?</b></p>	<p>It depends on what they are coming in for. If they are in for a BP check, probably not. If they are in for ODSP paperwork or to get a bus pass it might lead to a conversation.</p>	<p>I do a solution focused grief therapy model. I focus on strengths and ask what they are currently engaged in. This gives us a good</p>	<p>I always try to get a good baseline of a patient's health status including mental health. I do focus on the reason they are visiting me though.</p>		<p>I ask where their income comes from. Someone in the workforce might have a different social level from someone on ODSP.</p>	<p>It's tailored to what the person brings into the room. I don't have a preplanned template. I ask the client what they are hoping to get from therapy.</p>	<p>I just try to focus on what I can get done for the patient in their appointment.</p>

		starting point.					
<b>What is the most common internal SP you offer?</b>	Showers and laundry.	People usually see an NP before they see me, so most stuff internally has been offered. I do occasionally tell clients about the SSP art drop in.		Art. Safe supply kits. (not said by individual, but these are most common things on SSP side of 360 Clinic)	YMCA passes most frequently. Bus passes don't go through the NP. I help people get ODSP funding for a taxi if they can't use the bus.	I don't really offer any, we are currently limited in our programming. We don't offer group therapy, for example.	Transportation stuff.
<b>What is the most common external SP you suggest?</b>	I've made referrals to our social workers and our systems navigator. I've also tried to help get people into shelters.	I actively endorse 12 step programs. Everything from overeaters anonymous, to AA, and NA.	It depends on where I was working. For these kinds of populations, I would likely be connecting them with shelter systems and food.	External connections are often not accessible. Some food and shelter system recommendations.	A lot of our patients are linked with shelter systems. Also, the friendship center for people with indigenous roots.	CMHA, Elizabeth Fry Society, YMCA. Those would be the most common.	I link lots of people with Elizabeth Fry and CMHA.
<b>Do you ever get feedback from patients? If so, is it positive or negative?</b>	Only get feedback if they want to access the service again. Like if they want to book weekly showers.		Positive feedback mostly about shelters. Negatives can sometimes be that they didn't know about the SP sooner, or they had a hard time accessing the service.	Yes, and it is largely positive.	Mostly positive. Sometimes it is negative if they can't access it like getting a bus pass, but the routes aren't helpful. Sometimes people are disappointed by their lack of financials to do activities they once enjoyed.		Positive feedback about taxi fare and transportation covered by ODSP.

<p><b>What could the clinic do to increase access to SPs?</b></p>	<p>Bus passes, movie tickets. Food services.</p>	<p>I think finding a volunteer base that would attend events with people would be great. It would help my clients who experience social anxiety have a trusted person to attend a social event with.</p>	<p>The more SP's we can give the merrier. Healthcare is supposed to be all encompassing and increasing access to things that will help mental health will assist with that.</p>		<p>If we had the space to bring back the dietician and the cooking classes. Group therapy could help more people than one-on-one therapy. Having bus passes, movie tickets, or art programs could be good to increase access to programming in the community.</p>		<p>Yes. We have a lot of partners, but it can be difficult to stay in touch with them. It would be nice to get more gyms and community centers involved. Mental health programming would be huge.</p>
<p><b>Where should programming be expanded in the clinic?</b></p>	<p>Food services would be huge. Expanding drop-in times at SSP. Bigger or continued community gardening.</p>	<p>Additional showers. Increasing drop ins at SSP art would be great to get people out of the elements. Bringing back food programming and/or the dietician would be great.</p>		<p>More food. Clothing. Survival things. If we could get more nurses that would also be good.</p>	<p>Multidisciplinary programming. Things to help both socially and medically. Cooking programming can be an example or group teaching for common diseases, like diabetes.</p>	<p>A Mental health drop in would be great. Tackling issues each week, with no pressure to attend all the sessions. Making meals on a budget, coming up with a meal plan.</p>	<p>Get the community kitchen back, where people lean to cook on a budget and get to take the meal home with them. It would be good to have self-regulation-related groups, like art sessions or yoga.</p>
<p><b>Where are the biggest gaps in services/support in Peterborough?</b></p>		<p>Spaces for people to escape the elements. Legal services (free ones)</p>	<p>Affordable housing and shelters. One Roof is closing, so food service for people</p>	<p>Not enough hot meals. Not enough housing. Supervised consumption sites. CTS</p>	<p>Access to food and shelter is limited for our population. Not enough hot meals. Psychiatric</p>	<p>Top two would be food insecurity and housing insecurity.</p>	<p>Mental health. We never had a sufficient system, and it has only gotten worse.</p>

		to help people get ID and such. Transit and transportation (routes).	who struggle with food insecurity is only getting worse. Also, laundry services and showers.	is good but only services those who snort, inject, or orally consume drugs. There is no safe place for people who inhale drugs.	care is limited and gets bounced back to primary care too quickly. Access to dieticians is limited.		
<b>Do you foresee any obstacles arising from trying to implement SP?</b>	Making community partners. Inflation is making things difficult for everyone, so that makes it more difficult to get donations or volunteers.	Money. Case management, as it's very time and labor intensive. Additional staff / people would be needed.	Money. Making sure follow through happens since our vulnerable populations can struggle with maintaining appointments.	Money.	The biggest thing is time and resources. Human resources, financial resources, and physical resources (like space in the building).	Balancing what we would like to do with what realistically we can do for clients.	Our patients tend to be disorganized and have trouble keeping appointments. Since many live rough if we physically give them something, there is a high likelihood it will be lost or stolen. It will be hard to ensure people can show up for their SP.
<b>What kind of support does the clinic most need to implement SP?</b>	Getting someone to organize and run it. Money. Space to do it.	For internal programming the biggest one would be space. Externally it would be getting partners and staffing.	Money. Transportation. Having a staff member to run everything, and who could call and remind people of something like that. A volunteer		Having a clear set of guidelines for eligibility is important.	Money of course, and more physical space. Space to run group therapy or drop ins would be great.	Aside from funding. Staffing would be important. Having the physical space would be important as well, SSP took over where the community kitchen used to be.

			base could be very helpful.				
<b>Aside from funding, is there anything the Government could do to assist in implementing SP?</b>	Funding would be the bug thing. Funding for someone to run it. Maybe offer a tax exemption for people or businesses that get involved.		Awareness. Helping eliminate stigmas around mental health and substance abuse.	Making an exemption in the Smoke Free Ontario Act for supervised consumption sites to allow inhalable drugs. The Ontario government could recognize the work we do, currently funding comes from federal grants, when it should just be part of healthcare spending provincially.	Promoting SP as a health promotion strategy. That would be greatly beneficial, along with funding of course.	Openness to understanding the importance of social prescribing. Allowing cities to be creative with what money for SP should be spent on.	Stop dismantling the public healthcare system. A worsening public healthcare system puts additional strain on the primary care side of the clinic.
<b>Roughly what percentage of the patients you see experience mental health problems?</b>	At CTS 80-90%. In the clinic I'd say 50%	99%		90% maybe more.	90-100%	100%	99%
<b>Roughly what percentage of the</b>	CTS close to 100%. At the clinic 10-20%	Maybe 10%		Over 60% on the SSP.	At least 50%	At least 50%	60-70%

<b>patients you see experience unstable or no housing?</b>							
<b>Roughly what percentage of the patients you see experience food insecurity?</b>	CTS 100%. At the clinic 80%, it's hard to quantify because it is not something that is always talked about.	50%		100%	80-90%	At least 70-80%	100%
<b>Roughly what percentage of the patients you see experience mobility problems?</b>	Less so at the CTS. Here at the clinic around 10%.	30-40%		Not sure.	60% respiratory mobility as well as more obvious physical mobility issues.	60-70%	10-20%
<b>Roughly what percentage of the patients you see experience diabetes?</b>	Not many at CTS. Here maybe 25%. Lots of my appointments are related to diabetes management	I wouldn't know.		Not sure.	About 40%	Not sure.	20-30%
<b>Do you have any other comments?</b>		Having something like a 360 Pass would be great. Let's say it gets you: -on the bus -in the art gallery -to the movies once a month.	I just think it is wonderful we are trying to include SP in healthcare.	Having something for people to do physically is so important. Especially for people who are outcasts, stigmatized or criminalized			Better connections between organizations would be great. Since COVID I find communications have become more difficult. There are lots of people in the community doing great

		Something that's centralized and has lots of options.		in the community, because these things really affect their self-esteem.			work, we just wonder how to get in touch with some of them. Email only communication does not always cut it.
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## Appendix D—Transcriptions of Staff Interviews

\*Interviews were edited for clarity and grammar.

### **Interview 1**

*Interviewer:* What is your role at the 360 NPLC?

*Interviewee:* Registered Nurse. Splitting my duties between stuff here on the primary care side to see patients here and then also at the CTS (consumption and treatment services) treatment site where I see people, some of them are patients here, others are unattached, facilitating Primary Care and wound care.

*Interviewer:* How long have you been in your role at 360 NPLC?

*Interviewee:* Since June or July.

*Interviewer:* How long have you worked in your field?

*Interviewee:* Since 2021. I worked at a hospital for a couple of years full time, then left for my role here. It's a much better fit for me here. Covid really messed things up, making working at the hospital tough for me, I was starting to get really burnt out.

*Interviewer:* What does social prescribing mean to you?

*Interviewee:* The first time I had really heard about it was in today's meeting. So, from what I understand it's having a formal thing to give someone to prescribe them to do some sort of social event, whether it's meeting someone in the community or going to the movies or an art space. It's like a formalized thing you can do to help someone with social events.

*Interviewer:* An official definition of social prescribing is: "when health professionals refer patient to support in the community are obviously within their Community like within the clinic works too and that sense yeah examples are like yoga classes like Transit passes can even be access to food banks, or meals on wheels" With that in mind, would you say you provide social prescriptions to people here at the clinic?

*Interviewee:* Yeah so, I don't prescribe since I'm an RN, but I know that we have access to things. We can give 60 or 90 day gym memberships as one thing, the SSP side hosts art drop-ins where people can do painting, making tie dye T shirts, and other artwork. To some degree it happens, I don't know how formal it all is though.

*Interviewer:* When someone comes into the clinic, do you know if they would fill out paperwork that helps identify their social needs?

*Interviewee:* Not that I'm aware of at this time.

*Interviewer:* Whenever you first talk to a patient do you ask them any questions about the social and mental health side of what's going on in their life?

*Interviewee:* It depends on what they're coming in for I'd say. How it's set up now is they have a specific need and they come in for an appointment. Let's say for a blood pressure check, that may not be something they are asked about. Let's say they are here to fill out ODSP paperwork, or to get a bus pass, that might spark a conversation about those things.

There is not a formal thing that is done.

*Interviewer:* Considering what you offer at the clinic (including things like showers and laundry) what would you say are some of the most common social prescriptions you offer day to day?

*Interviewee:* If showers and laundry count, I would say that. Working down at the CTS too that's a big thing to ask me for to help so I I'm kind of a bridge I guess to the clinic down the CTS so it's all through coming in if I'm doing wound care, I could say "Hey you know it would be really beneficial for your wound care go down to have a shower." For example, there was one person who had gotten poison ivy, they had to wash all their clothes to get all the oils out. So those two are really hugely beneficial to patients I see both here and at CTS, would be those two services.

*Interviewer:* Do you talk about any other community resources with patients?

*Interviewee:* Being so new on the community side of things, I don't think I do.

So Josh is a social worker and Martin is a systems navigator for the safe supply team, so I've made referrals to them. And I have also tried to help get people into shelters if that counts.

*Interviewer:* "I would say that counts."

*Interviewee:* So yeah, I've helped people get set up with sleeping bags and tents as well. We would love to have a resource to help with these kinds of things.

*Interviewer:* Whenever you have "prescribed" these resources, like bus and gym passes or access to the laundry and shower services, do you ever get feedback about how those services work out for people?

*Interviewee:* No, not really. Unless it's when they want to do it again. I've had some people try to get showers booked weekly. I've also told people about drop-in art spaces we do on the safe supply side. There's also an event that someone here runs called the "Tweak Easy" it's an unsanctioned drug use spot. They set up tents to allow people to come and inject or inhale drugs once a week. It tends to be more of a social time for people to get food and games and safely use drugs. It is unsanctioned though.

No formal feedback at all.

*Interviewer:* Would you say the clinic should get increased access to social prescriptions?

*Interviewee:* Yes. Absolutely.

*Interviewer:* What would you like to see happen within the confines of the clinic to increase access?

*Interviewee:* Things like bus passes to get places, or buying a bunch of movies or play tickets, so people who otherwise wouldn't have access to social events can go out and do something fun. I know that is huge for people's mental health.

Food services would be huge, Peterborough has recently lost any kind of lunch service. Hosting a meal would be great. And we did this with the community garden at the St. Emmanuel Church, our team got access and at the end of the year they took the vegetables and had a big chili meal. It would be great to have something like that here more routinely. It's a good way to socially gather, and let people have a meal.

Expanding drop-in times for art stuff at SSP would be good too.

*Interviewer:* Do you see any obstacles arising when trying to implement social prescribing?

*Interviewee:* I think making community partners, it might be difficult to get groups and people on board in the community to partner with this. With inflation and everyone struggling to make ends meet, it can be hard to get people to donate things, like the free tickets for example. So getting people on board might be a challenge based on those stressors. In the clinic it might be difficult because we are always short staffed, so getting someone to run it or have staff implement it in house might be pretty difficult.

*Interviewer:* What kind of support do you think the clinic would need to implement this more official framework?

*Interviewee:* Depends on what direction you take it in. But yeah, it might be difficult to get someone to organize and run it. Extra funding would be needed. A space to do it. Getting

community members on board. You would need someone to communicate and organize with community members and other organizations might be difficult, you would need someone to take the lead on all of that.

*Interviewer:* Other than for funding, can you think of anything the Government could be doing to help implement social prescribing in any way?

*Interviewee:* I don't really know. Funding would definitely be the big thing. Funding for a position for someone to run it would be great. Maybe offering a tax exemption for people who are helping with the program, that adds incentive to help community programs and businesses get involved.

*Interviewer:* On a daily basis roughly what percentage of the patients you see struggle with or have one of the following:

Mental Health Illnesses?

*Interviewee:* If we are talking about the CTS, it is really high both diagnosed and undiagnosed. 80-90%. Unless you are counting drug use as a mental health problem because that's the main reason they go to the CTS, then 100%. At the clinic it's also pretty high, I'd say around 50%, maybe higher.

*Interviewer:* Diabetes?

*Interviewee:* Not something I've come across a lot at the CTS. Here a large part of our appointments are related to diabetes care. Probably a quarter (25%), it seems like that many of my appointments here are specifically related to diabetes management, or it comes up as a factor.

*Interviewer:* Unstable or no housing?

*Interviewee:* Same thing, at the CTS close to 100%. Here at the clinic, not that high but still pretty high, I'd say 10-20%.

*Interviewer:* Food insecurity?

*Interviewee:* CTS 100% again. Here it's really high, probably 80%, it's hard to quantify because we don't often talk about that.

*Interviewer:* Mobility issues?

*Interviewee:* Probably less so at the CTS. But there's still a decent amount of people. Here I would say 10%, everyday there is at least someone coming in with a cane or walker, or something like that.

*Interviewer:* Do you have any final questions or comments for me?

*Interviewee:* What's the next steps?

*Interviewer:* So being here today I am gathering information on what the demographic of the clinic is like and how things run a little. I am hoping to gain some insights so I can create a report with workflows and realistic ideas for how, if you get some funding, social prescribing could be done here.

## **Interview 2**

*Interviewer:* What is your role at the clinic?

*Interviewee:* I am a social worker and I do therapy, but also some case management.

*Interviewer:* How long have you worked here doing that?

*Interviewee:* 2 years

*Interviewer:* How long have you been doing social work for?

*Interviewee:* I worked in shelters and shelter environments as a PSW, for about 5 years I did that while I was doing my school. Then I worked as a social worker for the YES Shelter for 5 months, then I came here.

*Interviewer:* What does social prescribing mean to you?

*Interviewee:* I'm not sure. The way I actively use it is I try to get people involved actively in their community in a variety of ways, whether it be through entertainment, through social justice, through volunteering. I tend to try to focus it on ways where it will make my clients' lives better. For example yesterday I was working with a client finding somewhere for him to volunteer, finding places for him to help make a difference in his own life. He was experiencing loneliness and isolation, but he didn't want to be around people who were negative, he wanted to be around people who were fostering a positive connection. So we brainstormed around that.

*Interviewer:* You are definitely already practicing social prescribing in that sense, as you are finding people community supports to help them with their loneliness.

When you first see a patient, are there any forms they fill out that give you an indication of what their mental health status is or what their social needs are?

*Interviewee:* I don't do a formal assessment.

*Interviewer:* When you first talk to a patient, are there any specific questions you ask the patient about some of these more social aspects of their life?

*Interviewee:* I work from a solution focused grief therapy model, so I do look at strengths and I ask them what they are currently engaged in, what they do for fun. Often from asking these kinds of questions you get an idea of if they are feeling isolated or if they are actively participating in their own mental health and wellbeing.

*Interviewer:* Internally, do you recommend any programming that's offered here at the clinic to patients? eg. shower, laundry, bus passes. All those things could be considered a social prescription. Is there a more common one you are recommending to people?

*Interviewee:* It depends on need. People generally see a nurse practitioner before they get to my door, so most of the stuff we offer here has already been suggested, and those steps taken. But if we have an art drop in and I know someone is looking to engage more, I might recommend that. But I wouldn't say I do it regularly.

*Interviewer:* Externally, what would be the most popular programming you recommend?

*Interviewee:* I actively endorse the 12 step programs. Alcoholics anonymous, cocaine anonymous, overeaters anonymous.

*Interviewer:* Do you think this clinic should increase access to social prescriptions, and if yes, what do you think the clinic could do to increase the access?

*Interviewee:* When we were talking about it in the boardroom today, I was thinking about the people who come to me with social anxiety. I have phone calls with them, getting them out of the house can be a challenge, I have a few who come to my office, sometimes with another person or a family member and that helps.

I think finding a volunteer base that would help people attend, whether it be the art gallery or a drop in here, or even to drop into the individual's home, I think having a volunteer base could be very helpful. A group of people who are vetted, it could help both individuals. Someone who is socially isolated could volunteer and go out with someone else who is socially isolated, it would help them forge those bonds. So, I think creating a volunteer structure would be beneficial.

*Interviewer:* Do you think within the clinic anything should be expanded, not thinking about funding constraints, just in an ideal world?

*Interviewee:* There seems to be an overwhelming need for showers, and there seems to be more opening up in the community, like at the Trinity Church and at the Wolfe Street location. Getting people out of the cold, the drop ins at the SSP, it helps get people out of the elements. The trinity church will start offering drop in from 1-4. So having more opportunities for drop ins to get out of the cold could be beneficial.

I know that in the past there was cooking with a Dietician, but that was lost in the pandemic. But doing things around food, could be very beneficial to bring back.

*Interviewer:* You've already mentioned that we need more spaces for people to escape the elements, but do you want to mention any other areas where Peterborough has major service gaps in your opinion?

*Interviewee:* Transportation, getting around can be very difficult. It is cost prohibitive for some of our clients, I know that they get subsidized bus passes if they're on ODSP, I don't know if they get one on OW. I think transportation is a struggle for some people, like the routes that are serviced. Getting access to suitable housing is another, access to ID. I did an ID application for someone who was born in New Brunswick, and it was quick. Another is trustee services. CMHA and Salvation Army has programs for that, but their wait lists are I think about 2 years. Other than that, there really isn't anything unless you go to a Lawyer.

*Interviewer:* Do you see any big obstacles that might arise in trying to implement social prescribing either in clinic or in the wider community?

*Interviewee:* Where the money comes from is one. I think case management can be difficult, it is really time and labour intensive. I think that's where that volunteer base comes into play. I may want to go to the movies with my client but would that be a good use of my paycheck and my time, possibly not. In terms of engaging people, and how we could best use the people in the clinic, it would be helpful to supplement that labor externally. I think especially with the number of people who suffer from social anxiety, who won't do these kinds of things alone. They need to have a trusted person to start with to go out and access that social prescription.

*Interviewer:* What kind of support do you think would be most important and helpful for the clinic, aside from money?

*Interviewee:* Depends on if we are talking about internal or external programming. I think if we are talking about internal programming the biggest obstacle is space. Externally it would be getting partners and staffing.

*Interviewer:* On a daily basis roughly what percentage of the patients you see struggle with or have one of the following:

## Mental Health Illnesses

*Interviewee:* I don't like the term mental illness. People who have mental health struggles, I would say 99%

*Interviewer:* Diabetes

*Interviewee:* I wouldn't know. But sometimes I do become aware of these things, so I would say about 10%

*Interviewer:* Unstable or no housing

*Interviewee:* Maybe about 10%

*Interviewer:* Food insecurity

*Interviewee:* 50%

*Interviewer:* Mobility issues

*Interviewee:* 30-40%

*Interviewer:* Do you have any questions or comments for me?

*Interviewee:* I wonder if we could get some kind of 360 pass, like a pass that gets you on the bus and gets you to the art gallery, and maybe gets you to the movies like once a month. Something like the Y, we get our own cards to supply to patients that have lots of options for them to do. So, they don't have to keep coming back to us each week. Something integrated and centralized to supply patients.

## Interview 3

*Interviewer:* What is your role at the 360 clinic?

*Interviewee:* I am a nurse. My role will be both in the safe Supply and in the practice as well.

*Interviewer:* How long have you worked for the 360 clinic?

*Interviewee:* This is my second day.

*Interviewer:* How long have you been a nurse for?

*Interviewee:* I have been a nurse for 13 years.

*Interviewer:* What does social prescribing mean to you?

*Interviewee:* It's to help connect your patients to social situations, and help raise awareness of support in the community as well. I think the most obvious one is mental health, and how social connectedness is so important for that.

*Interviewer:* Are there any forms used at the clinic that helps identify mental and social needs of patients?

*Interviewee:* I would imagine there would be something based on places I've worked before and policies I've seen before.

*Interviewer:* This question can be broader, because obviously you haven't seen patients here yet. When you first see a patient is there anything you ask patients or do with them to help identify their mental or social needs?

*Interviewee:* Yeah, in past roles we always try to get a good baseline of the patients' health status including mental health status. Obviously focused on why they are there to see me. If any red flags are triggered, I try to look into their needs, so I can advocate for them and give them the best care that I can.

*Interviewer:* Did you work in Peterborough before joining the 360 NPLC?

*Interviewee:* I've worked at PRHC in maternal/child wing for 10 years, and I've worked on a casual basis at the medical center filling in for nurses taking vacation or on sick leave...I also worked in the addiction treatment center on Charlotte Street.

*Interviewer:* In any of these roles have you recommended any community support to patients?

*Interviewee:* Absolutely.

*Interviewer:* What would you say are some of the more common ones you have recommended?

*Interviewee:* It depends on where I'm working of course. When it comes to this particular population, I find I'm always recommending and helping connect people with the shelter systems and helping connect people to food. A lot of people aren't aware of what the community has to offer and if they aren't in a secure place with housing, and they don't have access to internet or cable then there isn't really a way for them to find out what is available in the community, so it's up to us to tell them about it. They can't just go online and search for it, they can't hear about it on the news, they really rely on other members in the community and the staffing at facilities like this one to connect them that way. Otherwise, they are in the dark.

*Interviewer:* When you recommend services, do you ever hear feedback about it? And when you do, is it more positive or negative?

*Interviewee:* Sometimes. Definitely when it comes to the shelters. At the hospital we were often referring to five counties and lactation support in the community, as well as maternal mental health. We got a lot of mostly positive feedback about that. I think the negatives that we got are that they didn't know about it before or they had a hard time accessing it.

*Interviewer:* Do you think the clinic should increase their access to social prescribing and if yes, what do you think the clinic could do to increase access?

*Interviewee:* Yeah, it's hard because I haven't worked here long enough to see what the baseline is like, but I think the more the merrier. There are always improvements that can be made, and I think the social prescription of helping patients get access to things that they otherwise couldn't afford would be great. Whether that be going to a movie or being social in ways that they wouldn't be able to otherwise, I think that is incredibly important for mental health. Through the pandemic it has become increasingly evident how important this truly is for everybody's health, to be around other people. We know we are social beings, and we need to get out and do that. I think it's such a wonderful thing that we are including in healthcare. Healthcare is supposed to be all encompassing and mental health has a lot of room for improvement, and social prescribing is a great way to increase that.

*Interviewer:* Do you think there are any major gaps in support in Peterborough that you think could be added to?

*Interviewee:* I think we have come a long way with housing, but there is still huge improvement to be made there. They are closing down One Roof, so I think only hot breakfast is available now and there is nothing after that. So, there are now no hot meals after breakfast, no food other than for little bits of canned goods that they might get. That is something that needs to be improved, as well as laundry services and showers.

*Interviewer:* Do you foresee any big obstacles when trying to implement social prescribing?

*Interviewee:* Financials are big. Our population is struggling, even people who have jobs, some of them fall under the poverty line. Another hurdle will be making sure it happens, these marginalized populations can have a hard time maintaining appointments. This can be for various reasons, maybe transportation or mental illness. Making sure we are able to follow through for them and help them follow through on the prescription.

*Interviewer:* What kind of support do you think the clinic would need to implement social prescribing?

*Interviewee:* Money would be a big one, we can't send someone to an event if it hasn't been funded, so that's obviously the clearest one. However, having a different staff member that can ensure there is transportation provided for them to get there, maybe call them if they have a phone to remind them. You know, ask them what they need to get there. Maybe they have social anxiety, and this is good for them, but they might need someone to go with them. There are lots of options, they might need a worker to go with them or a volunteer, or whatever the case may be, I think staffing and money are the two biggest things that they would need to make sure social prescription can follow through from start to finish, allowing it to be affected.

*Interviewer:* Aside from funding, do you think there is anything else the Government could do to help people implement social prescribing?

*Interviewee:* Awareness. I think awareness would be a big deal, there is still a big stigma when it comes to anything mental health, especially substance abuse. I think society is at a point where we are ready to accept some of this as well, we've all gone through life changing circumstances in the last 4 years with the pandemic. Everyone has seen some social situations that they never expected and then experienced the impact of it themselves. Learning about how this is such a huge part of health, and that it needs to be funded, needs to be supported. I think it would be much more accepted by the community as a whole than it would pre-pandemic. Finding a way to increase that awareness and make it relatable to the everyday member of society, I think would be wonderful to help show that we are really taking this mental health crisis seriously.

*Interviewer:* Do you have any other questions for me, or comments you wanted to make?

*Interviewee:* No, I think for me working here is still so fresh, that things are still surface level. But this is a wonderful thing we are attempting to include in healthcare.

#### **Interview 4**

\*This interviewee took some time to explain some of the goings on and important points of the Safer supply program.

*Interviewee:* On the safe supply side, we are a safer opioid use program funded through health Canada. One thing we do here is trying to have full care. We have art on the walls that is created by staff and people who use our services. We have funding for an art teacher who comes in once a month 2 days a week to facilitate art projects for us. We do pottery, which is ongoing since it's done in steps. We have a large percentage of indigenous people. We wanted to help get them access to their traditional medicines, which can help increase their health outcomes. We started a community garden to grow our own medicines, so we grow tobacco and sage and all sorts of

different herbs, as well as vegetables. This helps give access to their traditions, as well as gives people something to do. Our community garden is located at the St. Emmanuel church.

*Interviewer:* What is your role here at the clinic?

*Interviewee:* I am a medical office administrator and administrative assistant for the safer supply program.

*Interviewer:* How long have you been in that role here?

*Interviewee:* About 14 months.

*Interviewer:* Were you in a similar field before hand?

*Interviewee:* I worked in a number of dental offices in administrative roles. I also have lived and living experience with substance use and mental health. With my admin knowledge, and some outside of work knowledge that I had, this position was a good fit for me.

*Interviewer:* What does social prescribing mean to you?

*Interviewee:* I first heard of this term this morning, when we were told that you guys were coming in. So, I would say it has to do with linking people in terms of building community, which is a big part of what we do here. We know that access to prescriptions is not the only valuable part of why people come here. Whether it's different connections in communities, different types of activities, room for engagement and creative expression, and the other sorts of things that make a human being whole.

*Interviewer:* In what way would you say you practice social prescribing here on the safer supply side?

*Interviewee:* Here at the Safer Supply Program, we do that by offering weekly art drop ins with a facilitator. We also have a very creative staff team here, so a lot of us are bringing different ideas to the table in terms of art activities, or seasonal based activities, and land activities. Starting our community garden off site from here was a big project this spring that led to some meaningful engagement with people and help have access to fresh produce to share. We were bringing back produce to the clinic probably 3x a week for about 3 months. Tomatoes, beans, peppers, herbs for tea. We have had indigenous facilitators come in and teach us about plant medicines and the medicine wheel and other things as well.

We also offer survival gear and clothing via donations. We can get people things like jackets and socks. We also offer snack bags to our participants. So, there are a few things we do differently in our program to try and address the social needs just as much as the actual medical needs.

We have art programs a few times a week, but we always have colouring pages and pencil crayons. We had a staff member teaching some people to knit last week, there are things to keep people busy and engaged.

*Interviewer:* Do you find you recommend external support as well, and if you do, what are some of the more popular ones?

*Interviewee:* In the world we live in here and the people we help here, external connections are not accessible. Our folks typically do not have the financial means to access any sort of programming. You know if you are an unhoused individual, what's the likelihood of being able to sign up for volleyball, or be able to do something like that. People are coming here for programming, due to lack of accessibility we don't have a lot of things we are recommending for people to do in the community.

*Interviewer:* Do you find the people who come here already have connections to places like the YES Shelter, or the Warming Room. Do you find you are referring people out to them, or are people coming to you from them?

*Interviewee:* Kind of both. Some of our participants are very well connected in the community and others are not so much. Due to shuffling of things in the community, food programs are at an all time low in the Peterborough/ Nogojiwanong area, so I really hope someone steps up soon. As of today, One Roof's lunch program is disappearing.

*Interviewer:* Where do you feel like there are gaps in the Peterborough community that could be improved upon?

*Interviewee:* Absolutely massive. In Peterborough currently, there are no active food programs to offer meals to people in the community. One Roof is closing today, it's their last day. The Salvation Army has a breakfast program, but other than that food insecurity is probably one of the most major gaps in the community.

The other major gap is a supervised consumption site because there is the CTS, but it only supplies a safe place for people who inject or snort drugs or take drugs orally. There is a huge gap for folks who are inhalation drug users who aren't permitted to use their drugs in any safe consumption site. They are at risk of overdose and death every time that they use it.

Some of us here founded and staffed a volunteer and indigenous led mobile overdose prevention site. It's not sustainable, it has been ongoing for over a year, but it only runs once a week.

So, a safe consumption site, the food, and affordable housing now, those are the major major priorities. They are intersecting crises that are going on for the people that we work with.

*Interviewer:* In the clinic what do you think could be expanded?

*Interviewee:* More food for sure. Clothing would be good. Basic survival things. If we could miraculously make more nurses appear and hire them, then we could be seeing people more often or more promptly to try and keep people out of the emergency rooms for primary care issues.

*Interviewer:* Do you foresee any large hurdles or obstacles arising from trying to implement this kind of programming?

*Interviewee:* Yeah. money.

*Interviewer:* Aside from additional funding, do you think there is anything the Government could be doing to help these issues and help implement social prescribing?

*Interviewee:* In terms of the supervised consumption sites, making an exemption for allowing inhalation use. The smoke free Ontario act is currently preventing that from moving forward, so having a formal exemption from that to allow safe consumption that are already operating to expand what they are offering. Also, to have them in way more communities, not just to have them in Peterborough.

The Ontario Government could recognize the work that we are doing in safer supply, because currently we are getting funding from the federal government. The conservative government does not support safer supply. The provincial government should be supplying the funding through healthcare. It should be like any other branch of health care.

*Interviewer:* On a daily basis roughly what percentage of the patients you see struggle with or have one of the following:

Mental Health Illnesses

*Interviewee:* 90%. Maybe more

*Interviewer:* Diabetes

*Interviewee:* I'm not a clinician, so I'm not aware of that.

*Interviewer:* Unstable or no housing

*Interviewee:* At one point in our program, it was over 60%. How do you help people when their most basic needs are not being met? On a daily ongoing basis, how does someone recover or get better from anything else when they are sleeping outside in a tent in February? The housing bit is huge.

*Interviewer:* Food insecurity

*Interviewee:* 100%

*Interviewer:* Mobility issues

*Interviewee:* Not sure.

*Interviewer:* Do you have any other questions or comments you want to make?

*Interviewee:* Having things for people to do, if people are feeling outcast, or stigmatized, or criminalized in the community that really affects their self esteem and their sense of worth. Having things for people to meaningfully engage in, the art, the garden, the puzzles. Having something to physically do is very important to do, and we get a ton of engagement from people taking part in these things. It's really nice to see people's talents come out, having a sense of pride, and getting positive feedback from the staff is so important.

The garden is great, not just for our people, but sharing food with others in the community.

*Interviewer:* Do you hear feedback from the programming?

*Interviewee:* Yes, and it is largely positive.

## **Interview 5**

*Interviewer:* What is your role at the clinic?

*Interviewee:* I am a nurse practitioner.

*Interviewer:* How long have you done that here?

*Interviewee:* I started here in 2020. So, at first, I was virtual, and it was kind of weird.

*Interviewer:* How long have you been a nurse or nurse practitioner?

*Interviewee:* I have been a nurse practitioner since 2018.

*Interviewer:* What does social prescribing mean to you?

*Interviewee:* Those people who are vulnerable and suffering from isolation, looking at ways to through a medical lens find a way for them to not be isolated. Right now, what we can do is limited, but we have a YMCA pass, which is supposed to be for people getting physical activity, sometimes I use it just to get people out of the house and support their mental health. We also have some really isolated elderly people who live in nursing homes and through the lockdowns had a lot more insolation than the average person. Everyone felt it through COVID lockdown, but some of those retirement homes that were locking down the whole place, still are, when the rest of the community has moved on. So sometimes we go out for home visits, and there's not a whole lot of medical care that we do, but we sit with them for an hour, maybe once every two months.

*Interviewer:* When you first see patients, do they get forms that help identify these more non-medical needs?

*Interviewee:* We used to when we did initial intakes, we did demographic forms. I think it's less formal now.

*Interviewer:* When you first see a patient then, I guess you are maybe asking some questions that help you identify their mental and social needs?

*Interviewee:* Yeah, we always ask where their income comes from. If they are on ODSP they might not have the same social level as someone who is out in the workforce everyday. So some hidden questions kind of assess that too.

*Interviewer:* Internally what would you say is the most common social prescription you are offering?

*Interviewee:* On the primary care side, we are a little bit more limited. I think I most frequently do the YMCA pass in my practice. The bus passes don't need to go through a nurse practitioner, they don't need an order for that. So that might be happening, and I just don't know about it. The other thing I have done is that some people on ODSP have forms I can fill out for them that says, "Need Travel To" and I put the Y(MCA) as a place they need ODSP funding for. So, if someone can't use the bus or something, if I fill that out, they can get ODSP funding for a taxi if they need it.

*Interviewer:* Externally, are there any community organizations you find yourself linking patients with?

*Interviewee:* A lot of our patients are linked with shelter systems. Which isn't a recreational program, but is a community, I guess. There's also the friendship center for people with indigenous roots, so there's a link there and they provide social services depending on what the person qualifies for.

*Interviewer:* When issues do patients face that make you recommend these services?

*Interviewee:* We have a really wide range of isolated individuals and people that fall fairly low on the social determinants of health scale. We have refugees from all over the world, including lots from Syria, there are some who are younger and have come here without their families and they don't speak the language. That is one catchment area and I've already talked about the elderly who are secluded. We have people who use drugs who sometimes have lots of friends who have passed away from overdose, so they are at risk of social isolation. So, it is a wide range of people.

*Interviewer:* When you are recommending services, do you get feedback?

*Interviewee:* Mostly positive. Sometimes negative if they can't access it, like getting a bus pass, but the routes aren't helpful for where they were hoping to go. Sometimes there's people who would love to join a yoga class or soccer club for example, but finances are a big barrier, when we have those brainstorming sessions, we discuss hobbies and things they used to enjoy and I'll often hear things like "I used to love yoga, but I can't do it anymore, because I can't afford it". So having funding for those things would be super helpful.

*Interviewer:* Do you think the clinic should increase access to social prescriptions, and if yes, what do you think should be done?

*Interviewee:* Our clinic is a small but growing team. We used to do a lot of things in the clinic, like before the pandemic we had a dietician who would do cooking classes. Then when the pandemic hit all of that kind of dispersed. Since the pandemic our team has grown a lot, but our space hasn't, and the needs of our population has also shifted. We often talk about our social working program, if we could have group therapies to help more people than just one-on-one therapy would. We also envisioned what would be easy for the groups, which would be things like having bus passes or movie tickets or art programs, where we can say here's a referral, go do this thing. It puts less pressure on the clinic itself to be offering a bunch of programming.

*Interviewer:* If you expand programming in the clinic, where would you want to see that programming expand?

*Interviewee:* I think access to multidisciplinary programming. Things that would help my patients both socially and medically, like group programs where you have lots of people in.

Often those are driven by “we will feed you if you come”, because we have a lot of food insecure individuals. If we could do things where there’s also an educational aspect to it too that would be great. Like the cooking classes, there’s a social aspect. People like cooking, people like food, but they are also learning how to cook vegetables, how to afford vegetables. We used to have a food box program that made vegetables really affordable, it was about \$10/month and you would get weekly deliveries of fresh produce. But programming where you combine social with health they go hand in hand, and you get a good bang for your buck. Maybe a diabetes group where you go and talk about what it means to have diabetes, because right now we are doing these things in one-on-one appointments, so making it a group setting allows patients to be social with each other, while learning about things they need to know, while helping us save time.

*Interviewer:* Do you feel there are any major gaps in the services and support that Peterborough offers?

*Interviewee:* Yes, absolutely. Our access to food and shelter is very limited for our population. There is no longer a hot lunch service, so anyone who is accessing food services gets only one meal a day. Shelter has always been an issue, especially coming into winter months, it’s hard to have any kind of health care when your basic necessities aren’t being met. Psychiatry is very limited in Peterborough, you get one consult, then it bounces back to primary care with their recommendations. It can be very difficult for people, especially some of our more vulnerable patients to build any kind of trust or rapport with someone in just one session, to actually open up about what their mental health is like. So I think having any kind of psychiatry that is ongoing could be a huge benefit for a lot of people.

Access to dieticians is very limited, especially if you don’t have good finances. I’m thinking about dieticians for weight loss, eating disorders, managing things like diabetes and hypertension. We used to have a dietician here once a week, but when she retired, we had to relocate that funding to other things. Also, there are not many dieticians that only want to work once a week. Community programs for things like that would be great.

*Interviewer:* Do you see any major obstacles or hurdles arising from trying to expand social prescriptions within the clinic?

*Interviewee:* The biggest one is time and resources. Human resources, financial resources, physical resources, like space in our building.

*Interviewer:* What do you think would be the most important for the clinic (aside from funding)?

*Interviewee:* Having a very clear set of guidelines about things like eligibility criteria. This is when you can access this service, this is who things are for. I find when things are vague, when things are very open to interpretation it can be more difficult. Social prescribing is good, but it would be helpful to have really clear guidelines, like “if you see someone between this age and

this age experiencing this, you can give them this and this.” that way you don’t have to critically think every single time. Things like this also help with the abuse of power, if someone knows they can get a free movie pass, they might come every single week to get it, whereas having some limits on it might be good for preserving funding.

*Interviewer:* Do you feel there is anything aside from funding that could be done at the Government level that could help aid in rolling out social prescribing?

*Interviewee:* Probably a lot. It comes back to finances as the big one. But promoting it as a health promotion strategy would be great. We are in a conservative government right now and they don’t like to give money to things that they can’t immediately see a benefit from. I think the WHO understands people are dying from isolation and that it’s a critical piece of healthcare, but it’s not the same as having a statistic of “x number of people are dying of heart attacks secondary to smoking” which is a clear cut this is how you fix that. This is more difficult because it is so broad.

*Interviewer:* On a daily basis roughly what percentage of the patients you see struggle with or have one of the following:

*Interviewer:* Mental Health Illnesses

*Interviewee:* Broadly 100%. Specifically about 90%, like they are actually diagnosed. About 50% of my appointments mental health is one of the big things talked about.

*Interviewer:* Diabetes

*Interviewee:* About 40%. It’s higher than the actual population for sure.

*Interviewer:* Unstable or no housing

*Interviewee:* At least 50%. It’s hard because a lot of them with no housing don’t actually make it to the clinic. The people that I see are more likely to be housed than some of the ones we are trying to help.

*Interviewer:* Food insecurity

*Interviewee:* Probably 80-90%.

*Interviewer:* Mobility issues

*Interviewee:* 60%. Respiratory mobility can be a factor as well as more obvious physical mobility.

*Interviewer:* Do you have any other questions or comments?

*Interviewee:* No, I think that was really thorough.

## **Interview 6**

*Interviewer:* What is your role at the clinic?

*Interviewee:* I am one of the social workers.

*Interviewer:* How long have you worked in that role at the clinic?

*Interviewee:* 2.5 years.

*Interviewer:* How long have you been a social worker for?

*Interviewee:* Since 2005. So 18ish years.

*Interviewer:* What does social prescribing mean to you?

*Interviewee:* Just from this morning, I would say it is physicians and other HCP's suggesting or recommending activities for folks to go to if they are feeling isolated or they have poor mental health. If they have mental or physical barriers giving them activities for them to feel more connected, to help them experience some improvement in mental health.

*Interviewer:* How would you say you practice social prescribing in your role at the clinic?

*Interviewee:* As a social worker, it's one of those things that are in the fabric of the profession. You are looking for resources and things to support people out in the community, things that can provide things for people or help connect folks. So, when I'm having a conversation with people and they tell me "I haven't been getting out of the house much, I'm feeling unmotivated and tired. I wish I could get out more, even just walking more, but I don't want to do it alone." Then in my mind I can be sifting through my mind about different resources in the community that might help them, while keeping in mind any barriers specific to my patient. So, it's kind of like having a filing system in the brain of different resources.

*Interviewer:* Are there some resources you find yourself recommending to patients more often than others?

*Interviewee:* Yes. CMHA is one, Elizabeth Fry society, and the YMCA. Those are more common because we are more connected to those populations we are working with.

*Interviewer:* Internally are you recommending anything for patients?

*Interviewee:* No, we don't have any group programming. We have talked about things, but with the pandemic and so many restrictions and changes in our physical space. We needed to keep a place for staff to work out of and we had to prioritize that.

*Interviewer:* Where would you like to see internal programming added?

*Interviewee:* Oh gosh, there are so many things! I think a mental health drop in a group would be great. Have a different topic each week and spend the session unpacking topics like anxiety, sleep disturbance, depression. Something folks can drop into on weeks they want to with no mandatory attendance. Some sort of cooking thing, where people can come out and learn to make meals on a budget. I think it's one thing to come up with a meal plan, but come up with something realistic for the tight budgets they might be on, then they could also take some food home for free from that.

*Interviewer:* When you first see patients are there any forms they fill out first that help identify their mental or social needs?

*Interviewee:* No. I feel like we are very fortunate, we don't have any paperwork a person would be required to fill out for an assessment or a screening tool. As soon as they come into the sessions we can start working on things immediately, and having an explorative conversation around resources. It has a very conversational feel to it.

*Interviewer:* Do you have specific questions, or just let the conversation flow?

*Interviewee:* It's really tailored to what the person brings into the room. I don't have a preplanned mental template of what I'm going to ask, cause it's not my agenda. It's the clients. It has been single session therapy since I joined here. A person will come in for an appointment and they will be asked what they are hoping to get from therapy, then I ask follow up questions based on that.

*Interviewer:* Do you feel there are any gaps in the Peterborough community that you would like to see addressed?

*Interviewee:* Top two would be housing insecurity and food insecurity. It's heartbreaking to see how many people and families are struggling by not having a place to live, and food is becoming increasingly difficult to afford as well.

*Interviewer:* Internally do you see any obstacles arising from trying to implement social prescribing here at the clinic?

*Interviewee:* Yeah, I think we have to balance what we would like to have available for clients, versus what are the realistic expectations of what we could have available for clients.

*Interviewer:* What kind of support do you think the clinic needs to implement social prescribing?

*Interviewee:* I think money is the big one of course. Money is the root to everything. More space to run groups, we could have maybe multiple groups a day.

*Interviewer:* Do you feel like there is anything the government could be doing besides providing funding for clinics like this one to help implement social prescribing?

*Interviewee:* Aside from funding, it would be really nice to see an openness for them to understand the importance of social prescribing. And an open mind to be creative about what fits the scope of social prescribing, instead of just the narrow lens of “oh we can give out bus passes, or food vouchers”, really expanding the landscape and being open to creative thought. Peterborough might be able to think of some amazing things, but there might be government red tape around that.

*Interviewer:* On a daily basis roughly what percentage of the patients you see struggle with or have one of the following:

*Interviewer:* Mental Health Illnesses

*Interviewee:* 100%

*Interviewer:* Diabetes

*Interviewee:* I have no clue.

*Interviewer:* Unstable or no housing

*Interviewee:* Lowballing 50%.

*Interviewer:* Food insecurity

Lowballing again 70-80%

*Interviewer:* Mobility issues

*Interviewee:* *Interviewee:* Maybe lowballing 60-70%

*Interviewer:* Do you have any other questions or comments for me?

*Interviewee:* No, but if I do I will reach out.

## **Interview 7**

*Interviewer:* What is your role at the clinic?

*Interviewee:* I am a nurse practitioner. I do mostly primary care.

*Interviewer:* How long have you been doing that here?

*Interviewee:* Since October 2021.

*Interviewer:* How long have you been a nurse or a nurse practitioner?

*Interviewee:* I graduated as an NP in 2019. I started in March 2020 2 weeks before everything shut down.

I was an RN for about 2.5 years, and worked in Saskatchewan. Then I went to school in Ontario to be an NP

*Interviewer:* What does social prescribing mean to you?

*Interviewee:* It's something to try and help people with their mental health, but also their physical health. I find myself giving out gym memberships or connecting them with social workers.

We do a lot of nutrition stuff as well, sometimes even giving our meal vouchers.

*Interviewer:* What would you say is the most common social prescription that you give out on a day-to-day basis?

*Interviewee:* We do a lot of transportation. A lot of nutritional things, working through diet forms to help them get additional funding for if they might be lactose intolerant, or celiac. Giving out passes to the Y as well.

*Interviewer:* Before you see a patient, do you have any forms that people fill out to identify their social and mental needs?

*Interviewee:* I think it's been kind of a non-traditional hand over here; I'm taking over a practice from someone else. So patients have already been coming here, but I just haven't met them. So some people might have already gotten things from the previous NP, and they just need me to continue signing off on it so they can get their funding. I don't have a traditional intake process.

I'm their new NP, but I'm taking over a chart that's already been completed. Sometimes there might be a worker from OW or ODSP that might get in contact with me, and I'm quite happy to talk to them about resources and finding anything I can advocate for the patient. We do a lot of group conferences as well, like if they are seeing a social worker here and have an ODSP worker, sometimes we will all get together in a room and see what we are doing for the patient and how we can help each other in what they are doing for that person.

*Interviewer:* Do you have any specific questions you ask when you first see a patient to get an idea of their social and mental health?

*Interviewee:* It's kind of difficult because some of them maybe saw a different NP 3 years ago, and they are coming in to follow up on that problem. So a lot of stuff might already be in the chart. So it is a lot of just continuing care. There is often already something a patient is coming in for, like maybe they haven't been able to get their medication for 5 years, but they are ready to start again. So we might talk about why they weren't able to access their meds during that time and what was going on in their life then.

A lot of our people are very chaotic, and they want something addressed now, so you just try to get as much done for them in that appointment as possible, because it might take another 5 years before you see them again. You might never see them again.

*Interviewer:* Are there any community organizations you find you are linking people with more than others?

*Interviewee:* It's difficult because with COVID a lot of things have shut down or scaled back. A lot of things that were available are just coming back, just getting their funding back, so they are trying to work through their wait lists. So there is a lot of back up on some of that stuff too. We knew even before the pandemic that mental healthcare was lacking and as we were going through the pandemic the need for mental health support became even more apparent. We have never had adequate mental health support, and we will continue to not have the mental health stuff, mental health is not a priority necessarily. I think we have been so fractured because of the pandemic, and each organization has been trying to keep themselves afloat. I feel like now we are kind of spread thin, because we have CTS and the encampment and all this other stuff, we are trying to help all these other organizations.

In terms of outside programs, I suggest a lot of people use Elizabeth Fry, CMHA. A lot of our people are on passports funding or alternative funding, so they get support or connections through that.

*Interviewer:* When you are connecting people with internal or external supports, what kind of feedback do you get?

*Interviewee:* We do taxi fare, transportation is often covered by ODSP, and we have to fill out forms for people. It usually works out and they are happy, they just have to return occasionally to get us to sign off on it.

*Interviewer:* Do you think the clinic should increase access to social prescribing, and if yes what could you do to increase access?

*Interviewee:* We have a lot of partners, like Elizabeth Fry. They try to reach out and tell us about their programming, but it can be hard to stay in touch. Sometime I try to refer people based on these things, but then I hear back from them that there is a wait list or that they aren't eligible. It would be nice if we could maybe get more gyms and community centers involved. But mental health programming would be huge.

*Interviewer:* Internally, where would you like to see programming expand?

*Interviewee:* Pie in the sky dreams, it would be nice to get back to community kitchen stuff. Like how to make food for themselves on a lower budget, how to make a filling meal, then they could also take that with them home. It would be nice to get more self regulation groups, like groups where people could do art sessions, or yoga sessions. Having more involvement outside of coming in and just seeing the NP, having more social support programs.

*Interviewer:* Where do you feel like there are gaps in services in the Peterborough community?

*Interviewee:* Mental health. It's mental health, I think people everywhere, not just in Peterborough are crying for additional support. We have never had a sufficient system and it has only gotten worse. The burnout in mental health care has also been significant, which snowballs into worse mental health services.

*Interviewer:* Where do you see any obstacles arising from trying to implement social prescribing?

*Interviewee:* A lot of our people are disorganized. Not to be mean of course, it's just a lot of our people struggle with keeping a schedule or keeping an appointment. If you give them something there is no guarantee they are going to be able to hang on to it for longer than the day. If you give them a lotion, they might lose it in a couple of days. Or you give them a prescription, they might take it for a couple days, then they lose it, or could even be taken or stolen from them. So if it were something they had to take with them physically, they might have trouble using it, like if it was a ticket for next week, it's likely they wouldn't be able to keep it that long.

How much of a priority is it for them, do they have the time. Some people don't know hour to hour what their day is going to look like, so to give them a ticket and be like "hey we have this show in 4 weeks from now" they won't show up. A lot of people can't even make appointments they make for the next day a lot of times. So keeping that schedule, if it's a specific time they have to show up that can be difficult for some of our patients too.

*Interviewer:* What do you think are some of the main supports aside from funding that the clinic needs in order to implement more programming?

*Interviewee:* Aside from funding. We are going to be losing an NP in a few months, we are going to be down a SW. The staff turnover here is very high, and patients can get frustrated with that. They come in and meet somebody and they find they have good rapport, but then they come back, and that person is gone. Some people have been pleasantly surprised that when they came back a year later, I was still here.

Staff retention here is really difficult, I think it's a combination of the population that we work with and burnout in healthcare in general.

Space wise we are also struggling. SSP is great, and I respect what they do, but they take up half of our clinic. With the number of people, we have hired and the number of staff we are trying to retain, it makes it difficult for staff to all have somewhere to do what they need to do.

We lack the physical space to increase programming. The cooking stuff used to happen on the SSP side. There used to be a stove, fridge, microwave all those things over there, but now it's focused on SSP and being an art space.

*Interviewer:* Do you think there is anything the Government could do aside from funding to assist in implementing social prescribing?

*Interviewee:* Yeah, other than funding, which is bedrock. If we could stop dismantling the public healthcare system that would be fabulous. I think we both are very aware of what's happening with this movement towards privatization, and it's very concerning. Especially for a lot of the people that we serve here, they rely on the government for their funding and a lot of their ability to access anything. So it is difficult when the government wants you to pay for everything and you can't pay for it.

*Interviewer:* On a daily basis roughly what percentage of the patients you see struggle with or have one of the following:

Mental Health Illnesses

*Interviewee:* Probably like 99% of them. The vast majority, even if it's not the specific thing they are seeing me for, it's usually a big factor in their care and their day-to-day life.

*Interviewer:* Diabetes

*Interviewee:* I don't see them regularly. Katie does quarterly diabetes check ups. Probably about 20-30% of people who see me also have diabetes.

*Interviewer:* Unstable or no housing

*Interviewee:* 60-70%. Over half for sure.

*Interviewer:* Food insecurity

*Interviewee:* Everybody, honestly. So, 100%.

*Interviewer:* Mobility issues

*Interviewee:* Maybe 1-2 people a day and I see 8-10 per day, so I'd maybe say 10-20%.

*Interviewer:* Do you have any other questions or comments?

*Interviewee:* I would love to have better connections between organizations. We often get emails from individual organizations saying they are doing this or that, but I find it very fragmented. Since COVID I find communications between organizations difficult. A lot of people are trying to do it from a grassroots place as well. I know a lot of people in the community are doing really amazing work, for us we just wonder sometimes how do you get in touch with them?

Appendix E—Example Organizations in the Peterborough Area

<b>Organization</b>	<b>Contact Information</b>	<b>Website</b>	<b>More Info</b>
Four County Crisis Response	705-745-6484	<a href="http://www.cmhahkpr.ca">www.cmhahkpr.ca</a>	24-hour, confidential crisis support via phone, outreach, email and chat online – 24/7. Ages 16 and up.
Community Counselling and Resource Centre	705-742-4258	<a href="http://www.ccrc-ptbo.com">www.ccrc-ptbo.com</a>	Services include professional counselling, credit counselling, community service orders and a housing resource centre
Hope for Wellness Help Line	855-242-3310	<a href="http://www.sac-isc.gc.ca">www.sac-isc.gc.ca</a>	Immediate support for emotional distress. Telephone and online counselling are available in English, French, Cree, Ojibway, and Inuktitut.
Four Counties Addiction Services Team (Fourcast)	705-876-1292	<a href="http://www.fourcast.ca">www.fourcast.ca</a>	Out-patient services for individuals and/or family with addiction. Serving the counties of Peterborough, Northumberland, Haliburton, and the City of Kawartha Lakes.
Telecare Distress Centre of Peterborough	705-745-2273	<a href="https://www.telecarepeterborough.org/">https://www.telecarepeterborough.org/</a>	This is a free, anonymous, and strictly confidential 24-hour call line for people in need of a friendly person who will listen.

Canadian Mental Health Association	705-748-6711	<a href="https://cmhahkpr.ca/">https://cmhahkpr.ca/</a>	Various support and programs for individuals with mental health challenges
Kawartha Sexual Assault Centre	24-Hour Crisis Line: 1-705-741-0260	<a href="https://kawarthasexualassaultcentre.com/">https://kawarthasexualassaultcentre.com/</a>	KSAC is dedicated to supporting those affected by sexual violence and harm. In Peterborough, we offer crisis support, advocacy and accompaniment, individual counselling, group counselling, workshops, and prevention education.
Salvation Army	705-742-4391	<a href="https://mpeterborough.wpengine.com/?i=12531&amp;mid=1000&amp;id=305246">https://mpeterborough.wpengine.com/?i=12531&amp;mid=1000&amp;id=305246</a>	Offer free meals and food bank
One Roof Community Centre	705-874-1812	<a href="https://www.onerooftbo.ca/">https://www.onerooftbo.ca/</a>	
Good Neighbours Care Centre	705-742-9800	<a href="https://centraleastontario.cioc.ca/record/PET1420">https://centraleastontario.cioc.ca/record/PET1420</a>	Food bank
Sacred Heart	705-740-2071		Food Bank
Food not Bombs		<a href="https://www.foodnotbombspeterborough.org/">https://www.foodnotbombspeterborough.org/</a>	Community meal every Monday 6:30-7:30pm across from City Hall
Victim Witness Assistance Program	705-755-5150	<a href="https://www.ontario.ca/page/victim-services-ontario">https://www.ontario.ca/page/victim-services-ontario</a>	Support before and at criminal court; trial prep; victim advocacy, crisis intervention, and referrals.
PTBO Legal Clinic	705-749-9355	<a href="https://www.ptbo-clc.org/">https://www.ptbo-clc.org/</a>	Legal services for housing, workers rights, human right, domestic violence and more
Peterborough Social	705-748-8830	<a href="https://www.peterborough.ca/en/city-services/ontario-works.aspx">https://www.peterborough.ca/en/city-services/ontario-works.aspx</a>	Ontario Works provides help with

Services – Ontario Works			basic needs (like food) and shelter (like rent) to eligible people in need living in the City and County of Peterborough. You can also receive drug and dental benefits or help with child care and avoiding eviction or utility disconnection.
Aboriginal Housing	866-391-1061	<a href="http://www.ontarioaboriginalhousing.ca">www.ontarioaboriginalhousing.ca</a>	To provide safe and affordable housing to urban and rural First Nation, Inuit, and Métis people living off-Reserve in Ontario
Nijkiwendida Anishnaabekweg	705-741-0900	<a href="http://www.nijki.com/">http://www.nijki.com/</a>	Counselling & Healing Services for Indigenous Women & Their Families
Nogojwanong Friendship Centre	705-775-0387	<a href="http://www.nogofc.ca">www.nogofc.ca</a>	The Nogojwanong Friendship Centre strives to enhance the quality of life for Indigenous People in the City of Peterborough and the surrounding area. It provides a place of acceptance and well-being for urban Indigenous people through a wide range of community-based programs & services.
New Canadians Centre	705-743-0882	<a href="https://nccpeterborough.ca/">https://nccpeterborough.ca/</a>	Supporting immigrants, refugees and other

			newcomers in the Peterborough and Northumberland regions.
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