Value and Resources for Social Prescribing

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SOCIAL PRESCRIBING FEASIBILITY STUDY

Assessing the Potential for an Accessible Mental Healthcare Service through Community Interactions and Unique Requirements

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Abstract

This report will evaluate the feasibility of integrating social prescribing services into the Peterborough 360 Nurse Practitioner-Led Clinic (NPLC). The clinic focuses on preventative care and health promotion, aiming to address healthcare barriers faced by various marginalized groups through accessible primary care services. Social prescribing is a holistic and patient-centred approach to healthcare that intends to encourage interconnectedness, health promotion and empowerment through different social activities in the community. The research includes a literature review on social connectedness, implementation strategies, and international examples of social prescribing followed by interviews with staff members of the clinic regarding their opinions on the feasibility of social prescribing. In addition to this, a resource table was completed including local resources in the community that could potentially be incorporated into a social prescribing program if found to be feasible. The findings indicate strong support for the integration of a social prescribing program at the clinic, with the belief that such a program could mitigate depression factors and foster a sense of belonging. However, the results suggest that there are larger, more imminent issues that must be addressed before re-assessing the need for social prescribing, highlighting a demand for system navigation, additional funding, awareness promotion, and strategic planning. The research indicates a high rate of staffing burnout within the healthcare system, which discourages the adoption of a social prescribing program at this time, as it would require additional staff members to coordinate and lead such an initiative. Overall, the research aims to discover strategies to overcome identified barriers to improve the mental healthcare system which could eventually lead to the implementation of programs like social prescribing, as it was not found to be feasible at this time.

Introduction & Background

In the constantly changing environment of primary healthcare, providing comprehensive, accessible services to all members of the community has always been of the utmost importance. Primary care is known as the first point of contact for individuals seeking a variety of healthcare services, focusing on preventative measures while addressing all domains of well-being, typically consisting of family doctors, nurse practitioners, and other medical professionals. The Peterborough 360 Degree Nurse Practitioner-Led Clinic (NPLC) prioritizes preventative measures and health promotion with an emphasis on the healthcare barriers that marginalized groups encounter. The clinic strives to provide accessible and inclusive primary care to individuals who are struggling within the community, whether that be from poverty, trauma, homelessness, social isolation, or mental health. While delivering primary care to a wide range of clients in the local Peterborough area, the NPLC currently has a lengthy waitlist for new clients due to a lack of resources, staff, and funding.

Background research has shown the many benefits of social connectedness and a perceived sense of belonging such as enhancements to mental health, quality of life and overall well-being. Social interaction and community involvement have been shown to provide individuals with a sense of purpose, reducing levels of stress and anxiety while increasing resilience, empathy, and self-worth (Foster et al., 2020). An intervention known as Groups 4 Health (G4H) which works towards both cultivating and sustaining group memberships to better individual health supported this finding (Haslam et al., 2019). G4H was initially developed with the understanding that social groups such as our chosen support systems can influence our emotions and behaviours such as whether we adopt certain habits (Haslam et al., 2019). With this in mind, Haslam et al. (2019) hypothesized that feelings of loneliness among participants would be reduced significantly with more time spent in the group interventions. They found sufficient evidence to conclude that when compared to treatment-as-usual, those who participated in group activities experienced a reduction in social anxiety and levels of loneliness (Haslam et al., 2019). Individuals with comorbid, chronic diseases or disabilities are typically within the top 10% of frequent attenders with primary care physicians and with significantly more medical appointments than those deemed to be ‘healthier’, they are more likely to experience interpersonal issues or solitude (Cruwys et al., 2018). In the context of primary healthcare and the different domains of these services, the existing literature addresses the non-clinical concerns

that come with aging including social isolation, community involvement, and loneliness (Costa et al., 2021). After reviewing articles, controlled and non-controlled studies, as well as mixed-methods studies, Costa et al. (2021) found that eight out of ten studies examining psychological well-being concluded that social prescribing – a newly emerging approach to healthcare – had a positive impact on the individual.

Understanding the fundamental need for human interaction and the consequence of social isolation represents the foundation for social prescribing and its incentives for development. Social prescribing is a holistic and patient-centred approach to healthcare that aims to encourage interconnectedness, health promotion and empowerment through different social activities (Centre for Effective Practice [CEP], 2023). A large component of social prescribing is not only suggesting certain social activities but ensuring they are completely accessible to all clients, in this case specifically marginalized groups of people. Health promotion in this context is referred to as a systematic approach between healthcare professionals and clients to enhance overall health, consisting of different strategies to prevent disease or injury while encouraging healthy behaviour and lifestyles. This includes prescribing activities ranging from paint classes, a group hike, cooking classes, or book clubs (CEP, 2023). As our society grapples with inequalities in access to healthcare, particularly for vulnerable populations, the concept of social prescribing emerges as an alternative route, aiming to break down the barriers faced by these individuals. The inverse care law is a concept which suggests that those with the greatest need for healthcare are often at the greatest disadvantage and receive the least attention, meaning those who stand to gain the most from social prescribing are socially isolated and are the most difficult to form meaningful connections with (Brown et al., 2021). The project completed with the 360 Nurse Practitioner-Led Clinic (NPLC) seeks to better understand the unique requirements of the community and explore the feasibility of providing accessible healthcare through social prescribing, attempting to combat the inverse care law.

Through literature review and background research, a few key elements of social prescribing have emerged, outlining the requirements for the successful initiation of these services. Two of the most significant features of a social prescribing program are the creation of an individualized plan for clients and the existence of a link worker or coordinator who is often the creator of these plans (CEP, 2023; Paquet et al., 2023). Rather than solely relying on clinical treatment, social prescribing incorporates a link worker, who works collaboratively with clients

on a needs assessment – a structured process developed to identify and understand specific requirements and challenges relevant to individuals within a community (CEP, 2023). A link worker facilitates social prescribing by using the needs assessment to connect general practitioners, community services and patients to determine what kind of social activities the client would enjoy and benefit most from and how the client can access their chosen form of social connectedness. Within the literature, social prescribing programs were found to be most successful when incorporating medical professionals who can refer patients to link workers, who then establish a unique and effective care plan (Paquet et al., 2023). In addition to this, the need for educated and skilled link workers was identified, specifically when developing relationships with patients as this was found to enhance the level of personalization and care incorporated into each plan (Foster et al., 2020). In the study completed by Foster et al. (2020), participants regularly attended social activities as part of their personalized care plan such as leisure facilities, art classes, and craft groups and findings showed evidence of an increased sense of well-being and confidence as well as improvements in quality of life.

Some other key features identified from research on current social prescribing programs in areas ranging from the United Kingdom to Catalonia and Italy include adequate referral mechanisms, follow-up check-ins, strong local relationships, creation of community alliances, and proper training of primary care professionals (Baska et al., 2021). Each of these countries have attempted a form of social activity as a way of treatment, most of them closely linked to the primary health care system but all with a similar goal; to empower, support and educate all kinds of communities (Baska et al., 2021). However, these countries received specialized funding dedicated to the creation of social prescribing programs, coming from a partnership with the government in England, the National Lottery in Ireland, and many rounds of funding from the government in Wales (Baska et al., 2021). In the United Kingdom and Catalonia, social prescribing was found to be integrated into the pre-existing primary healthcare system, with the addition of websites to be used by healthcare professionals, community-based activities to be used alongside medical treatment, and the use of population healthcare data (Baska et al., 2021). From 2012 to 2017 the social prescribing initiative in Catalonia has grown extensively, including 288 professionally trained participants and a primary care-integrated website including 344 activities and 1622 total resources (Baska et al., 2021). Italy was found to be lacking a structured program for social prescribing, but instead showed evidence of an initiative with similar

components in which there were social circles – organized by the clients at community centres – dedicated to activities such as card games, dancing, art, and walking tours (Baska et al., 2021). Some other global examples of strategies for delivery include self-referral and the inclusion of social prescribing services at pre-existing wellness centres (Morse et al., 2022). However, self-referral or 'signposting' which is done through providing broad resource lists without follow-up, has been considered different from social prescribing as it does not incorporate the components of tracking progress and referral mechanisms (Morse et al., 2022). According to Morse et al. (2022), programs in Spain and Portugal have chosen to make social prescribing available to all interested individuals, while other areas (Canada, Germany) include only primary care referrals, some include outpatient service referrals (USA), rehabilitation (Singapore), and acute care referrals (Australia). Some areas also incorporate standardized screening tools specifically for marginalized communities struggling with food insecurity or social isolation as well as mental health screening instruments (Morse et al., 2022). These findings highlight some of the different options for the implementation of social prescribing programs across the world, all of which have had positive outcomes, which is relevant to the current research regarding the feasibility of such a service and how it could be delivered at the clinic. Programs in other areas also address how social prescribing can be funded, and the possibilities of repurposing and reallocating resources to avoid the need for additional funding, which can directly relate to the current project and its lack of funding. Research within other regions and studies on long-term effects provide a contextual understanding of social prescribing and enhances the quality of research and impact of social prescribing implementation.

Despite the research highlighting the many positive benefits of social prescribing programs, there are many drawbacks, limitations and skepticism associated with this kind of mental healthcare service. Although individualized care plans are a significant component of social prescribing, this requires many experienced, proficient facilitators or link workers who must spend hours devoting their time to helping each client. In the case of individuals who are socially isolated, chronically ill, or experiencing poverty this kind of responsibility can be demanding and emotionally exhausting; therefore, adequate coping mechanisms and counselling for link workers were found to be crucial (Foster et al., 2020). In addition, there are many ethical concerns regarding the initiation of these programs, not only for the clients but also for the link workers and general practitioners (Brown et al., 2021). For marginalized communities, the

introduction of a holistic mental healthcare program may result in a decrease in social legitimacy that comes with medical care and medication, as well as the possibility that introducing social prescribing in the community could intensify the pre-existing injustices between marginalized populations and others (Brown et al., 2021). This could happen if social prescribing programs are implemented but not made entirely accessible (due to cost, transportation, etc.) therefore those who are more fortunate in the community are given priority, even though those who need social prescribing the most are likely individuals who struggle with funds and transportation regularly. Other ethical concerns include support for the emotional burden that is taken on by link workers, and the fact that there is no definitive line between which cases must be medical, and which can be socially treated (Brown et al., 2021). A comprehensive understanding of these ethical concerns is essential to the project as it protects participant rights, maintains research integrity, and increases the credibility of findings. Although social prescribing has been found to improve health and well-being, specifically throughout the United Kingdom in which community cohesion and identity are emphasized, some accompanying limitations include the possibility for the programs to become complex or disorganized due to the variation between models of integration and the lack of standardization (Wakefield et al., 2020). The differences in these models may cause inconsistencies in the delivery and recruitment methods due to a vague list of referral criteria and therapeutic inconsistencies. Some other challenges include acquiring sustainable funding, creating a 'culture shift from a medical model to social' and enduring a considerable amount of skepticism from the medical community (Baska et al., 2021; Wakefield et al., 2020).

The literature highlights the importance of social connectedness and how social prescribing targets the fundamental need for human interaction while also outlining the key elements and different strategies to implement a program of this variety. There are many global examples of pre-existing social prescribing programs that have been proven to be effective, despite the challenges faced by those involved. Each of these findings provide contextual understanding of the feasibility of a social prescribing program for the marginalized communities associated with the Peterborough 360 Degree NPLC and the many benefits, barriers, and strategies that will be introduced throughout the following research report. Success for this project would be characterized by a robust assessment of the community's need for social prescribing, coupled with heightened levels of community involvement, receptiveness to a novel

healthcare approach, and specific steps to be taken in the near future. Furthermore, the success of a social prescribing program specifically would entail improved healthcare accessibility, alleviating the NPLC's current waitlist and the provision of assistance and healthcare to the most vulnerable individuals. Conversely, project failure could be evident in various aspects such as inadequate or unreliable research findings, ambiguous implications, or unclear goals for the future.

Ethics

This study was reviewed and approved by the Trent University Research Ethics Board. The application included: the interview questions, informed consent forms, project proposal and letter of information. The interview questions can be found in Appendix B of this report.

Methodology

Procedure

When aiming to explore the need for social prescribing services at the 360 NPLC, a comprehensive understanding of data collection and potential sources of information is crucial to the research process. The project began by defining clear research objectives to be examined, providing a direction for the research, which are as follows.

1. What is the need for social prescribing at the Peterborough 360 Degree Nurse Practitioner-Led Clinic?
2. How can a social prescribing program be implemented at the Peterborough 360 Degree Nurse Practitioner-Led Clinic?
3. How can social prescribing impact the clients' quality of life?

The first source of information was secondary data through a literature review from a variety of existing studies, specifically academic journals and research articles. This review specifically investigated social connectedness, key elements of social prescribing implementation strategies, and current international examples of social prescribing as well as the associated challenges and barriers. This review provided background information on social determinants of health, indicated the significance of the project, and contextualized the research by providing real-world examples of social prescribing. An ethical application was completed and approved by the Trent University Research Ethics Board to interview both staff members and clinic clients, which

includes those facing housing insecurity, addiction, or poverty. Once ethical approval was obtained, participants were recruited and interviewed with a short set of open-ended questions regarding their opinions on social prescribing, mental health, and personal experiences.

The interview questions administered to the staff focused on some main factors associated with social prescribing (see Appendix B). The questions were developed using both information from the current literature as well as input from the NPLC and project coordinator. These questions were designed to assess the staff members' background knowledge of mental health as well as their opinions towards the community based on their daily interactions with clients and observations. In addition to these interview questions, an alternative form of participation was provided through a Qualtrics survey, which consisted of identical questions to be answered through an online platform. This was supplied to staff members who did not have time to complete an interview or were not available on the day interviews took place and copies of the survey link were left at the clinic for any staff members who were unaware of the project that may have been interested in participating.

Due to limitations specific to this project, clients of the NPLC were unable to participate, so interviews were conducted with staff members only. The responses to these interviews were transcribed and thematic analysis was conducted to find relevant key themes, common opinions, and patterns. This allowed for the identification of potential benefits of a social prescribing program, current barriers to mental healthcare, and recommendations to address these barriers and implement a social prescribing program. Finally, current available community resources for mental health and social engagement were examined and used to create an example resource table outlining the existing resources and social activities in Peterborough. This table includes specific organizational criteria for each resource including their level of accessibility, affordability, and inclusivity for vulnerable populations. This provides context for the existing resources available to the marginalized populations of Peterborough and how they can be utilized with the future implementation of a social prescribing program.

Data Collection

The staff members were asked what challenges they believe the community faces when accessing healthcare, if they believed social prescribing would benefit the community based on their day-to-day observations, and if so, how they think it could be integrated, including the role

they believe healthcare providers would play. They were also able to provide detailed reasoning for why or why not a social prescribing program would benefit the community, as well as insight into how receptive they believe the clients would be. Due to staffing shortages and scheduling barriers, a total of 8 staff members were interviewed, with one employee choosing the alternative survey option with identical questions. The staff members ranged from nurse practitioners (25%), nurses (25%), social workers (25%), and administrative assistants (25%). They were provided with informed consent forms and were informed of their confidentiality and right to change their minds at any time.

It is imperative to not only acknowledge potential biases that exist when interviewing staff members but to also take steps to mitigate these biases, ensuring the credibility of the research. Some potential biases that exist for this specific project include selection bias, response bias, observer bias, and confirmation bias. To avoid these, all clinic staff members were invited and welcome to participate, ranging in age, ethnicity, and gender. To mitigate response and observer biases, all participants were ensured of their anonymity and confidentiality, reducing their perceived need to respond in a socially desirable way, as identities were not exposed at any point during the project. Finally, to avoid confirmation bias, deliberate action was taken to remain neutral and objective throughout the project, engage in critical thinking, and seek diverse perspectives when gathering data. This helped to improve all areas of research and allow for unbiased, valid, and reliable research results.

Data Analysis

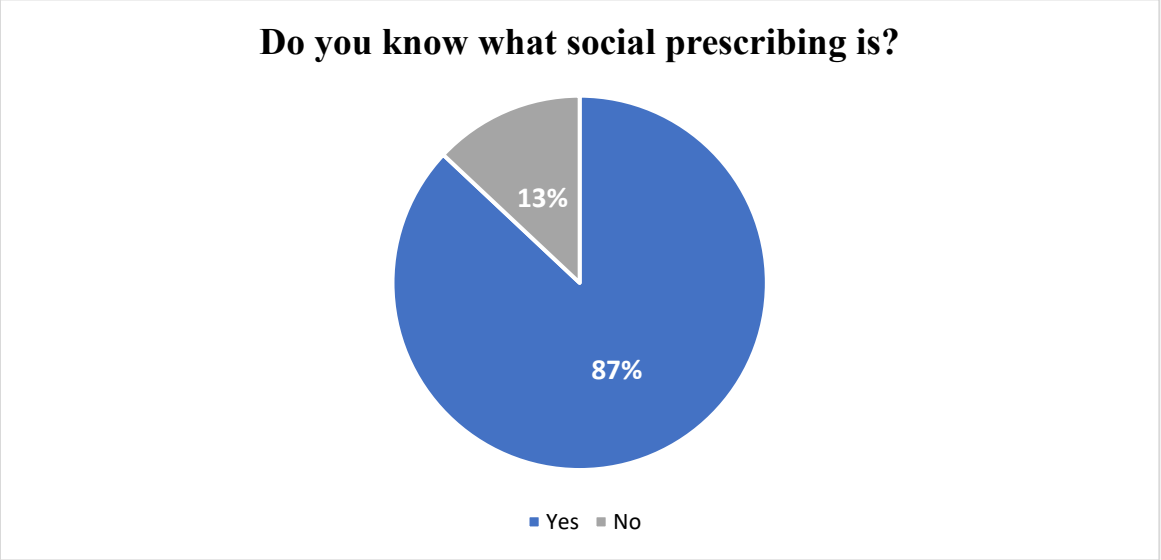
The data acquired through the interviews was manually transcribed and then categorized by recurring themes, words, and patterns through thematic and content analysis. Broad themes were identified before creating smaller, more specific sub-themes. After familiarization with the data, it was interpreted within the context of the project, revealing any existing insights into the possible benefits and disadvantages of a social prescribing program, specifically taken from the thoughts of those who would be involved the most. Throughout this stage, graphs of the data and recurring themes were created to help visualize the results, which can be found in the major findings section. These findings aim to offer valuable insight and possible next steps for the NPLC, identify barriers to a social prescribing service, how it can be delivered and whether the barriers can be overcome to positively impact clients.

Major Findings

This section of the report represents the findings of the data gathered through the interviews, which illustrate the participants' range of knowledge and perceptions regarding social prescribing and barriers. The participants were asked if they were aware of social prescribing prior to this study which is depicted in **Figure 1.** All other major findings were organized into three main categories; social prescribing beliefs (**Figure 2**), implementation strategies (**Figure 3**) and identified barriers when accessing mental healthcare (**Figure 4**).

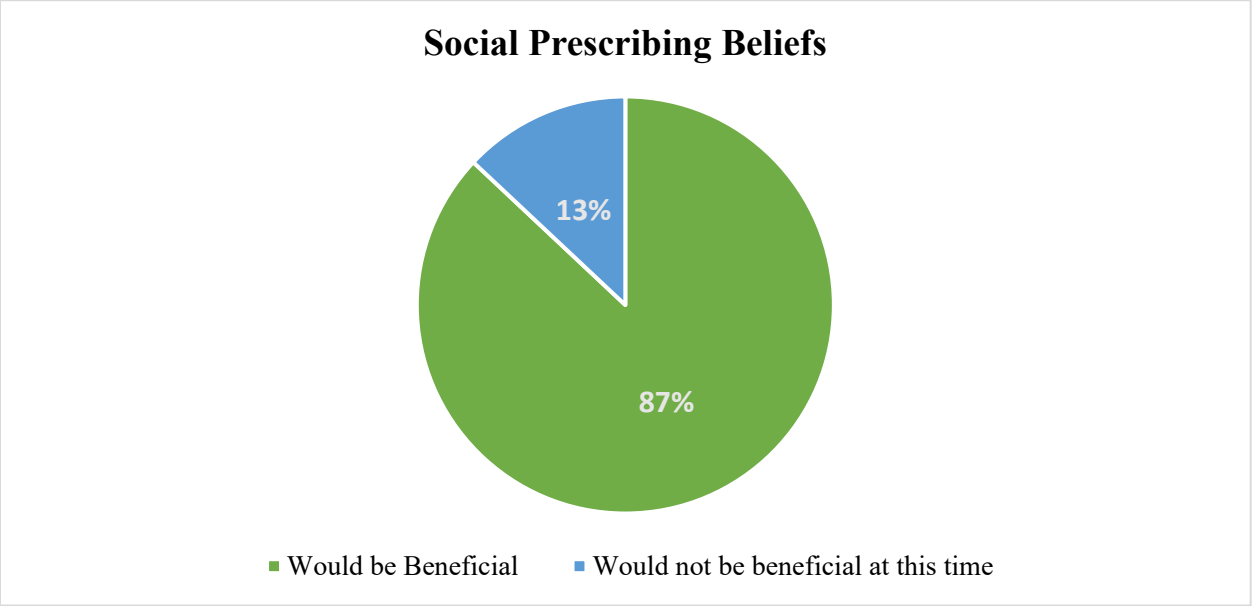
Interview Results

Figure 1: *Participants' knowledge of social prescribing*



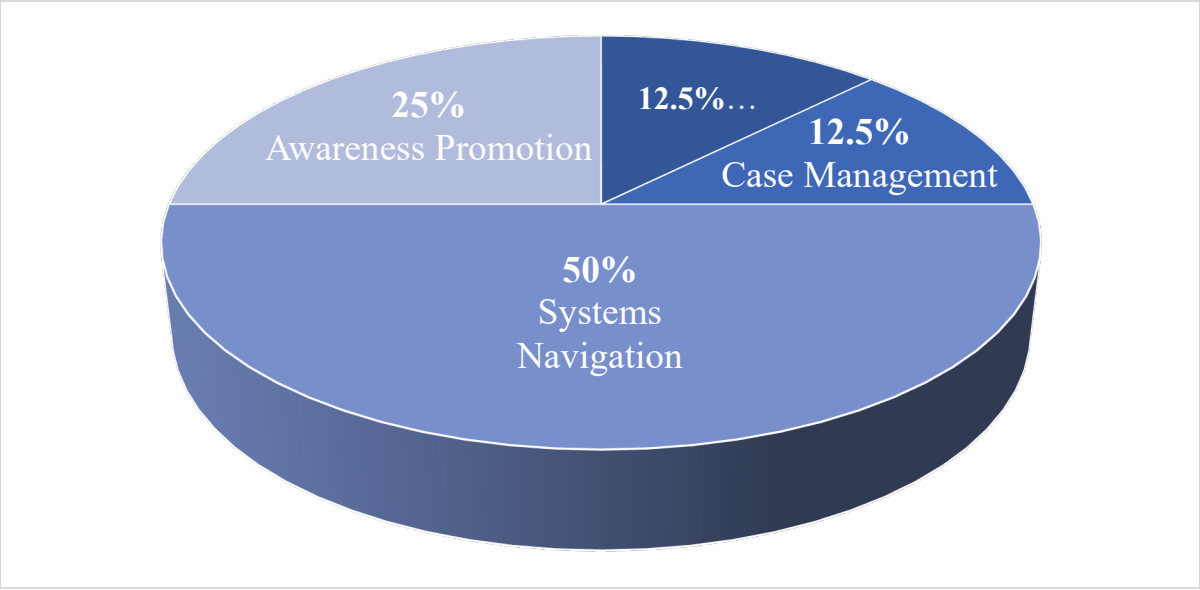
After completing interviews, 87% of participants reported they did know what social prescribing was before the study and were able to give examples of what social prescribing means.

Figure 2: *Participants' current beliefs toward social prescribing*



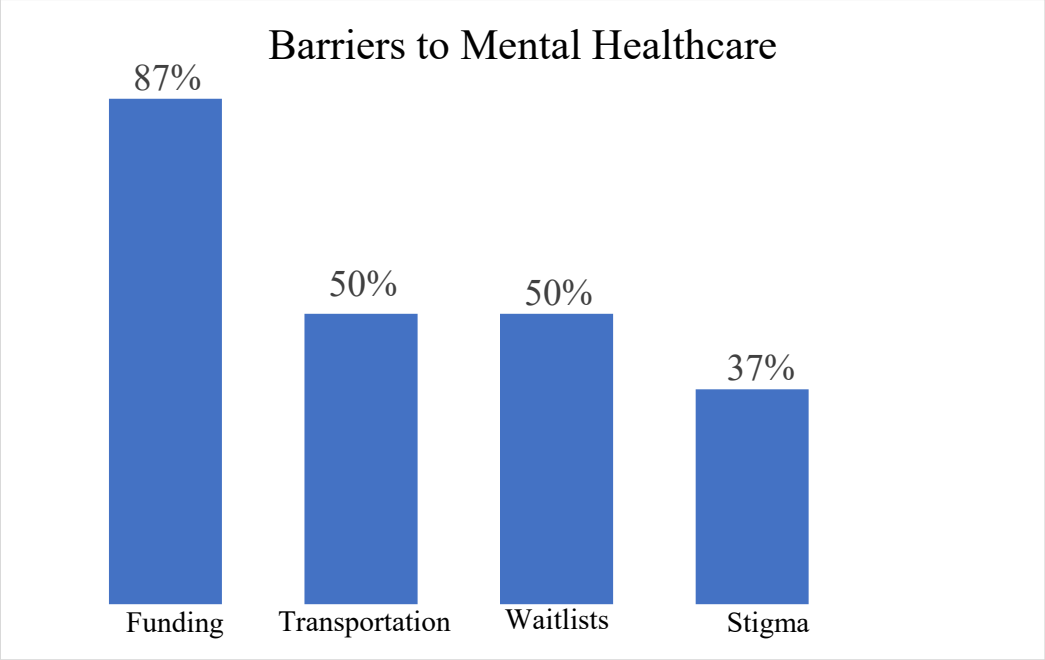
According to participants, 87% believed that social prescribing would benefit the community and specifically clients at the NPLC if implemented. The other portion of participants, 13% believed that social prescribing is not a priority when compared to other barriers and would not be beneficial at this time.

Figure 3: *Implementation strategies identified by participants*



Participants identified strategies they believed would be best if a social prescribing program were to be integrated into the clinic currently. The role of a systems navigator was the most popular with 50% of participants identifying this as a main concern amongst clients at the clinic.

Figure 4: *Common barriers to mental healthcare identified by staff members.*



Participants were asked to identify barriers they often see clients experience or barriers they are aware of when attempting to access mental healthcare. Funding was the biggest by far, with 87% of staff naming it as a significant barrier. This was followed by transportation and waitlists at 50% and stigma at 37%.

Discussion

The interviews conducted aimed to identify recurring themes, terms, and opinions among participants, which were used to make conclusions regarding the feasibility of social prescribing services at the NPLC. The main findings were organized into three categories; current social prescribing beliefs, implementation strategies, and identified barriers when accessing mental healthcare. In addition, these findings were used to identify the next steps and plans of action that could be developed to determine how these services could one day be provided and integrated into the existing clinic operations. The results of the interviews demonstrate that most of the staff members (87%) were already aware of social prescribing and what it means. One participant

reported that they believe social prescribing helps clients to "achieve more of a social life" and gives them "information on how to better their mental health." Participants understand why social prescribing may be implemented and each of its potential benefits, specifically for marginalized communities. One individual mentioned that "social determinants of health and inclusion, social interaction, and purpose are what really make an impact on people's health." This demonstrates a thorough understanding of social connectedness among staff members and supports the theory behind the benefits of human interaction and a perceived sense of belonging as seen in numerous research studies (Haslam et al., 2019; Foster et al., 2020).

The same number of participants reported they believe a social prescribing program would benefit the NPLC if it were to be integrated. The participants provided meaningful insight into the potential of a social prescribing service and their experience with clients, indicating that the low-income status of the clients would make them excellent candidates for such a program. Specifically, one participant reported that "75-85% of patients are low-income and many are experiencing homelessness" while another participant said social prescribing would provide clients with "third spaces where they can exist for free" as clients are "kicked out of the shelter from 9-4 and can only come back to sleep…they are kicked out of anywhere that is warm after 15 minutes". These quotes illustrate the staff members' compassion for the marginalized population in Peterborough, their drive to help, and their relationships with clients experiencing social isolation and other struggles. The staff members demonstrated an extensive amount of awareness and experience with marginalized communities, intensifying the credibility behind their responses. When discussing their opinions regarding social prescribing, one staff member said, "Social isolation is a major contributing factor to depression but also a symptom of depression…It would be a huge benefit to have social prescribing…It would also help the clients to branch out of their typical activities and expand their horizons…it's incredibly important to get away from some of those negative local activities and the drug scene".

When asked about existing examples of unofficial social prescribing within the clinic, one participant said, "A community garden has been really successful, it provides people with a responsibility…I've seen how positive it has been for some of the participants." In addition, multiple staff members mentioned the existence of an agreement the clinic has with the local YMCA. The staff members reported that the clinic has received funding to provide some of the clients with subsidized memberships or day passes to participate in some of the programs offered

at the YMCA, as well as the positive impact it has had on these individuals. This highlights the benefits that the staff members believe social prescribing could have for the clinic and the clients specifically, how it could improve and impact their quality of life. According to staff, these social engagement strategies have positively impacted clients, clearly aligning with the findings from prior literature regarding the sense of purpose social prescribing can provide (Foster et al., 2020). The 1 participant that did not believe social prescribing would be beneficial to the NPLC at this moment (13%) did not necessarily think that it is a negative service, but rather they believed there were more important, pressing issues and other aspects of healthcare that must be addressed before assessing the feasibility of social prescribing at this clinic. One participant reported, "I don't think we have a need for a social prescribing program necessarily… what would be helpful is system navigation," a term that was mentioned by many other participants during other parts of their interview, specifically for implementation strategies.

When asked about how they could envision the integration of social prescribing into the NPLC's daily activities, many staff members (50%) reported systems navigation to be a beneficial concept. Systems navigation can be described as the dedication to linking individuals with support, addressing treatment barriers, coordinating services, and monitoring progress (Fishman et al., 2017). One participant reported that the "system only works well if you're a good self-advocate" and another staff member shared a brief example, "If a patient has already been approved for ODSP [Ontario Disability Support Program], at no point does someone inform them of what they're now eligible for…. People are left to figure out the system on their own …even though they have already been approved for a disability and need extra support." These statements indicate the need for systems navigation, assisting marginalized individuals and those struggling to understand the complexities of the resources offered to them and providing them with specific information to expand their awareness. This aligns with the incorporation of link workers, one of the key elements of social prescribing identified within the literature to be necessary when implementing a social prescribing program (Paquet et al., 2023). As mentioned previously, employing link workers provides social prescribing clients with a direct contact, someone who can help them to identify the specific requirements and challenges they might be experiencing, and how they can develop a unique, effective care plan to overcome them (Paquet et al., 2023). A main difference between systems navigation and a link worker, however, is that the link worker would only be able to assist the client in developing their care plan specific to

their treatment, whereas a systems navigator could assist the clients with any challenges they are experiencing related to life including finances, food instability, technology, and other areas.

Awareness promotion was also mentioned by 25% of the staff members to be an important strategy for integrating a social prescribing program. According to staff, this is due to a "lack of transparency and communication from social services" and "accessing specific resources must be what the client wants, not always what the clinician wants." These staff members believe that although a social prescribing program would be beneficial to the clinic, it would be difficult to encourage clients to participate solely because they would not know it exists. In addition to this, one participant said, "Give the staff the education and knowledge of what's out there [as possible resources for social engagement] and what you can connect people to." For this reason, suggestions for increased awareness using posters, media, and word of mouth among the staff were key in future attempts to inform the clients of such a program. This supports the need for a social prescribing resource table (as seen in Appendix A), which demonstrates how these resources could be provided to the staff members to be used in their treatment process. The existing literature does mention the need for increased awareness among clients (Morse et al., 2022), however, there is limited research on social prescribing programs for individuals experiencing homelessness and poverty, making it difficult for them to learn about new programs due to a lack of access to technology and media.

Finally, 12.5% of staff members identified case management and policy to be key factors when implementing a social prescribing program. Case managers can be described as individuals who help clients develop individual care plans for recovery, identify main causes of concern, and act as an intermediary between the client and other healthcare professionals assisting with their care (Victoria State Government, n.d.). Case management is common in healthcare and is already a large part of the NPLC's processes thus encouraging staff members to suggest this as an implementation strategy. One staff member said, "The primary care team can determine what is needed from a diagnostic perspective, then it could be facilitated through mental health commissioners and social workers to practically put it in place." This quote represents how case management and the connections between multiple aspects of healthcare working towards a similar goal can be effective. The creation of individual care plans as a key factor in case management directly supports one of the main elements of social prescribing – the need for personalized plans (Paquet et al., 2023). The realization that the clinic is already practicing one

of the key factors of social prescribing supports case management as an adequate integration method for this kind of program. The suggestion for a specific policy holds similar results as one staff member believed, "Creating a policy for when to use [social prescribing] and who gets it" would be helpful. This is similar to the standardized screening tools that have been incorporated into some areas, specifically for marginalized communities which has significant relevance to this clinic's population (Morse et al., 2022). In addition, the suggestion for a policy with specific criteria implies the integration of a referral system (which can be from primary care, self-referral, rehabilitation, etc.) which is seen in many cases of existing social prescribing programs across the world (Morse et al., 2022). In general, the implementation strategies suggested by the staff members at the NPLC seem to align with the various methods utilized by current social prescribing programs in other areas, as seen within the literature.

When asked about barriers the staff members are aware of when clients are attempting to access mental healthcare, the most significant barrier identified was funding, with 87% of clients listing this. One staff member said, "[Clients] may not be able to afford the movie tickets they are prescribed or visit to the YMCA…they may have a membership at the YMCA but can only afford a month…what long-term benefits does that provide?." This specific quote provides insight into just how multi-layered the funding barrier can be for marginalized populations, specifically those experiencing poverty. This highlights the potential benefits social prescribing may have for the clients, but the lack of long-term funding does not provide a stable foundation for a social prescribing program. Another staff member said, "Finding free or subsidized options is horrendous, five dollars a day can even be prohibitive for some people," which demonstrates the potential obstacles that could arise when trying to form community alliances with potential organizations that are willing to participate in a social prescribing program. Another quote from a participant was, "For this population, even food is an issue" which emphasizes the severity of poverty some of these clients are experiencing and the bigger, more pressing issues that must be addressed first, such as food insecurity. The emphasis on funding as a barrier to social prescribing corresponds with the existing literature, as each area with a successful social prescribing program has received additional funding to specifically improve the quality of the program and allow for increases in staffing, resources, and training. This highlights the need for additional funding at the NPLC if a social prescribing program were to be implemented, which could assist with the costs of employing additional staff for case management, policy creation,

and systems navigation, help to reduce the cost of alliances with local organizations and produce different awareness promotions.

A second barrier identified by 50% of staff members was transportation, with one participant reporting, “If someone found out there was an Indigenous drum circle that meets up the street but it’s far for them, they would benefit from transportation, how can we get them there?” Due to the unique situations of the NPLC’s clients and the low-income status experienced by many, transportation is a significant barrier when attempting to access healthcare services, especially if the client requires transportation or during inclement weather. Although there are existing services for transportation to medical appointments, one staff member said, “ODSP [Ontario Disability Support Program] and OW [Ontario Works] only cover medical appointments…maybe if the activity was prescribed as medical, the transportation could be covered under these programs.” In addition, a participant reported, “Some people live outside of city limits, cabs are expensive.” Each of these statements once again emphasizes the funding barrier that is experienced by the clients as well as how social prescribing services could benefit them – when an activity is prescribed medically, it’s possible that existing services could provide this transportation. Although important, the transportation barrier is not one that is commonly found in the existing literature on social prescribing however this could be due to the lack of research on marginalized populations specifically, failing to account for those who cannot afford to travel great distances. These findings call attention to the need for local, accessible resources that can be utilized in a social prescribing program and the potential for the inclusion of incorporated transportation, such as a bus pass or taxi chit; other suggestions mentioned by staff members of the NPLC. However, even when an individual can afford the cost of an activity as well as their transportation, they are often met with additional barriers.

Another barrier identified by 50% of staff was the existence of waitlists and wait times for certain services. One participant said, “People make an effort to reach out for help, then are met with more barriers like having to join a waitlist,” which underscores the importance of individuals receiving assistance when it is most needed because if they do not, they may become discouraged in the healthcare system. Furthermore, participants reported, “waitlists are unacceptably long,” “There are free resources, but there are wait times for those free resources,” and “Getting ODSP is a huge challenge, most people are denied or waiting a year.” Each of these statements indicate how extensive wait times for resources can exacerbate the struggles that

many clients are already experiencing, and despite the current services that are available to assist these individuals, attempting to receive this assistance poses a significant challenge alone. These kinds of barriers have been mentioned in current research, specifically regarding the many injustices that exist between marginalized communities and others and how the implementation of social prescribing programs has the potential to intensify them (Brown et al., 2021). This demonstrates the occurrence of these barriers across the world among many different communities, emphasizing the need for more funding, resources and availability for mental health resources as recognized by one participant, "There has never been enough mental healthcare…there are not enough people."

Finally, the fourth significant barrier identified by 37% of staff was the perpetuation of a stigma surrounding mental healthcare. One participant said, "[The clinic] tries with every aspect to ensure patients feel welcomed, valued and equal…many patients will not go to the hospital because they will not be treated properly, they will be treated with disrespect or called an addict." This illustrates exactly how the presence of such a stigma may be discouraging to an individual attempting to seek help for their mental health and how they may be made to feel insignificant or disrespected. Mental health has carried a stigma for many years and although it is beginning to be more recognized in the general population, this stigma against those with mental illness or addictions often leads to feelings of shame or guilt when trying to battle these health issues and can worsen symptoms at times (Centre for Addiction and Mental Health [CAMH], n.d.). This has been identified in current literature as well, specifically with the skepticism that accompanies mental healthcare in the medical field and the legitimacy that is often doubted (Brown et al., 2021). This finding aligns with limitations within prior research and demonstrates why individuals may choose not to participate in a social prescribing program – out of fear that they will not be taken seriously or made to feel ashamed. This indicates the need for increased education and awareness, proper support systems, and inclusive attitudes when adopting this kind of program – which aligns with the key features of follow-up check-ins, strong local relationships, and proper training of primary care professionals (Baska et al., 2021).

Other barriers identified by staff members included a lack of access to technology, as most of the clients are low-income and do not have regular access to wi-fi, phones, computers, etc. This makes the integration of social prescribing difficult as most activity options require online registration, and some social activities take place primarily online via Zoom calls or group

meetings. This presents a barrier for most of the clients and emphasizes the need for systems navigation as mentioned before, most individuals would benefit from assistance when attempting to register for an activity, join an activity online, complete an online intake form, make a phone call, or even creating an email so they can be notified of important events in the community.

In conclusion, the interviews conducted for this research aimed to explore the feasibility of implementing social prescribing services at the NPLC, focusing on recurring themes, opinions, and potential strategies identified by participants. The majority of staff members demonstrated an understanding of social prescribing and expressed belief in the potential benefits of its integration into the clinic, citing the high percentage of low-income clients and the positive impact of existing community engagement initiatives. Implementation strategies suggested by staff aligned with existing methods of established social prescribing programs elsewhere including systems navigation, awareness promotion, case management and referral policies. However, significant barriers were identified, including funding constraints, transportation limitations, lengthy waitlists for services and the perpetuation of stigma surrounding mental healthcare. Each of these findings underscore the need for additional resources, support systems, and community partnerships to address the multifaceted challenges faced by marginalized populations seeking mental healthcare. Overall, while there is considerable support for the integration of social prescribing at the NPLC, careful consideration of implementation strategies and proactive measures to mitigate barriers are essential for the successful adoption of such services.

Limitations

Bearing these findings in mind, it is important to address the many limitations experienced throughout this study. The first is the significant staffing shortage across all mental healthcare services. In general, due to COVID-19 and other dominant issues, the presence of staff within the healthcare system is steadily decreasing, as mentioned by one staff member, “We have an acute health human resource crisis…We can’t staff hospitals or primary care…The primary team is struggling to manage the day-to-day demands of primary care…All NPLCs in the province are struggling with limited staff”. This emphasizes the high demand for additional staffing across many healthcare systems, which was a large limitation in this study. Specifically, the NPLC consists of only 16 staff members and although the sample size for these interviews (N= 8) seems small, it was representative of half of the current NPLC staff. Regardless, these

staff members are experiencing an overwhelming workload and an immense amount of stress on these individuals which can result in extremely high rates of burnout – especially in the healthcare system when dealing with marginalized individuals. This staffing crisis resulted in a lack of time to interview the staff members and although passionate and willing to participate, most staff members could barely find time for a ten-minute interview. This meant that interview questions were limited, which may have caused restrictions on the information gathered and the detail staff members felt they were able to provide in such a short time – stressing the importance of additional staffing, funding and resources provided to healthcare workers. Due to this staffing crisis, the clients of the NPLC were unable to participate in the research project.

Although ethical approval was received to interview the clients of the NPLC, it became apparent near the end of the project that due to staffing shortages, this would no longer be possible. Additional staff were required to supervise and oversee interviews with clients of the clinic and due to differences in scheduling and unforeseen staffing issues, at no point were any of the staff members available to fill this role. This resulted in an absence of input from the clients, individuals who deserve the right to be heard and voice their opinions on a matter as important as the potential integration of a social prescribing program at the clinic. Without their opinions, the findings lack generalizability because although the staff were able to voice their praises and concerns for social prescribing services, the clients were unable to explain whether they would be interested in such a program, describe explicit barriers they have experienced, or report on what kind of activities they would most benefit from. Therefore, this must be considered when making conclusions and interpreting the findings of the interviews as the individuals who would likely be impacted the most by such a program were not able to provide any insight.

Another limitation of this study could be the lack of awareness and research that has been conducted on social prescribing, which may have impacted the participants' responses. Working at a nurse practitioner-led clinic dedicated to helping those experiencing poverty, food insecurity and mental health struggles requires compassion and commitment to bettering the community. Therefore, although the participants of the study were expected to provide unbiased responses to the questions, the likelihood that they would be open to a program dedicated to improving the mental health of clients is quite high, which may have presented a bias in responses.

A limitation that was discovered when attempting to create an example resource table of potential social prescribing activities (seen in Appendix A) was the lack of updated, local,

consistent resources available to the public. In addition, almost all of the resources found required an online registration, which poses a challenge to those without access to technology who are unaware of such resources. While support was shown for the implementation of a social prescribing service, this requires the availability and existence of current socially engaging activities that are open to the public, affordable, and accessible to everyone, which Peterborough seems to be lacking. This does not provide supporting evidence for seamless integration of social prescribing services, especially with the barriers identified by staff members, as the resources available do not align with what is required for this program. This indicates the importance of two of the key elements of social prescribing; strong local relationships and the creation of alliances (Baska et al., 2021).

Recommendations & Future Research

Given the results of the interviews with the staff of the NPLC, the prior literature review completed, and the limitations identified, some recommendations can be made for future research regarding the implementation of a social prescribing program in Peterborough. First and foremost, the contribution of clients' opinions, experiences and concerns is fundamental for any further research on this topic. Determining if clients find joy in social engagement and community activities and whether they have previously participated in any form of unofficial social prescribing is crucial to further understanding the receptiveness and interest they may demonstrate for this service. Their perceptions of effectiveness and challenges when engaging in potentially prescribed activities would provide important insight into whether such a program would be well received within this community.

A second recommendation would be to interview many more participants in this field, such as mental healthcare providers at other facilities and organizations, as well as staff members at local homeless shelters and community centres as this was seen as a tentative beginning to social prescribing in Italy (Baska et al., 2021). Therefore, acquiring insight from others who routinely interact with the marginalized communities in Peterborough could provide a better understanding of the best ways to implement social prescribing services and how receptive the clients in the area may be. A longitudinal, detailed study could include specific activities provided to individuals willing to participate to determine how certain social engagement activities impact them over a longer period. This would require additional funding, but, if

possible, it could enhance the understanding of what resources would be best received in the area, which could better inform decisions when forming local alliances.

Future research should include a more in-depth analysis of what resources are currently available in Peterborough, how often they are updated, and the accuracy of their online information. Although a small amount of research was conducted to determine approximately how many resources are available to the public and what they entail, a detailed and thorough search of all local options would likely be beneficial. This would help to inform decisions made about activities and understanding how often these websites are updated with new information is important for implementation purposes. Furthermore, a recommendation for social prescribing services would include the maintenance and upkeep of a resource table like the one created for this project (see Appendix A). A routinely updated, accurate list of potential resources is essential when attempting to connect a client with a treatment option as incorrect information or suggestions could greatly impact the clients' trust and receptiveness for engaging in such a program.

Recommendations also include the incorporation of the implementation strategies suggested by staff members as well as identifying solutions to the barriers. This would consist of the creation of a referral policy to determine when to utilize social prescribing as well as standardized tools used for these referrals. This would provide a regulated system for when to incorporate social prescribing into primary care treatment, reducing the chances of disorganization due to differing methods among the programs. Further research should also investigate the feasibility of social prescribing in other areas of Peterborough such as the community centres as they may have more capacity, funding, and resources to provide this kind of service, especially if done at a recreation centre where gyms and fitness classes are available on site.

Finally, additional research should be completed on the benefits of systems navigation and how such a role could work to eliminate some of the obstacles preventing further assessment of social prescribing. If a systems navigator can provide individuals with information and instruction on how to better understand the resources available to them and how they can be used to their advantage, this could begin to reduce the struggles associated with poverty, food insecurity, and homelessness. However, this requires additional staffing which is difficult due to the staffing crisis, increased funding to encourage these changes, and willing participants to

utilize the information provided to them. A study investigating the efficacy of a systems navigator at the NPLC would provide further insights into many other aspects of social prescribing services.

Conclusion

In conclusion, the findings of this study provide valuable insights into the feasibility of implementing social prescribing services at the NPLC. The results suggest that there is considerable support and enthusiasm among staff members for the integration of social prescribing into the NPLC's services. However, the disparity between their enthusiasm and the many barriers and limitations they identified indicate the need for increased funding, solutions to the staffing crisis, insight from clients, and additional resources such as transportation assistance, systems navigation, and awareness promotion. Participants identified specific implementation strategies, such as systems navigation, awareness promotion, referral policies, and case management, as effective approaches for facilitating the adoption of social prescribing programs within the clinic, partially accounting for the challenges they expect to experience. Addressing these barriers and completing further research is a crucial next step for the successful future implementation and sustainability of social prescribing initiatives within the clinic's current setting.

Despite the challenges and limitations, the findings of this study suggest that social prescribing holds significant promise as a complementary approach to mental healthcare. By leveraging existing community resources, fostering partnerships, and implementing tailored interventions, social prescribing has the potential to maximize the quality of life and perceived sense of belonging and purpose among clients. While clearly expressing a positive attitude toward social prescribing services overall, the results of this research indicate that integrating social prescribing into the NPLC’s standard operations is not currently feasible. By dedicating resources toward overcoming existing barriers, such as securing additional funding and staff members, there exists the possibility that social prescribing services could eventually prove advantageous for the NPLC.

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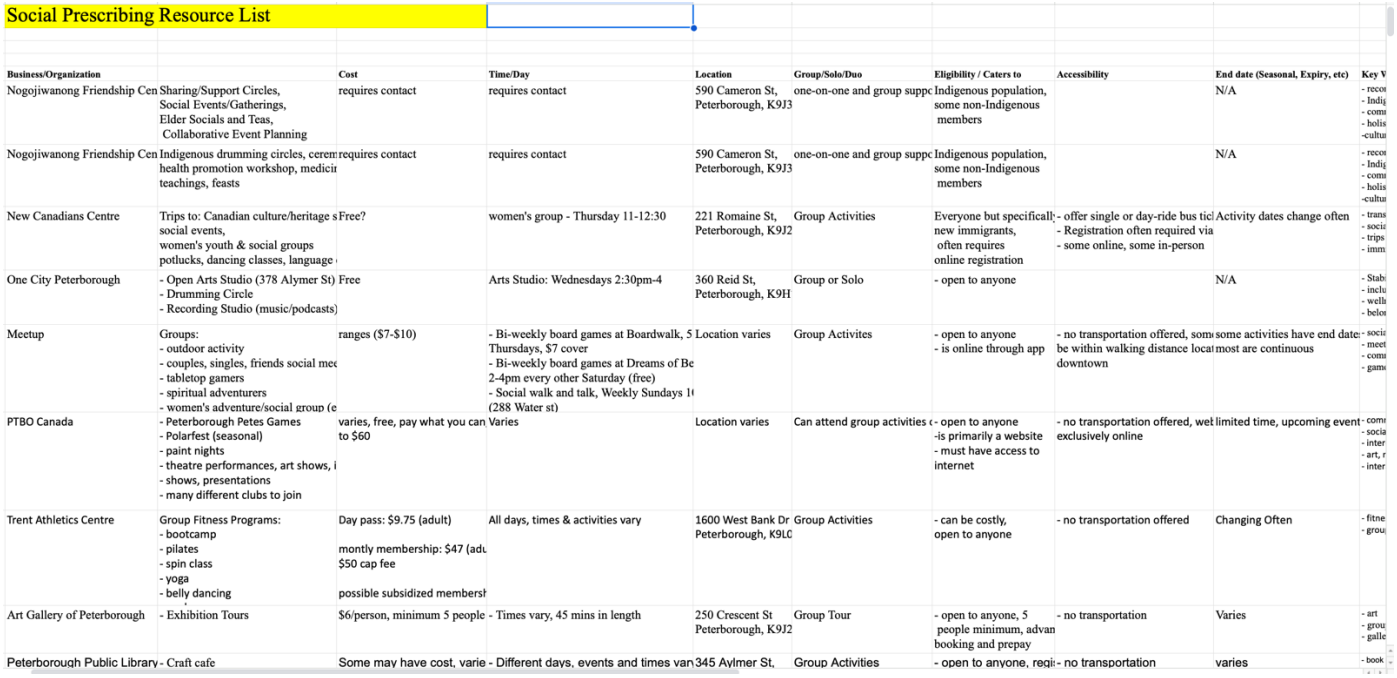
Appendices

Appendix A: Resource Table Example

This includes a screenshot and link to the example resource table completed for social prescribing activities and resources within the downtown region of Peterborough.

[Social Prescribing Resource List]



Social Prescribing Resource List

Business/Organization		Cost	Time/Day	Location	Group/Solo/Duo	Eligibility / Caters to	Accessibility	End date (Seasonal, Expiry, etc)	Key V
Nogojiwanong Friendship Cen	Sharing/Support Circles, Social Events/Gatherings, Elder Socials and Teas, Collaborative Event Planning	requires contact	requires contact	590 Cameron St, Peterborough, K9J3	one-on-one and group suppc	Indigenous population, some non-Indigenous members		N/A	- recc - Indig - comi - holis -cultu
Nogojiwanong Friendship Cen	Indigenous drumming circles, cerem health promotion workshop, medicir teachings, feasts	requires contact	requires contact	590 Cameron St, Peterborough, K9J3	one-on-one and group suppc	Indigenous population, some non-Indigenous members		N/A	- recc - Indig - comi - holis -cultu
New Canadians Centre	Trips to: Canadian culture/heritage s social events, women's youth & social groups potlucks, dancing classes, language	Free?	women's group - Thursday 11-12:30	221 Romaine St, Peterborough, K9J2	Group Activities	Everyone but specificall new immigrants, often requires online registration	- offer single or day-ride bus tic - Registration often required via - some online, some in-person	Activity dates change often	- trans - socia - trips - imm
One City Peterborough	- Open Arts Studio (378 Alymer St) - Drumming Circle - Recording Studio (music/podcasts)	Free	Arts Studio: Wednesdays 2:30pm-4	360 Reid St, Peterborough, K9H	Group or Solo	- open to anyone		N/A	- Stab - inclu - welk - belo
Meetup	Groups: - outdoor activity - couples, singles, friends social mec - tabletop gamers - spiritual adventurers - women's adventure/social group (e	ranges ($7-$10)	- Bi-weekly board games at Boardwalk, 5 Thursdays, $7 cover - Bi-weekly board games at Dreams of Be 2-4pm every other Saturday (free) - Social walk and talk, Weekly Sundays 1 (288 Water st)	Location varies	Group Activites	- open to anyone - is online through app	- no transportation offered, some be within walking distance local downtown	some activities have end date most are continuous	- socia - meet - comi - gam
PTBO Canada	- Peterborough Petes Games - Polarfest (seasonal) - paint nights - theatre performances, art shows, i - shows, presentations - many different clubs to join	varies, free, pay what you can to $60	Varies	Location varies	Can attend group activities	- open to anyone -is primarily a website - must have access to internet	- no transportation offered, wel exclusively online	limited time, upcoming event	- comi - socia - inter - art, r - inter
Trent Athletics Centre	Group Fitness Programs: - bootcamp - pilates - spin class - yoga - belly dancing	Day pass: $9.75 (adult) montly membership: $47 (adu $50 cap fee possible subsidized membersh	All days, times & activities vary	1600 West Bank Dr Peterborough, K9L0	Group Activities	- can be costly, open to anyone	- no transportation offered	Changing Often	- fitne - grou
Art Gallery of Peterborough	- Exhibition Tours	$6/person, minimum 5 people	- Times vary, 45 mins in length	250 Crescent St Peterborough, K9J2	Group Tour	- open to anyone, 5 people minimum, advan booking and prepay	- no transportation	Varies	- art - grou - galle
Peterborough Public Library	- Craft cafe	Some may have cost, varie	- Different days, events and times van	345 Aylmer St,	Group Activities	- open to anyone, regi	- no transportation	varies	- book

Appendix B: Interview Questions for Staff Members of the NPLC

An alternate plan for the staff as they will likely be very busy and will not have a moment is to provide a Qualtrics survey with the same questions used in the interview.

Once the informed consent form has been signed, the participant has received a copy (if necessary) and is still interested in participating, the interview will begin. The questions will be as follows.

1. Can you tell me how long you have been working at the clinic?
    a. Can you describe to me your position and what your role is here at the clinic?

2. Do you know what social prescribing is? Did you know what it was prior to beginning this interview?
    a. If so, how would you describe social prescribing?
    b. If not, I can provide them with a description of social prescribing –a holistic, patient-centred approach to healthcare that encourages interconnectedness, health promotion and empowerment through social activities with peers such as group classes, book clubs, or a community garden. Link workers determine what social activities the client would benefit from and enjoy the most and create a plan outlining how the client can access and participate in their chosen forms of social activity, allowing them to connect with others in their community.
3. What challenges or barriers do you believe clients at this clinic or other places you have visited often face when trying to access healthcare?

4. Have you encountered any barriers or limitations when trying to connect clients with social activities or engagement strategies to better their mental health?
    a. If so, what were they?

5. In your opinion, do you believe there is a need for a social prescribing program at this clinic?
    a. If so, who do you think it would benefit the most? (if they say yes)
    b. Why not? (if they say no)

6. How would you envision the integration of a social prescribing program into the clinic's existing healthcare services?
    a. What role do you think healthcare providers would play in this process?
    b. What challenges would you anticipate if a social prescribing program were implemented?

7. Do you have any other thoughts or things you would like us to take into consideration when completing this project?

That will be my final question. From there I will tell them that the interview is finished, remind them that they have my email on the forms provided, and they may contact me at any time if they have any questions. I will remind them that if they choose to withdraw or change their mind, they can just contact me to let me know and all their information and responses will be immediately destroyed. I will thank them for their time and conclude the interview.