Collaborative Evaluation & Research Centre

Supporting Innovative Research and Evaluation

Latrobe Health Assembly Social Prescribing Project Evaluation Report 2023/2024

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COLLABORATIVE EVALUATION &
RESEARCH CENTRE

SUPPORTING INNOVATIVE RESEARCH AND EVALUATION

Evaluation Report of the Implementation of a Social Prescribing Pilot Project in the Latrobe Valley

2023/2024

ACKNOWLEDGEMENTS

The Collaborative Evaluation and Research Centre (CERC) Federation University Gippsland, acknowledges Aboriginal and Torres Strait Islander people as the traditional owners and custodians of the land, sea and nations and pay our respect to elders, past, present, and emerging. The CERC further acknowledges our commitment to working respectfully to honour their ongoing cultural and spiritual connections to this country.

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ABOUT THE AUTHOR

The Collaborative Evaluation and Research Centre (CERC) Federation University Gippsland is an innovative initiative that aims to build evaluation capacity and expertise locally in Gippsland, and nationally and internationally. As a local provider in Gippsland, Victoria, the CERC understands the value of listening to the community and has the ability to deliver timely and sustainable evaluations that are tailored to the needs of a wide variety of organisations.

Professor Joanne Porter is the Director of the CERC. Joanne has led a number of successful research projects and evaluations in conjunction with local industry partners. She has guided the development of the CERC since its formation in 2018.

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1. EXECUTIVE SUMMARY

1.1 INTRODUCTION

Social Prescribing (SP) is becoming more widely known and utilised within healthcare, currently used within primary care in the United Kingdom (UK) and emerging in countries such as New Zealand and Australia (Annear et al, 2019[1]). The Social Prescribing model aims to provide personalised support for vulnerable people who, through various determining factors, find themselves socially isolated, lonely, and disconnected from their community. Such isolation and disconnect is known to have detrimental influences on both mental and physical health (Freak-Poli et al, 2022[2], Walker et al, 2019[3]) and thus, the concept of addressing social needs or potential barriers to connection via a Social Prescribing program aims to improve health outcomes by means of non-medical intervention. The social prescriber, often referred to as a 'Community Connector', not only signposts activities, but helps to minimise barriers and supports people in reconnecting with positive connections that enhance their lives, building personal confidence and reigniting purpose.

The Latrobe Health Assembly (LHA) initially introduced a Social Prescribing pilot program in 2021, located at Hazelwood Health Centre in Churchill and at the Churchill Neighbourhood Centre. An evaluation of the pilot was reported in 2023, where 47 clients had been referred and utilised the service over 21 months. Following this evaluation, the pilot program was extended and relocated to a different health provider and location. A new social prescriber was employed, and the program was implemented within the Latrobe Community Health Service (LCHS) network.

The Collaborative Evaluation and Research Centre (CERC) was commissioned to evaluate the second phase of the pilot, aiming to capture the process, outcomes, and impact of the pilot, with the new Community Connector and new location. This report details the findings of the second phase of the program using the same collaboratively designed evaluation tools used in the initial trial period. The findings of the second phase of the pilot include data collected over 15 months, between February 2023 to April 2024, and was obtained from the same number of client referrals as the previous pilot (n=47), as well as from nine different types of referring practitioners from across the various sites of the LCHS health network; reflecting the reach and impact of the program in the Latrobe Valley and surrounding areas.

1.2 KEY FINDINGS AND IMPLICATIONS

Relocating the pilot program into the Latrobe Community Health Service has not seen the dramatic increase in client referrals as expected. However, it did result in a wider range of health providers utilising the service as part of their practice. In comparison to the previous pilot period where only

[1] Annear, M., Lucas, P., Wilkinson, T., & Shimizu, Y. (2019). Prescribing physical activity as a preventive measure for middle-aged Australians with dementia risk factors. *Australian Journal of Primary Health*, *25*(2), 108-112. https://doi.org/10.1071/PY18171

[2] Freak-Poli, R., Phyo, A. Z. Z., Hu, J., & Barker, S. F. (2022). Are social isolation, lack of social support or loneliness risk factors for cardiovascular disease in Australia and New Zealand? A systematic review and meta-analysis. *Health Promotion Journal of Australia*, *33*, 278-315.

[3] Walker, E., Ploubidis, G., & Fancourt, D. (2019). Social engagement and loneliness are differentially associated with neuro-immune markers in older age: time-varying associations from the English Longitudinal Study of Ageing. *Brain, behavior, and immunity*, *82*, 224-229

one referral came from a General Practitioner (GP); the new model saw 67% (n=28) of clients referred by GPs, located across various sites of the organisation. Referrals also came from nurse practitioners, dieticians, a refugee nurse, drug and alcohol and care coordination personnel; all grateful to have an additional referral option to address their client's social needs, in order to improve health outcomes:

> *"…it's nice to be able to offer something which isn't just a pill or a potion".* Practitioner (GP)

Cost analysis comparing the two phases of the project demonstrated that although client contact increased in Phase 2, the present model was not necessarily a cost-efficient solution to providing social support. However, evaluation participants suggested that with greater awareness, there was the potential for increased referral capacity, with a resultant improvement in cost effectiveness. Role efficiency throughout the project was adversely impacted by lower-than-expected referral numbers. The average cost per engagement (visit) was $436 in Phase 2, compared to $496 in Phase 1, a decrease of $59 (13.6%) per engagement. The average cost per client contact hour was $631.50 in Phase 2, compared to $1,871 in Phase 1, a decrease of $1,239 (196%) per contact hour. This exceptional decrease was due to a combined increase in the number of client engagements and the longer duration of these engagements seen in Phase 2.

Although not all clients participating in the program made sustained social connections, client engagement with the program improved, with the average number of visits increasing from 4 visits per client in the previous model, to 6 visits per client in the current model. Many anecdotal success stories were provided during the evaluation, from both clients and referring practitioners, including improvements that were seen in client confidence, physical activity, creative outlets, and opportunities to 'give back' to the community through volunteering, teaching, and supporting others. Clients reported making new friends, new contacts, and no longer feeling *'like everyone's a stranger'* within their own community. Whilst not all successes were able to be formally measured through data collection methods, these successes were noticed through improved mental health, improved self-esteem, and a more positive client demeaner as reported by the clients, the Community Connector, and the referring practitioners:

> *"I have done over 25 walks with them* [Heart Foundation Walking Group] *now. Absolutely love it and I've got to know some fabulous people through there. So, it has made a huge difference in my life."* Client

For others, engaging with the Social Prescribing program was not enough to help overcome the personal challenges they had in reconnecting with their community. For some, barriers such as pain, mobility, or financial concerns, could not be addressed by the Community Connector, and although these clients truly valued their association with the program, they were unable to fulfill their connection desires.

The program has been described as '*invaluable*', '*life changing'* and making *'a huge difference',* with the key contributing factor being that of '*time*'. The Community Connector had the privilege of time, scope, and resources, to spend appropriately addressing the needs, desires, and challenges of the client, of which the referring practitioners stated, they did not have:

> "*I know what (the clients) really need, but I don't have the time and it's out of my scope."* Practitioner

Authentic and truly personalised support was now being achieved through the Community Connector, as practitioners were unable to spend time researching, planning, and preparing clients for positive social connection experiences. Therefore, the role of Social Prescribing was described as helping to '*bridge some of the gaps'* within healthcare.

The main reason given by participants for low referral rates, was that the publicity and promotion of the Social Prescribing pilot had been insufficient, or perhaps ineffective. Clinician awareness and understanding of Social Prescribing was limited, and many participants stated they only learnt about the program by chance, many months after it commenced in the organisation, through speaking with the connector in the corridor. For those practitioners who did embrace and value the service, they were also afraid that, like many other transient funded support programs introduced into the Latrobe Valley, the full potential of Social Prescribing may not be achieved. Innovative and novel programs like Social Prescribing need appropriate marketing and time to become established and accepted, within the health system and the community. Therefore, evaluating the success of such programs before they are fully established, working at full capacity, and recognised within the community, may have been premature:

> *"…it's going to be something that's going to (SIC) take 5-6, however many years, to really get it established and for people to feel confident… for GPs, and practice managers, and practice nurses to understand it... this will take time." Practitioner*

Regardless of these challenges, the clients, referring practitioners and the Community Connector, all see both the need and a future, for the Social Prescribing program in the Latrobe Valley. The Community Connector describes the role as '*the best job I have ever had'* and believes '*being embedded in a large health service*' has '*worked really well'*. The second iteration of the pilot has provided opportunity to trial different connection strategies and build resources and social networks which will lead to a more effective and efficient service. As a result, the future of Social Prescribing in Latrobe '*is really exciting!*'

1.3 KEY RECOMMENDATIONS

1. The Social Prescribing program should continue to provide a community connection service within LCHS in the Latrobe Valley, with increased referral pathways. Referral agency should be expanded to include any healthcare provider within the organisation, local community service providers, Neighbourhood centres and include client self-referral.

2. Increased publicity and marketing of the service is required to ensure practitioners are aware and understand the scope, capability, and capacity of the Community Connector role, as well as how to refer into the program.

3. Further evaluation of the Social Prescribing program should be prolonged to allow time for program and role establishment.

    a. The Community Connector role is unique and will develop according to the population it serves and the needs of the population. Therefore, it will take time and increased client numbers to determine an appropriate workload and service capacity, whilst maintaining a quality and effective service. Until maximum capacity is achieved, true cost effectiveness cannot be determined.

b. Community and provider acceptance and uptake will only occur after adequate exposure and information about the program. Further promotion and access to Social Prescribing resources both within and external to the organisation will mean the community will become more familiar with the service.
c. Further development of data collection tools is required to measure program impact effectively and appropriately.

4. The Community Connector should have a stable and permanent location, to allow storage of resources, promotion of community activities and contacts, as well as maintain a familiar place of exposure for the community and other healthcare providers. The current transient nature of delivery has not been efficient, nor has it provided a welcoming, confidential, and familiar place to meet with clients.

LATROBE HEALTH ASSEMBLY SOCIAL PRESCRIBING PILOT PROGRAM 2023-2024

Latrobe Community Health Service

- 47 Client Referrals (Feb 2023-April 2024)
- 9 different referral sources (67% from GPs)
- 191 Client Visits
- First visits: 90% >30 mins duration, 45% >60 mins
- 2-18 visits per client (Average 6 visits per client)
- 277 client phone calls, 164 texts, 105 emails

Evaluation sources

- Referral and client visit forms
- 7 Referring Practitioner interviews
- 9 Client interviews
- 3 Community Connector interviews

Additional care option

"...it's nice to be able to offer something which isn't just a pill or a potion" Referring Practitioner

Connector support

"I dont think I would have gone if I didnt have her with me..." Client

First impressions

"I'm really trying to make that first experience, a really good one… because that sets the tone for the rest..." Community Connector

Successful Connections

"I absolutely love it and I've got to know some fabulous people... so it has made a huge difference in my life" Client

Social Prescribing was designed to improve mental and physical health through addressing isolation and social disconnection. The Community Connector role aimed to support vulnerable people to overcome barriers and make sustainable connections within their local community. Improved social connection has built confidence, improved self-esteem and provided purpose, while shifting the focus away from poor health.

"...the more normal you can make your life, the less likely the symptoms are to bother you."

OUTCOMES & RECOMMENDATIONS

- **TIME and SCOPE** - the Community Connector role requires the resources to provide truly holistic support.
- **RESEARCH and KNOWLEDGE** - are required to produce appropriate opportunities for connection that meet clients' needs.
- **PROGRAM AWARENESS** - improved program promotion is required to maximise impact on the Latrobe community

2. INTRODUCTION-THE SOCIAL PRESCRIBING PROGRAM

Social Prescribing (SP) is a modern approach to primary care in which healthcare professionals may offer non-medical referrals to patients with the aim of addressing social determinants of health that are influencing the health of their patients (Moore et al, 2023)[4]. More than just 'signposting' to appropriate support services, referrals are being made to this new role known as Social Prescribing, where the '*link worker*' or '*Community Connector*' can help connect patients into social networks and help to overcome existing barriers that potentially contribute to poor health outcomes (Sharman et al, 2022)[5]. Non-medical interventions, such as involvement in community groups, art, music, exercise, and volunteering, or socio-economic support services such as housing, employment, and legal assistance (Brandling & House, 2007)[6] have been seen to help improve overall health outcomes and potentially reduce demand on GP and hospital interventions (Polley et al., 2017)[7]. Multiple Social Prescribing models exist around the world, including in the United Kingdom, USA, New Zealand and more recently in Australia, with variances noted in delivery and evaluation techniques (Ayorinde et al, 2024[8]; Annear et al, 2019)[9]. Despite the value of the role being widely disseminated, continuity and standardisation of practice is lacking. Research about Social Prescribing has demonstrated the diverse nature of the role, including the various names by which the worker identifies (Moore et al, 2023)[4] Professional identity and role definition is vague, with practice currently dependant on many variables, such as funding expectations, available resources, staff skill levels, and mixed participation from both referring practitioners and public consumers (Moore et al, 2023[4], Sharman et al, 2022[5]). Such variance within the role has led to disparate practice outcomes, where some link workers are restricted to simply 'signposting', directing patients towards community activities or supports; where others are able to spend more time accompanying clients to activities and supporting them to establish new connections. Therefore, evidence suggests that formulating an ideal role description and capacity is difficult due to the authentic nature of this contemporary position (Moore et al, 2023)[4].

The previous evaluation report developed by the CERC, explained the initial development of the Social Prescribing pilot program for the Latrobe Valley. The pilot was originally established in Churchill and was located at the Churchill Health Centre and Churchill Neighbourhood House. The 2022/2023 report provided details of the evaluation, reflecting the reach and impact of the pilot using a mixed methods approach. The evaluation contained data collected between the period July 2021 to March 2023, and included 47 referred clients during this time. Deciding to extend the pilot for another funding period, the program was relocated to a larger health organisation in the area; Latrobe Community Health Service (LCHS), widening the potential reach and scope of referring practitioners. In addition, a new Community Connector was employed and saw her first referred client in February 2023. CERC was

[4] Moore, C., Unwin, P., Evans, N., & Howie, F. (2023). "Winging It": An Exploration of the Self-Perceived Professional Identity of Social Prescribing Link Workers. *Health & Social Care in the Community*, *2023*(1), 8488615.

[5] Sharman, L. S., McNamara, N., Hayes, S., & Dingle, G. A. (2022). Social prescribing link workers—A qualitative Australian perspective. *Health & social care in the community*, *30*(6), e6376-e6385.

[6] Brandling, J., & House, W. (2007). Investigation into the feasibility of a social prescribing service in primary care: a pilot project.

[7] Polley, M., Chatterjee, H., & Clayton, G. (2017). Social prescribing: community-based referral in public health. *Perspectives in public health*, *138*(1), 18-19.

[8] Ayorinde, A., Grove, A., Ghosh, I., Harlock, J., Meehan, E., Tyldesley-Marshall, N., ... & Al-Khudairy, L. (2024). What is the best way to evaluate social prescribing? A qualitative feasibility assessment for a national impact evaluation study in England. *Journal of Health Services Research & Policy*, *29*(2), 111-121.

[9] Annear, M., Lucas, P., Wilkinson, T., & Shimizu, Y. (2019). Prescribing physical activity as a preventive measure for middle-aged Australians with dementia risk factors. *Australian Journal of Primary Health*, *25*(2), 108-112. https://doi.org/10.1071/PY18171

again commissioned to evaluate the second iteration of the program. Recognising that a short cross-over period did occur as the Churchill program ended and the new program was established at LCHS, it has been agreed (LHA and CERC) that this report will only report on data collected from the new LCHS site and regarding work carried out by the new Social Prescribing Community Connector.

Note: In this report, the person employed to do the Social Prescribing role will be referred to as '*Community Connector'*.

3. THE EVALUATION

3.1 AIM OF THE EVALUATION

This evaluation aimed to assess the process, the outcomes and the impact of the Social Prescribing pilot being delivered within the LCHS network across the Latrobe Valley and surrounding areas. It hoped to identify the benefits and challenges of delivery, the reach of the program, and determine how the program was received by the community and local health professionals.

As mentioned above, literary evidence indicates that the evaluation of Social Prescribing programs is difficult due to the uniqueness of the role, and therefore, a collaborative workshop was also conducted to establish an agreed meaning of success. The findings from this workshop are detailed later in the report (4.1 Meaning of Success).

3.2 EVALUATION RESEARCH QUESTIONS

The overall evaluation of the pilot project addressed the following research questions:

1. What was the impact of the Social Prescribing model on primary health providers in the Latrobe Valley?
2. What was the impact of the Social Prescribing model on referral recipients?
3. What were the perceived benefits and challenges to introducing a program for Social Prescribing in the Latrobe Valley?

3.3 DATA COLLECTION & TOOLS USED

The evaluation of the Social Prescribing pilot program utilised a variety of data collection tools in a mixed methods approach that provided information about process, outcomes, and impact. Details about analysis and the evaluation strategies are provided further on in this report, in Section 7: Methodology. A combination of data sources was provided by LCHS, the Community Connector, and the Social Prescribing clients. Participants included Gippsland community members (clients), health providers and the employed Community Connector for the Social Prescribing program. Data were collected between the period of February 2023 to April 2024. Figure 1 illustrates the various data sources used in the evaluation.

Quantitative Data

- SP program referral data
- SP client assessment forms
- Survey of SP clients
- Cost analysis of SP program

Qualitative Data

- Interviews with SP clients
- Interviews with referrers to SP
- Interviews with community connector

Figure 1: Data collected for evaluation

4. EVALUATION FINDINGS

4.1 THE MEANING OF SUCCESS

The CERC were invited to organise and facilitate a 2-hour workshop in July 2023, where members of the Social Prescribing working party and key stakeholders attended to discuss and define the success of the social prescriber role currently being delivered in the Latrobe area. The workshop commenced with an updated report on the outcome of the first round of project evaluation, highlighting process modifications and initial outcomes, leading up to the present-day delivery of the role. The current Community Connector was in attendance, along with six other members of the working party and three members of the evaluation team. The purpose of the workshop was to identify how the success of the role was to be measured. The interactive activities encouraged participants to be creative and think outside the square, considering the many different ways the success or impact of the role could be determined.

4.1.1 Participant perception of the role

Before the group presentation commenced, five participants were invited to provide their own perception of the Social Prescribing role in Latrobe in a few sentences via a brief 2-minute individual interview. Providing these ‘barbeque’ type statements gave insight into the various understanding and expectations of the role and indicated how participants each perceived the purpose and success of the position.

Although there was difference in perceptions, understanding of the role and expected outcomes, there were many similarities, as captured in the word cloud illustration below (Figure 2). The most common perceptions were that the Social Prescribing role was developed to support existing medical care, where referrals are made into a complimentary service helping people in Latrobe form connections with community, to reduce isolation and improve social supports. The most common terms captured from the participant statements were social, community, health, connection, referred and medical.

Figure 2: Word cloud for perceptions of Social Prescribing

The group were then presented with an initial image (see Figure 3), that represented any project: symbolising the goal (treasure), the journey (ship), the risks (shark) and potential things that hold a project back (anchor). Working in two groups, the participants were asked to create their own visual story boards, collaboratively drawing each of the four elements within their own stories.

Figure 3: Goal, Journey, Risks workshop image

4.1.2 Participant story boards

Group 1 created a tree house (Figure 4) where they explained that the journey was to go up into the tree house using a signposted ladder, with different branches represent different options of clients (medical services, diagnosis, treatment) including different destinations for Social Prescribing, Men's Sheds, friends, and others.

Figure 4: Tree house drawing by workshop participants

Group 2 constructed a high-flying kite (Figure 5), where the goal was to fly high on the wind, avoiding risks such as trees where the kite could get caught and tangled. The rock is what could potentially hold the kite down and prevent it from flying high and achieving the goal.

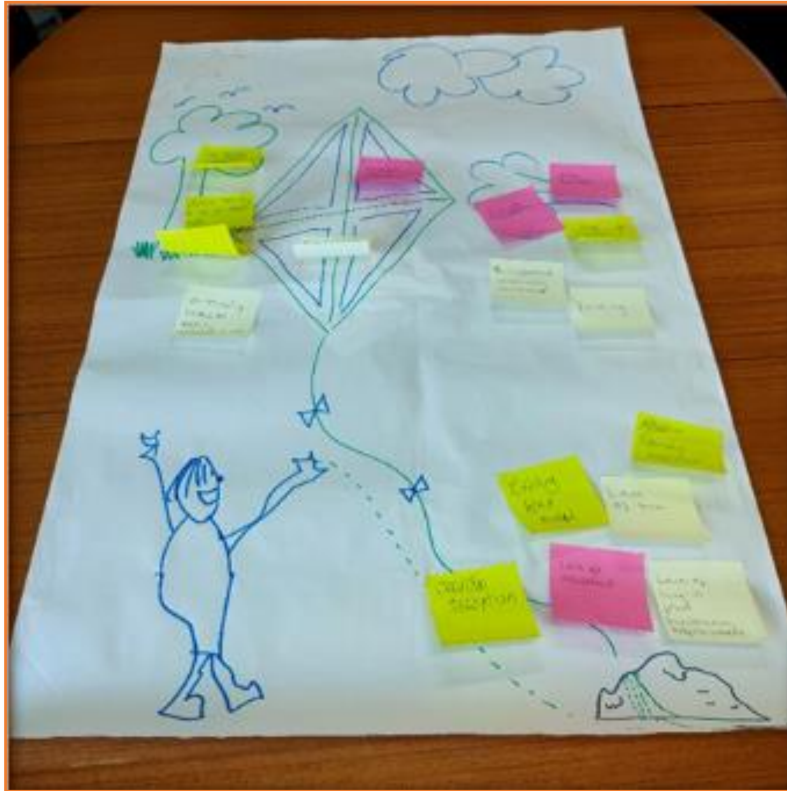


Figure 5: Kite drawing by workshop participants

Participants were then asked to write on sticky notes what they thought were four key elements in relation to the Social Prescribing project: The goals and aim, what was needed to get there, what potential risks might present, and what things might hold the project back (Table 1). The two groups suggested the following:

Table 1: Elements of the Social Prescribing Program

Element	Group 1: Social Prescribing journey
Goal	• Healthier and more connected community group- retain connected patients • Easier access to services (referred patients to less likely engage services unless necessary-eg: less visits to GP)
Needed to reach goal	• Getting more people connected with their community • Community connector impact recognised by community Eg: LCHS patients value community connector roles • Supported community connector and interested community • Lots of options for being together and experiencing the world
Risks	• Not sustainable and no interest from agencies • Decreased Volunteerism- going the extra mile in orgs- soft quitting • Engagement with health professionals to ensure referrals • Promotion of project to public to increase awareness • Unexpected changes to plan (cracked tree branch) • Slow uptake from community or lack of interest from professionals • Risks- out of funding+ sustainability of program
Holding us back	• Hand holding- physically support the person to attend the social prescriber. Introduce them onsite- check in • Post Covid couch Velcro • Bipartisan support of model- GOVT (local, state, Fed), AHPRA, AMA • Sign posters- need a group org for support and comms • How are they obvious to all? How do DRs and med personnel know? • Role of advocacy? Role of promotion? How many people on LV know of social orgs clubs (Men's Shed) • Audit: How many orgs/clubs in LGA? Destinations for clients (eg Men's Shed) What motivates them-unites them? Why no interest? - low volunteers • Close the loop- referral- drop off -why? - check in
Element	**Group 2: Social Prescribing journey**
Goal	• Connected people to a range of different services and options • Reduced burden on healthcare system eg: less non-medical GP visits
Needed to reach goal	• Passionate knowledgeable connector • A supported community connector • Funding • Lots of referrals • Public awareness
Risks	• Not enough referrals • Service taking a lot of time • Not appropriate referrals • Community connector feeling unsupported
Holding us back	• Training required • Evolving service model • Lack of trust • Clear job description • Lack of awareness • Lack of buy-in from healthcare professionals

4.1.3 Measuring success of the role

After each group had shared their view of the Social Prescribing model currently running in Latrobe, the discussion was then redirected back to all participants to consider how success may look. A further diagram was created as participants shared thoughts about the potential impact and outcomes the Community Connector could create, should the role be effective in achieving the desired goals previously mentioned. Group discussion included a start point (referrals made from GP to social prescriber) and end point (clients engaged in community social groups/connections). Therefore, the group saw the role of the social prescriber sitting in the middle between two different types of barriers (Figure 6); first the resistance of medical staff to make referrals to the Community Connector and, then the need to overcome the many access barriers of the clients to engage with the social groups/connections. These barriers could be the cost, transport, varied interest, and lack of knowledge of group existing within local area.

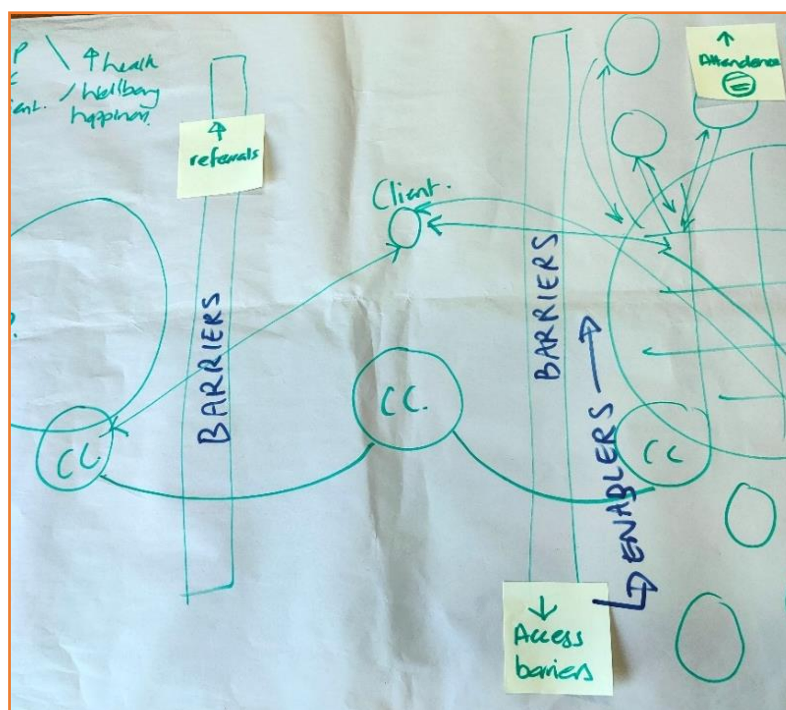


Figure 6: Perception of Community Connector's role

From this discussion and visualisation, it was then determined that success was potentially more than measuring the number of referrals, more than reducing the number of GP visits that were more socially indicated, but rather, reviewing the number of clients who made, and sustained, a connection with a social group. Suggestions were made about having periodic check-ins to determine if clients remained engaged. It was also discussed that success could be considered if a client attended more than one session with the social prescriber, as potentially it would take an undetermined number of sessions to establish a good understanding of the clients' interests and abilities, identify barriers for that person and then organise person-centred connections that were appropriate and sustainable. It was therefore established that a successful social prescriber role would enable connections by reducing existing access barriers and establishing sustainable appropriate social connections for their clients, as opposed to the number of GP visits the client may require.

Therefore, the view of success shifted from the impact the Social Prescriber could have on GP clinics and the medical model of healthcare, to the impact the role could have on clients and their reconnection to community. Participants could identify several ways in which this success could be measured, both quantifying the outcomes as well as using client and healthcare staff interviews, all within a set time frame. These suggestions are tabled below (Table 2).

Table 2: New measures of success

Instead of success looking like…	**New view of success could look like…**
Reducing number of GP attendances post referral with social prescriber	Increasing number of *appropriate* connections made for clients to community groups by overcoming access barriers for individuals (cost, transport, awareness)
Counting number of referrals to Social Prescriber	Finding ideal number of sessions required to make *sustainable* connections
Counting number of clients who make a connection/ attend a community group	Conduct check-ins (3 monthly, 6 monthly etc) to examine *sustained* connections

The workshop was useful in establishing a collaborative focus on how the Social Prescriber role could be evaluated, and potentially informs other community stakeholders who were not present at the workshop, how the success of this program can be measured and interpreted.

4.2 QUANTITATIVE FINDINGS

Quantitative data was collected using the secure online survey platform, Qualtrics. Data was extracted and descriptive statistical analysis was conducted using Excel. Data was collected from 1st Feb 2023 through to end of April 2024, and was collected via four sources:

- Client referral form
- First client session form
- Returning client session form; and
- Client psychometric survey.

In addition to the completion/partial completion of the above-mentioned forms, additional data were provided regarding the various forms of contacts used to connect with clients, and the working hours and renumeration of the Social Prescribing employee, in order to conduct a cost analysis.

4.2.1 Client demographics

A total of 47 clients were referred into the program since relocating to LCHS, of which 62% (n=29) identified as female and 38% (n=18) as male. No participant identified as 'non-binary' or 'other'. The clients' age ranged between 18-87 years, with the average age being 52 years. Approximately two thirds (66%) of the referred clients were located in Morwell (45%, n=21) or Traralgon (21%, n=10), with others living in the areas of Warragul, Moe/Newborough, Churchill, Yinnar and Boolarra. From those participants who attended a first visit with the Community Connector (n=42), 50% (n=21) resided within the postcode of 3840, which includes Morwell, Hazelwood, and Maryvale. A further 21% (n=9) lived in 3844 postcodes, encompassing Traralgon, Tyres, and Traralgon South (Figure 7).

Figure 7: Location of first visit clients

Of those clients who attended a first visit with the Community Connector, 9.5% (n=4) stated they spoke English as a second language, whilst 2.4% (n=1) identified as Aboriginal and/or Torres Strait Islander. Findings were similar to 2021 ABS Census data that identified 8.8% of households in the Latrobe Valley used a non-English language, significantly less than the Victorian average of 30.2% and Australia wide average of 24.8% (Australian Bureau of Statistics, 2021)[10]. The most common age bracket for those who did attend a first visit, was between 55-64 years (31%, n=13), followed by 14% (n=6) between the ages 65-74 years (Figure 8).

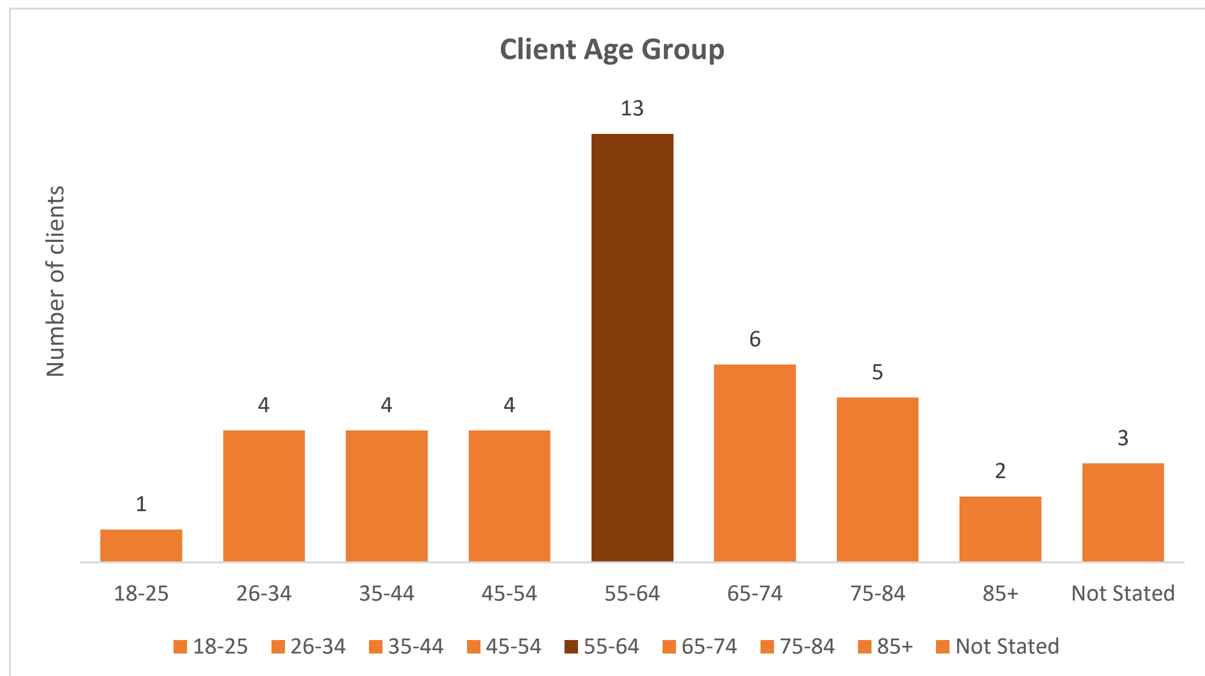


Figure 8: Client age groups

Personal Circumstances

From the 42 clients who participated in the program, 31% (n=13) were single, 21% (n=9) were divorced, 19% (n=8) were married or living in de facto relationships and 12% (n=5) were widowed (Figure 9). Two thirds of the participants (67%, n=28) lived alone, whilst 21% (n=9) lived with partner /children. Most participants did not have a carer (90%, n=38), and of the 42 participants, only six reported having dependent children.

[10] Australian Bureau of Statistics (2021) retrieved from https://www.abs.gov.au/census/find-census-data/quickstats/2021/20504

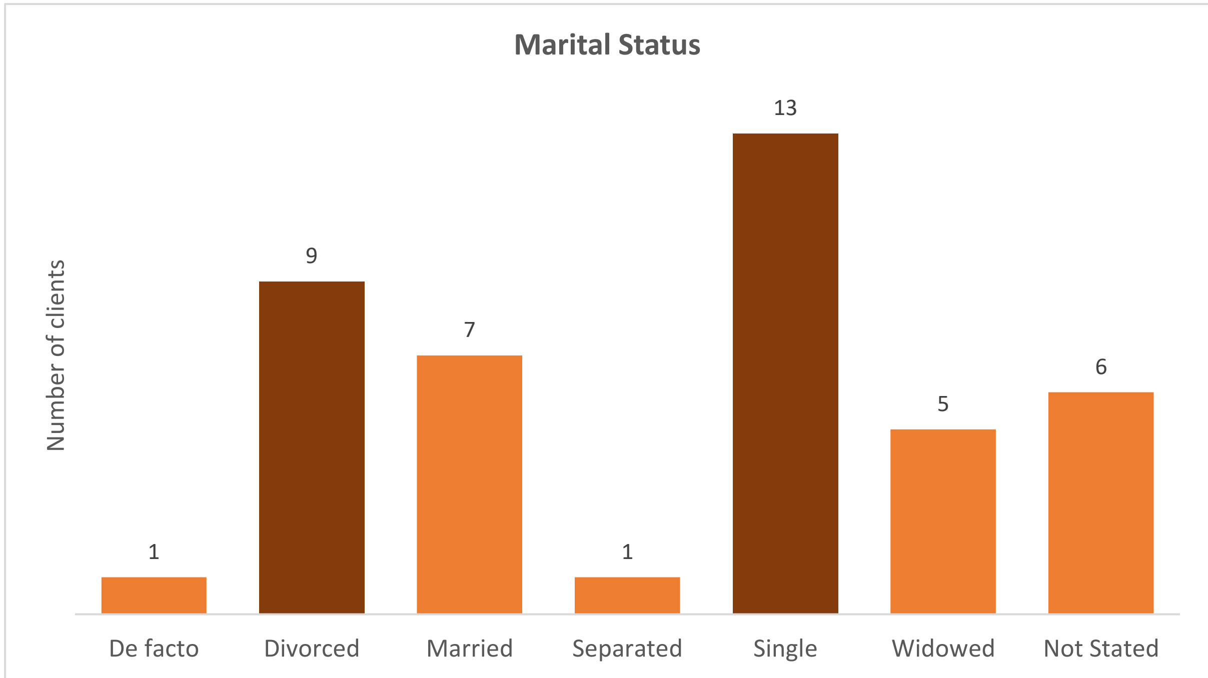


Figure 9: Marital status of clients

Transport and connectivity

With mobility and transportation, a key factor in social connection, especially in rural or regional locations, a substantial proportion of the participants (69%, n=29) reported having a licence to drive (Figure 10), with 62% (n=26) using a car as their normal mode of transport. Another 29% (n=12) relied on public transport as their normal means of transportation (Figure 11). All clients had access to some form of digital communication, with 50% (n=21) having access to the internet through a computer and mobile phone, and 36% (n=15) accessing internet through phone only.

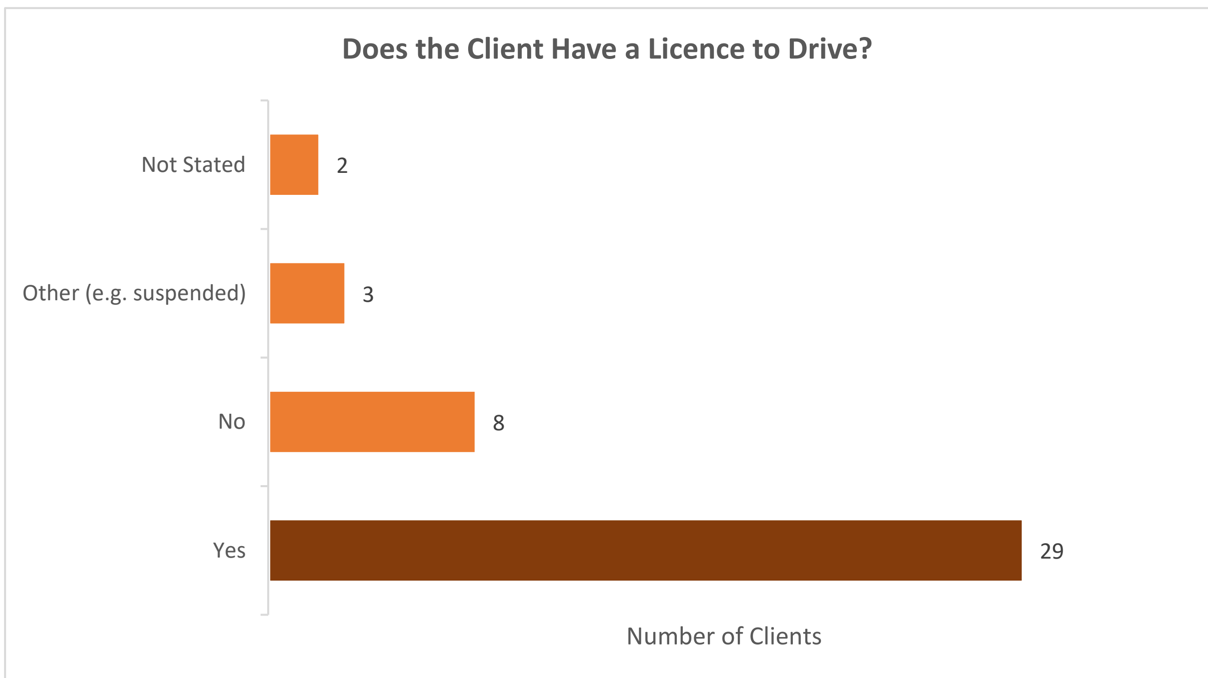


Figure 10: Clients with driving licences

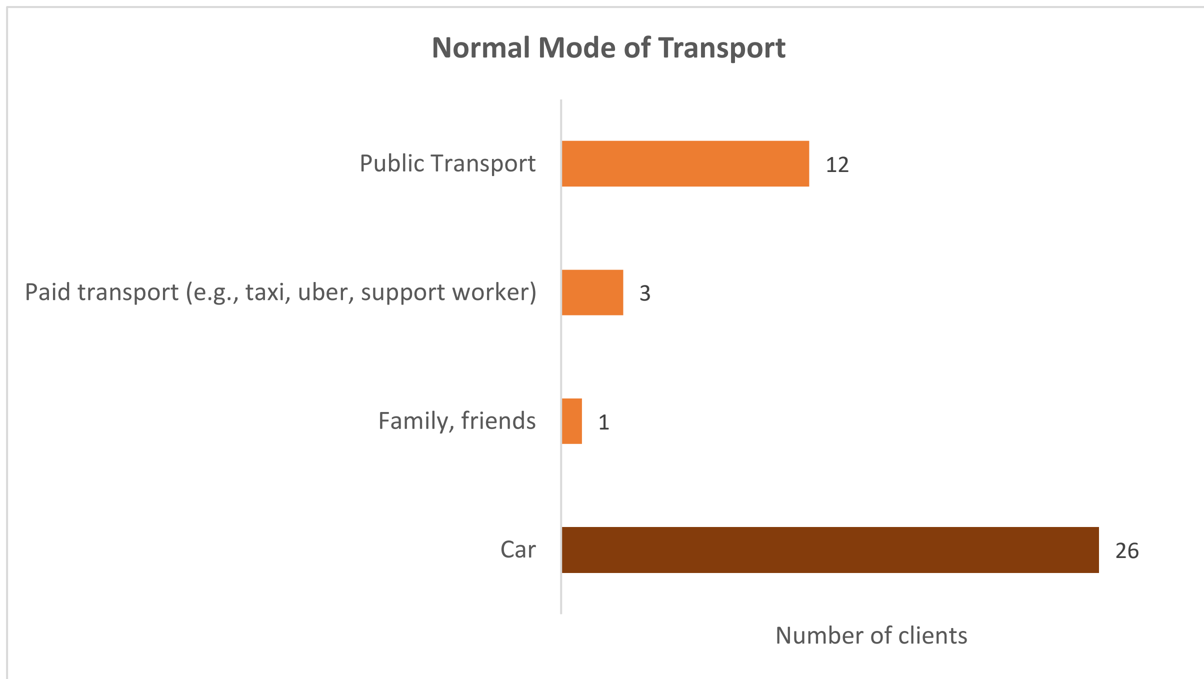


Figure 11: Client mode of transport

4.2.2 Client wellbeing

Eight clients (19%) identified themselves as smokers, whilst 60% (n=25) did not consume alcohol and 19% (n=8) consumed less than ten alcoholic drinks per week. Past health history was poorly reported within the referral process; however, some clients had reported chronic health conditions, or multiple comorbidities such as cardiac, stroke, diabetes, asthma, arthritis and hypertension (high blood pressure). Others had reported psychiatric conditions such as anxiety, depression, bipolar, ADHD and autism as an existing diagnosis. For many clients, no existing health history was documented by the referring practitioner.

Current Life Stressors

Clients who continued to meet with the Community Connector after the first visit (returning clients) were asked to identify key areas of their life that were currently causing them stress. A total of 288 stressors were identified by participants, some choosing multiple contributing factors during at any given time. During their returning visits with the Community Connector, approximately one third of the current life stressors were identified as being family/friends related (34%, n=99). This was followed by the clients' perception of their own health (20%, n=50) and mental health (22%, n=64), and how they contributed to their happiness and ability to engage (Figure 10). Finance, employment, and skills were also noted by 18% of participants as additional stressors. In addition to identifying stressors, 96% (n=123) of clients who returned to see the connector after their initial appointment reported social isolation/need for community connection as the primary reason for referral.

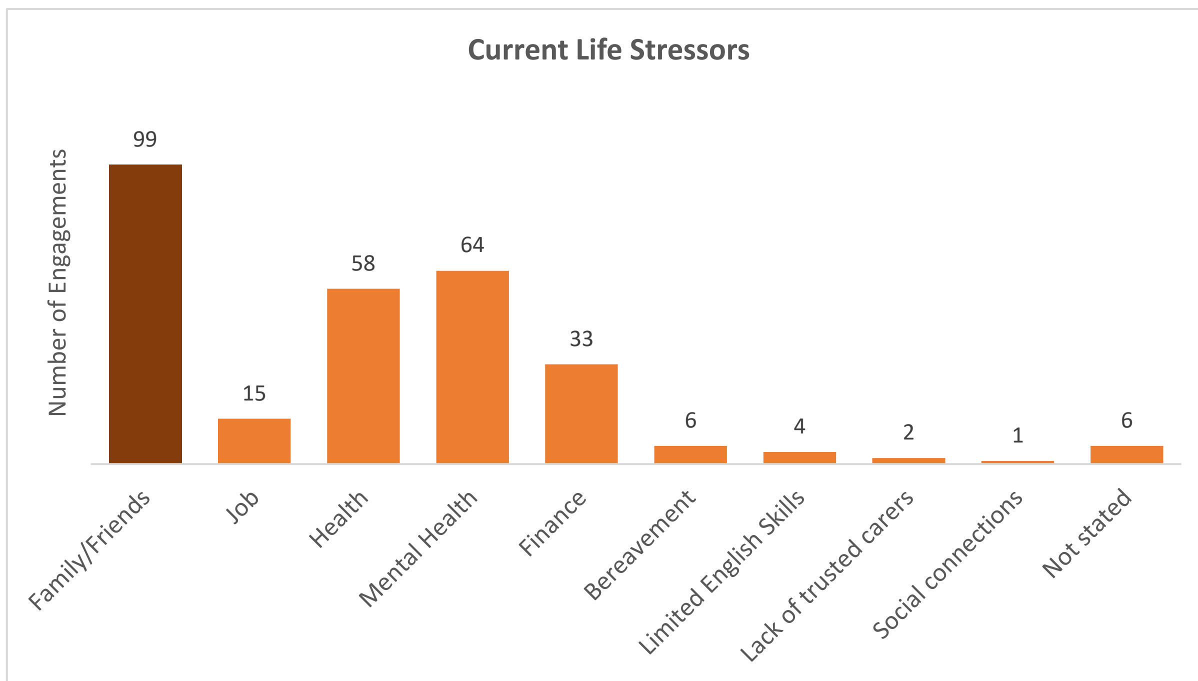


Figure 12: Current life stressors

Existing Community Involvement

Some clients reported already have some existing connections within the community, before speaking with the Community Connector. These existing activities varied from fishing, caravanning, sports (golf, swimming, watching footy), music and films, singing and dancing, planned activity groups (PAG), Men's Sheds, arts and crafts (knitting, crocheting and painting), cooking, exercising (tai chi, pool, gym, walking the dog), multicultural groups and mothers' groups. Many clients gave reasons as to why they could not continue with these activities due to transport or financial concerns, or how they no longer felt comfortable attending.

4.2.3 Client referral details

Across the 15 months of practice at LCHS, the Community Connector made a total of 277 phone calls, sent 164 text messages, 105 emails and six letters to people who had been referred into the service. These clients/potential clients were referred by a diverse range of practitioners including GPs, Nurse Practitioners (NP) (10%, n=4), outreach workers within LCHS, dietitians (7%, n=3), care coordinator, Alcohol and Other Drugs (AOD) worker, and a refugee nurse. However, 67% (n=28) of client referrals came from the LCHS GPs. The busiest months for referrals over the LCHS model period were between May and September 2023, with November 2023 busy with referrals from that month and the month prior (Figure 13).

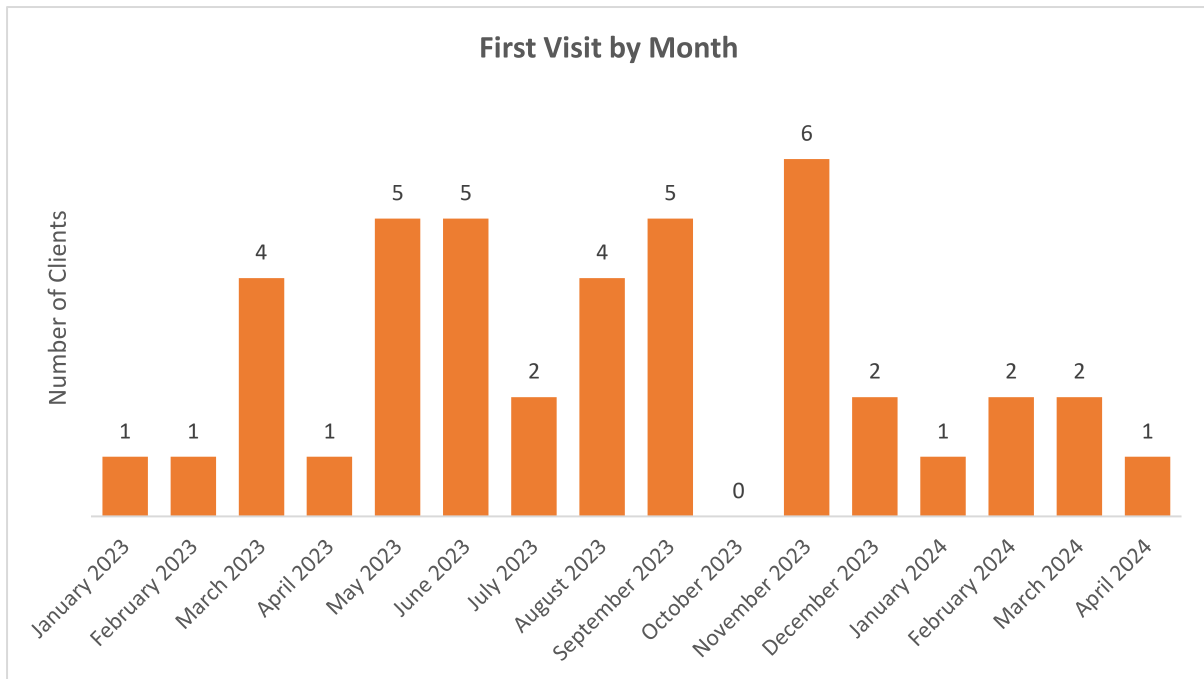


Figure 13: Numbers of new clients per month

From the 47 referrals made by the referring practitioners, 42 clients attended an initial first visit with the Community Connector to discuss their interests and connection possibilities. From these, 32 clients continued to meet with the Connector, with a further 149 'return visit' meetings conducted (Table 3).

Table 3: Summary of client visits

Connection with Social Prescribing Program	Number of clients	Number of visits/contacts
Initial referrals	47	47
First visits	42	42
Returning/follow up visits	32	149

Reasons for Referral to the program

For clients attending follow up meetings after the initial consultation with the connector, the overwhelming reason for referral was for social isolation and the need for community connection (96%, n=123). Other reasons that were noted included confusion about services, to focus on activity, GP concern, and healthy eating options to maintain good health.

4.2.4 Client engagement

A total of 42 'first visit' appointments were provided, of which 98% (n=41) were conducted as face-to-face meetings, with 90% of these lasting more than 30 minutes in duration. Half of these meetings (45%) were in excess of 60 minutes (Figure 14).

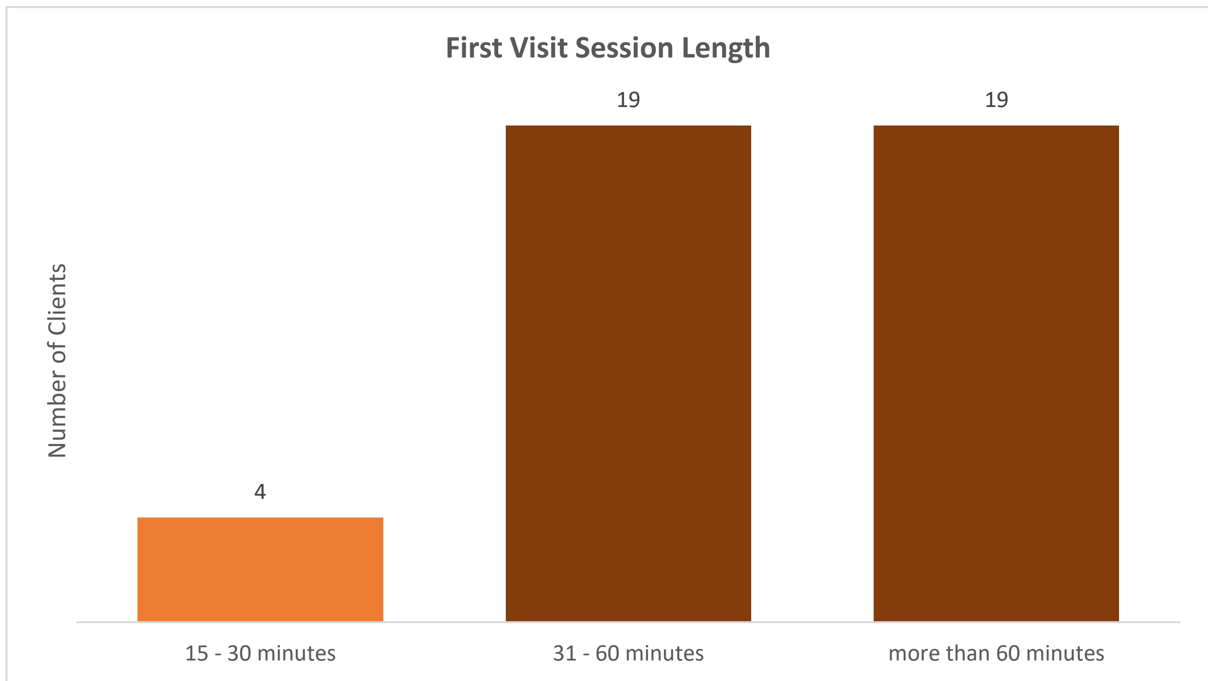


Figure 14: Duration of first engagements

In addition, a total of 149 'returning engagements (visits)' were held, where 75% (n=111) were conducted face to face and 23% (n=34) held via a phone call. These follow up sessions varied in duration dependant on the contact method utilised. For example, of the 24% of sessions held via telephone, 81% were less than 15 minutes long. More than half the face-to-face sessions (56%, n=83) were 30 minutes or longer in duration, with 17% (n=25) lasting more than one hour (Figure 15).

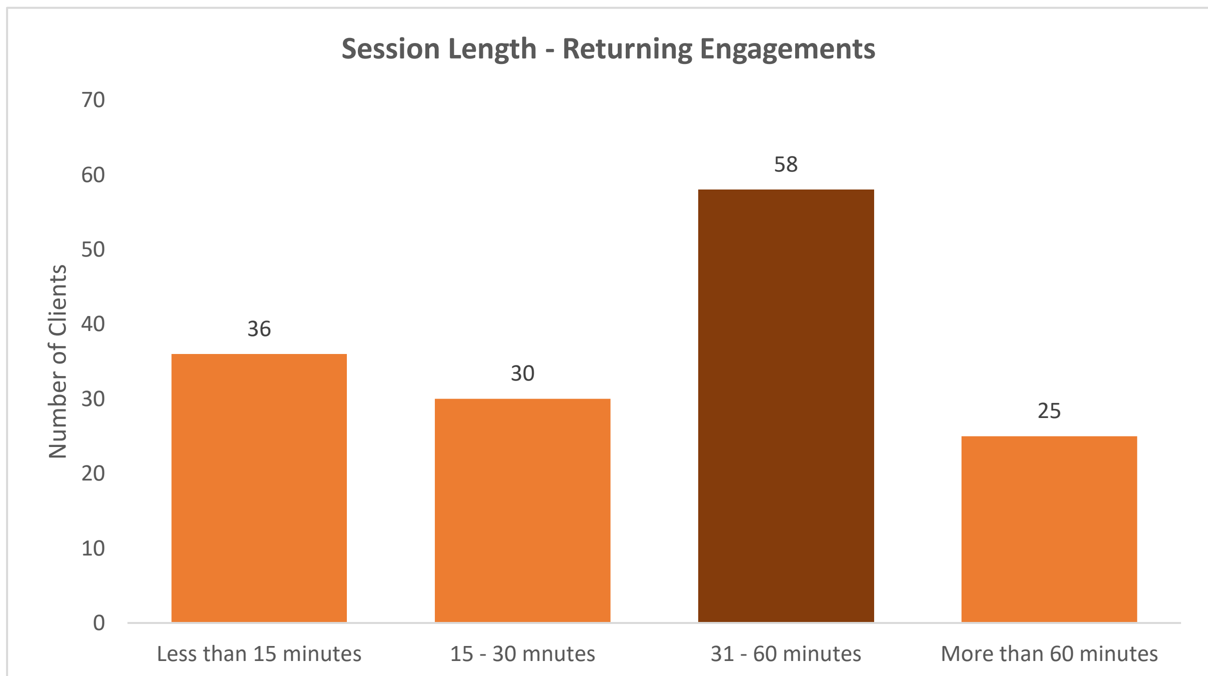


Figure 15: Duration of returning engagements

The Connector went to great lengths to meet the clients in an environment appropriate to their needs. The Connector travelled throughout the Latrobe Valley area to meet with clients in Moe, Churchill, Morwell, and Traralgon. Meetings were occasionally held in the clients' home, or during opportunities where the connector had travelled with a client to escort them to a new activity such as multicultural friendship groups or walking groups. Having this flexibility enabled 62% of client meetings to be conducted in settings outside of the traditional healthcare settings, which potentially contributed to successful client engagement with the program, with only two reported missed or cancelled appointments. Those meetings conducted within LCHS venues account for the remaining 38% of visits. The various venues utilised for meeting clients included the four LCHS healthcare sites, café catchups, general walking catchups and various community support groups (Table 4).

Table 4: Meeting locations

Meeting location	**Appointments scheduled in this location (n)**
Anglicare - Morwell	1
Cafe – Moe, Morwell, Traralgon	13
GippsTAFE Morwell	2
GRAC Hydro Pool - Traralgon	1
Heart Smart Walking Group - Traralgon	9
Home Visit	30
LCHS (Churchill, Moe, Morwell, Traralgon)	**43**
Moe Multicultural Friendship Group	3
Morwell Leisure Centre	1
Phone Call	30
Senior Citizens - Morwell	1
Stroke Support Group	1
St. Vincent de Paul Crisis Centre - Traralgon	2
Supported Playgroup	2
Text	2
Traralgon Neighbourhood House	1
Walking catchups	3
Total	**145**
Total face to face contacts	**113**

After the initial consultation meeting, the number of returning visits per client ranged from 2-18 visits. Although the average number of visits conducted equates to 6 visits per client, the majority of clients accessed the service between two and five times. Interestingly, two clients accessed the service on 14 occasions, whilst one client had 18 follow up visits with the connector (Figure 16).

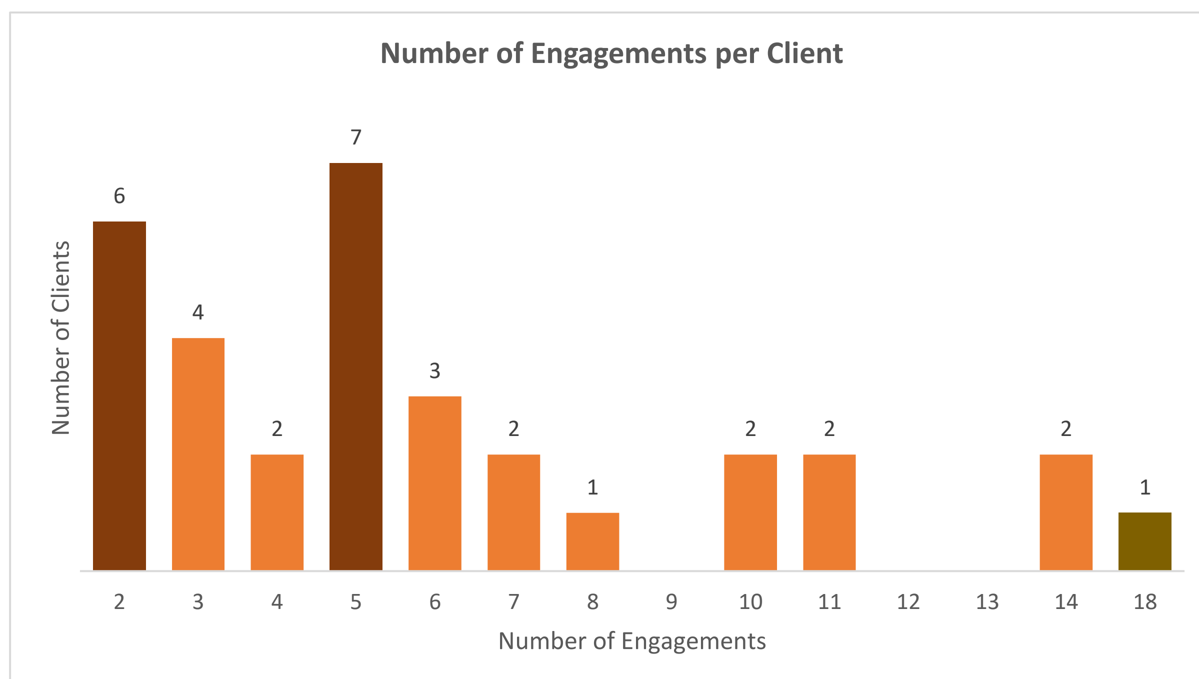


Figure 16: Number of engagements per client

4.2.5 Community connections

The importance of ensuring individualised connections was seen through the vast array of community connection suggestions offered by the connector. Through thorough investigation at the initial consultation with the client, understanding a 'one size fits all' approach was not viable, the connector was able to suggest appropriate connection opportunities, such as those listed in Table 5.

Table 5: Suggested connection activities

Category	Suggestions provided by Community Connector
Sport and recreation	Fishing clubs, motorbike club, bird watching, Borrow Box (Library), Fishcare, GRAC aerobics, Golf clubs, cycle clubs, dancing, ten pin bowling, bingo
Creative activities	Creative writing/poetry, drawing/painting groups, photography groups, Traralgon Library knitting group, poopy creators, LCHS Buddy Bears, Folk art, ceramics, quilting groups
Music and culture	Gippsland Acoustic Music club, Latrobe Regional Gallery, Rock 'n Roll groups, film clubs, choirs
'Giving back' activities	Volunteering -Op Shops, Red Hatted Ladies, Community House, Latrobe Youth Space, Men's Shed, volunteering local Primary School, Repair Café- Morwell Neighbourhood House, Driving

	instructor, Probus, CWA, Volunteer cooking, Historical society, animal rescue/volunteer groups
Exercise and health	Community garden, walking groups, Men’s Kitchen, Yoga, tai chi
Personal growth	U3A, Multicultural Friendship group, coffee catchups-English practice, LCHS Men’s Group, Traralgon Neighbourhood Learning House, Playgroups, language groups, further study (VCE,TAFE)

In addition to these activity options, the connector also recommended further referral to other support services that may help the client to overcome existing connection barriers. These included: disability care workers groups, volunteer coordinators, career counselling- Skills and Job Centre, National Disability Insurance Scheme (NDIS) contacts, Headspace, and financial counselling services. Appendix 1 provides examples of the community connections offered and supported by the Connector.

4.2.6 Client surveys

A client survey was also offered to clients that had engaged with the program, utilised to capture participant perceptions and experiences, and to measure any impact their participation may have had on their lives. The client survey included a combination of 4 validated psychometric tests (some modified), to measure change over time in relation to participation in the program. The four included psychometric tests were 1) the 9-question Patient Health Questionnaire (PHQ-9; modified), 2) the Generalized Anxiety Disorder 7 (GAD-7), 3) the Mood Disorder Questionnaire (MDQ; modified), and 4) the UCLA 3 Item Loneliness Scale (UCLA-3).

Only 10 participants completed the evaluation survey provided, with the sample consisting of five females and five males. All spoke English as their first language, and ages ranged between 55-84 years. The majority (70%, n=7) survey participants report having attended between 2-10 visits with the connector, with one participant meeting more than 11 times. Despite their engagement with the program however, most participants still reported feeling down and depressed, having trouble sleeping, having poor appetite, feeling nervous or anxious, worried, and that mobility was an issue. These responses were stated by 80-90% (n= 8 or 9) participants across the survey. Due to minimal participation with the client survey, credibility and generalisability of the results are limited.

Despite this, seven of the ten participants stated they were ‘satisfied’ or ‘extremely satisfied’ with the service provided, with only one stating they were ‘dissatisfied’. This participant also stated they ‘*have been very depressed’*. Similarly, one of the two clients who were ‘neither satisfied nor unsatisfied’ stated ‘*It’s nice to see (Community Connector) and enjoy a coffee and a chat. We get along well, and she has had some good ideas and contacts for more social stuff for me. Be that as it may, I’m still not overly social.*’ One satisfied client was pleased to complete the survey and provide feedback, as their *‘…answers may help me and others…*’ Other positive participant responses included *‘I hope it will continue to be available and funded for socially isolated people. It is life changing and wonderful*‘, with another highlighting the influential nature the program had on their personal growth and community reconnection:

'Thanks to this program I have joined the heart foundation and the local stroke support group. I would not have had the confidence in myself to have initiated either had it not been for the assistance and support I received from this program… This program has enabled me to make friends and develop meaningful and enduring friendships. This is a huge development for me because prior to this program I knew no one and would not have been able to accomplish what I have. I stayed home all the time and neither saw nor (SIC) engaged in conversation with anyone. I truly am very grateful to participate in this program and am all the better for it… This program is a vital link for people like myself whom otherwise would have remained disengaged and unable to make such steps to improve my quality of life.' Anonymous.

4.3 SERVICE COST ANALYSIS

A cost analysis was completed to explore the sustainability of the program. Cost data related to salaries and wages and did not include overheads, including administration, equipment, travel, and vehicles, which were absorbed within the overall LCHS budget. It is noted that the Community Connector in Phase 2 was onsite weekly at each of the three LCHS primary care sites of Morwell, Traralgon, and Churchill, compared to Phase 1 where the Connector was located only at Churchill.

Project timeframes:

- Phase 1 – July 2021 to February 2023
- Phase 2 – March 2023 to April 2024

To ensure consistency across the life of the project, a review of costs associated with Phase 1 was undertaken as part of the current cost analysis. The analysis compares information from the two timeframes included in the project and attempts to quantify the monetary cost of the two phases (Table 6).

Several measures have been used to compare costs across the phases:

Cost per client:
This was the actual cost for each client who accessed the Community Connector. It should be noted that this measure is very blunt and did not take account of the number of visits or length of visits.

The average cost per client in **Phase 2 was $1,764**, compared to $1,940 for Phase 1, a decrease of **$176 (10.0%) per client**.

Cost per engagement:

This metric provided a cost for each client engagement and includes both face to face and phone/text consultations.

The average cost per engagement (visit) was **$436 in Phase 2**, compared to $496 in Phase 1, a decrease of **$59 (13.6%) per engagement**.

Cost per client contact hour:

This measure provided an estimation of cost per direct client hour of service.

The average cost per client contact hour was **$631.50 in Phase 2**, compared to $1,871 in Phase 1, a decrease of **$1,239 (196%) per contact hour**. This exceptional decrease was due to a combined increase in the number of client engagements and the longer duration of these engagements seen in Phase 2.

Table 6: Average Costs

Measure	Phase 1	Phase 2	Variance	% Change
Cost Per Client	$1,940	$1,764	-$176	-10.0%
Cost Per Visit	$496	$436	-$59	-13.6%
Cost Per Client Contact Hour	**$1,871**	**$631.50**	**-$1,239**	**-196.2%**

Average length of engagements

In addition to seeing nearly twice as many clients (n=191), the Community Connector in Phase 2 of the project spent considerably more time in individual client engagements than in Phase 1, on average 33.8%, or more than 10 minutes extra per client (Table 7).

Table 7: Average Direct Contact Minutes per Engagement

Project Phase	Total Engagements	Average Minutes Per Engagement
Phase 1	96	31.4 minutes
Phase 2	191	42.0 minutes

Total session length

Client sessions were divided into four groups to gain some measure of the length of time the Community Connector was spending with each client.

Clients in Phase 2 of the trial had on average much longer individual session times than those in Phase 1, including 44 clients with a consultation time greater than 60 minutes in Phase 2, compared to just 4 clients in Phase 1. It was similar for clients receiving a consultation of between 31-60 minutes, 77 clients in Phase 2, compared to 33 clients in Phase 1 (Figure 17).

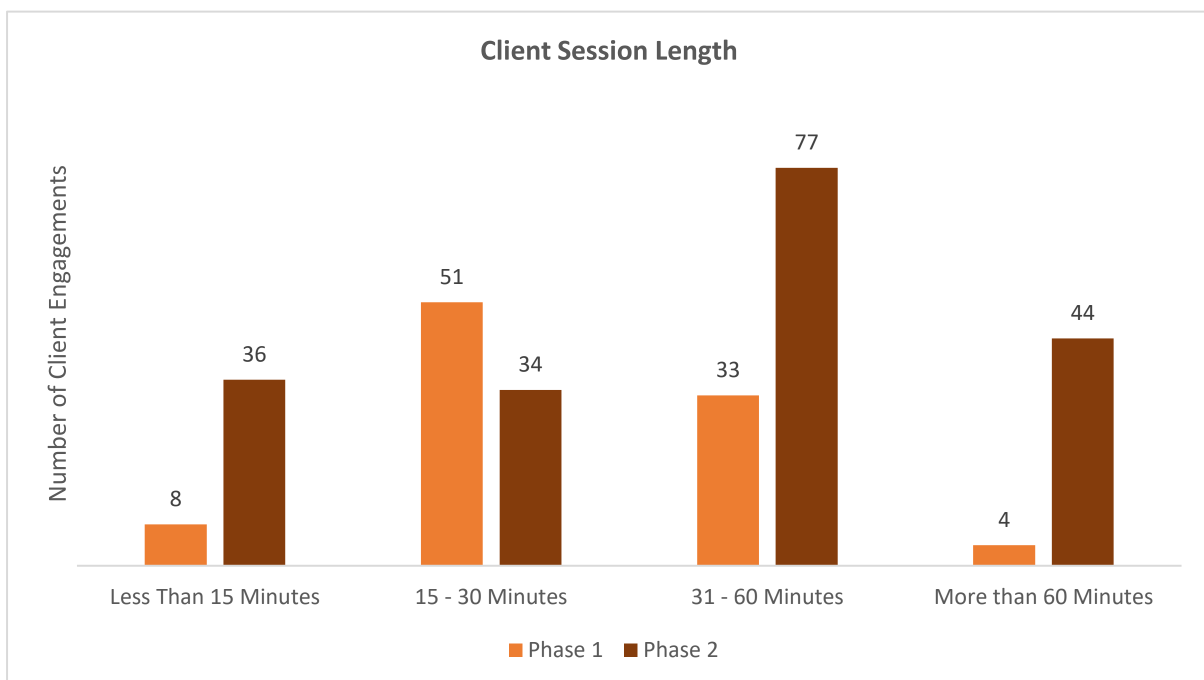


Figure 17: Client Session Length

Client sessions were divided into first engagement (visit) and returning engagements (visits).

First Sessions

More first session clients were seen in Phase 2 (n=42) compared to Phase 1 (n=35). A total of 98% of Phase 2 first visit clients were seen face-to-face. In comparison 69% of Phase 1 first visit clients were seen face-to-face, some of which may be due to the ongoing challenges associated with the COVID-19 pandemic restrictions during that time.

Considerably more time was spent with clients as part of their first engagement during Phase 2, with 19 clients having a session of 31-60 minutes and another 19 clients having a session that exceeded 60 minutes. This compared to Phase 1 where 13 clients (including face to face and phone consultations) had an engagement that lasted 31-60 minutes and only one client had a visit that exceeded 60 minutes (Figure 18).

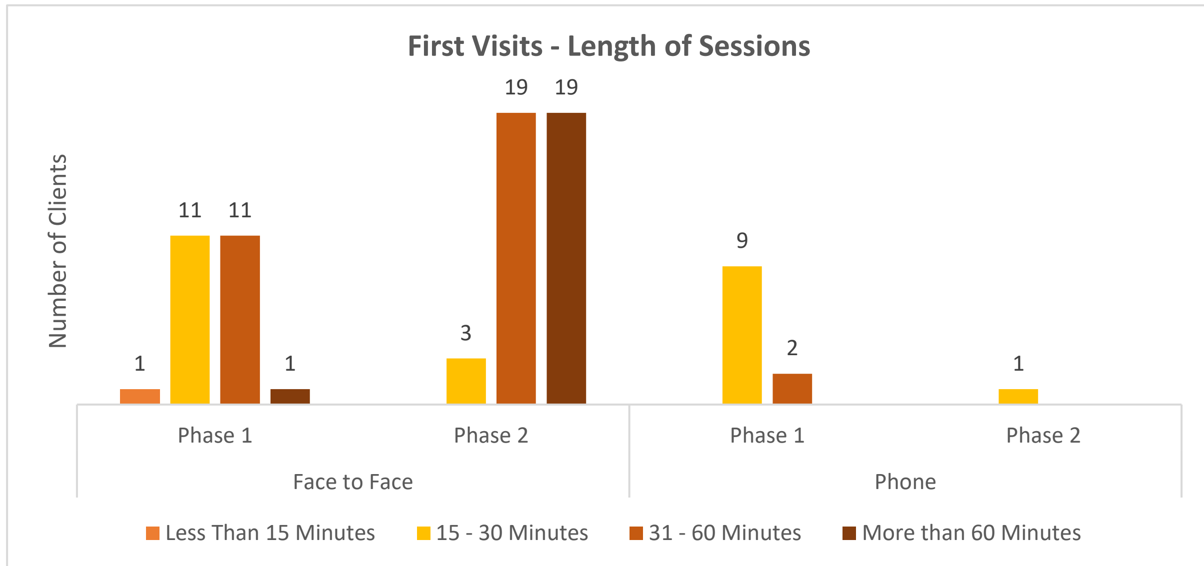


Figure 18: First Visits - Length of Sessions

Returning Clients

The length of engagement sessions for returning clients was consistently higher in Phase 2 than in Phase 1. This was particularly true for face-to-face engagements where 83 engagements (75%) in Phase 2 were more than 30 minutes, compared to Phase 1 with 13 engagements (43%) in excess of 30 minutes (Figure 19).

Only 3 clients had a face-to-face engagement longer than 60 minutes duration in Phase 1, compared to 25 clients in Phase 2. Many of these clients had multiple consultations greater than 60 minutes.

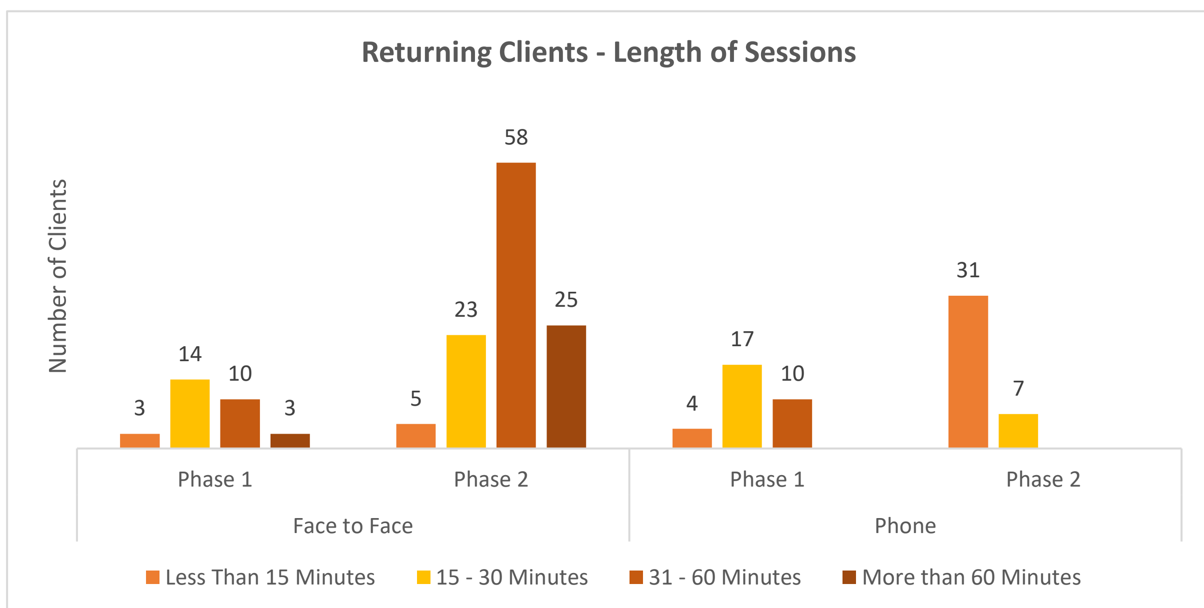


Figure 19: Returning Clients - Length of Sessions

4.4 QUALITATIVE FINDINGS

4.4.1 Interviews with social prescribing clients

A total of nine Social Prescribing clients consented to participate in qualitative interviews, wanting to share their experiences and thoughts of the program. Individual semi-structured interviews were conducted via the phone, audio recorded and transcribed verbatim. A thematic analysis was then conducted using the six-step framework established by Braun and Clarke (2022)[11]. Three major themes were identified from the analysis and are illustrated in Figure 15 below.

In addition to the thematic findings from analysing the content of the interviews, reflexive awareness of the researchers also discovered an additional outcome from clients engaging with the Social Prescribing program. Whilst conducting individual client interviews, it became obvious that several of the participants were very lonely, had things they wanted to say, often taking the conversations on tangents. There was a strong sense of frustration or bitterness towards the current inability to access services or supports in the area that they felt they really needed and could improve their lives. These participants voiced concerns about financial or mobility constraints, agism, existing disrespect and prejudice, gaps in services, or simply feeling like 'no one cares.' Participating in the interviews gave them opportunity to have a voice and be heard, which at times led to emotional declarations and concerns. Although many stated they had not made sustainable social connections yet, they each explained the complexity of their situations (without exposing personal details to the research team) and valued their time spent with the Community Connector, and the support she provided.

Independent to the client experiences within the program, the researchers felt there was a tangible sense of the clients' desperation to be heard, be listened to, and valued. These people wanted a purpose and had things to offer but felt no one was interested, or just wouldn't listen. These emotive connotations were difficult to measure, yet they substantiate the importance of having someone like a Community Connector; who is not medically focused; who is not restricted by 15 minute appointment schedules; who has more freedom in meeting someone for a coffee or chatting over the phone for an hour; who is therefore able to listen and explore the individual needs of each client with patience, compassion and empathy; whilst helping them to make suitable social connections that bring purpose and value to their lives. Therefore, the following data provides insight into how these participants describe and value the Social Prescribing program and how it may or may not be meeting their needs. The participant voices are represented throughout the findings, to support the identified themes, yet they have been allocated a code to ensure anonymity (e.g.: C5=client 5).

[11] Braun, V., & Clarke, V. (2022). Conceptual and design thinking for thematic analysis. *Qualitative psychology*, *9*(1), 3. https://doi.org/10.1037/qup0000196

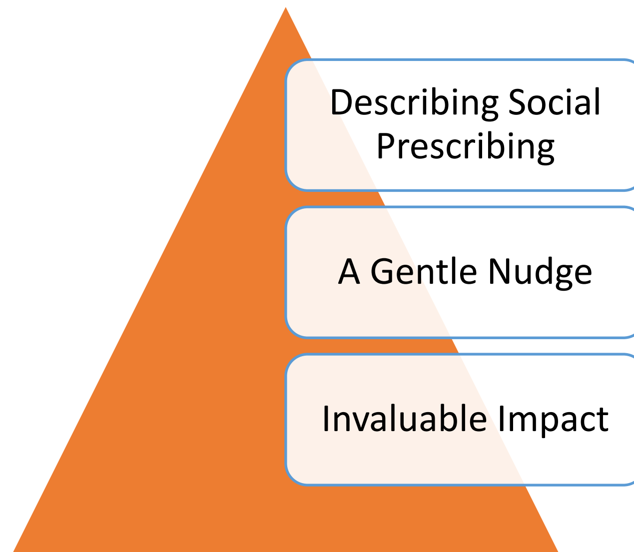


Figure 20: Thematic analysis of client interviews

Describing Social Prescribing

The first major theme captures the initial connection made between the participants and the Community Connector. Two subthemes provide explanation of why referral was made, and by whom, whilst also describing the ideal characteristics clients perceived as necessary to make the program a success. The clients described why they valued this particular support program, and why they participated. These outcomes are captured within the subthemes: *Identifying the need for Social Prescribing* and *The right fit*.

> *"…there's a lot of people out there that can't be funded by anything, that would really benefit from the (SIC) service, in that social way…we're all like the bits at the bottom of the chip packet, the crumbs…we don't fit in the NDIS or the aged care. No, we're the crumbs of society because we don't fit anywhere." C5*

Identifying the need for Social Prescribing

The first minor theme incorporated the referral process and who and why, people were being referred into the program. It appeared that the participant referrals were made from GPs and one dietitian at LCHS, after clients had expressed they were lonely, '*sick of being on my own*', and '*struggling to make connections within the community since moving*'. Even though one client had been seeing the same GP for years and seen counsellors at LCHS previously, with the Social Prescribing program now in operation within the organisation, the GP was now able to refer the client to the Community Connector hoping to further address other potential social needs. The clients all stated how appreciative they were to have been referred to the Community Connector as although some had tried to seek help themselves, they often felt '*no one understands…*':

> *"…because I get so sick of being on my own and half the time I can't be bothered getting out of bed."* C9

Although the practitioners were identifying appropriate clients to refer into the Social Prescribing program, for some clients there was still an underlying sense of frustration or a feeling of not being heard. One client embraced several opportunities offered by the Community Connector which did lead to more social interactions, however felt that her persistent pain was still not being addressed. Despite being more socially interactive and having formed new friendships, '*it doesn't take the pain away*.' She felt that although her social wellbeing was being attended to via her participation in the program, her medical concerns continued to cause her anguish, and her pain was a persistent barrier in her ability to sustain the new activities she was trying to enjoy. Similarly, another client saw community connection as a societal expectation. Although he too was very grateful he had been referred into the program, he referred his situation to a joke he had recently heard: '*how many councillors does it take to change a light bulb? Only one. But the light bulb has to want to be changed*' *C2*. He explained how he had several people, *'my doctor, my accountant, (the Community Connector)… all wanting me to get up and get out and meet people and socialise…' C2*. He stated he felt '*pressured*' and although he had lived in the Valley for many years and still didn't know anyone, he was *'…not overly concerned about it' C2*. Therefore, with the intent of the Social Prescribing program being to support social reconnection, it appeared that although appropriate referrals were being made, success was dependent on how willing the client was in engaging with the connection opportunities on offer.

The right fit.

Despite participants appreciating and valuing their involvement with the program, they emphasised the importance of having the right type of person employed in the Community Connector role. The current Community Connector was deemed '*kind*', '*caring*', '*helpful*', '*non-judgmental'* and '*open minded'*. The clients believed '*it all comes down to the individual in the role*' *C8*, and that the right personality, as well as knowledge and skills made this role work. They considered '*knowledge on community events and places where people can access stuff*' *C4*, as pivotal, but also valued the ability to *'really listen'* to people as a key role characteristic:

> '…*it's the first time I felt (SIC) comfortable with someone, who I think understood. Not so much a medical problem… but the mental' C3*.

The participants discussed the genuine, friendly, and helping nature of the current Connector and although they did recognise professional boundaries, stated she was' *the type of friend I would like to have personally*' *C3.* Recognising that these personal traits were more than just the role itself, one participant claimed:

> *"…she enjoys her work and enjoys obviously talking to people and so on… a certain amount of it is attributable to (the Community Connector) and her personality, but I think it's the job. The job description is well aligned with the outcomes that are sought*" C2.

A Gentle Nudge

As a key objective of the Social Prescribing program was about reconnecting people back into their local communities, the second major theme captures both the connections made between the client and the Community Connector, as well as how she managed to link them back into community activities. Two minor themes; *connecting to the client* and *supporting local connections*, provides insight into how the clients built therapeutic relationships with the connector, and the impact this had on engaging them within their communities. *Connecting to the client*

One of the key messages that came from clients was the authenticity of support that was provided by the connector. Each client felt special and that they were individually supported, depending on their needs or capabilities. Participants were grateful at how adaptive the support sessions were, as the connector offered to meet with clients in locations that were accessible or did not cause additional stress or discomfort. For example, meetings were conducted at a café over a coffee, or locations where the client could bring their dog along, so they didn't stress about their companion being left at home. The connector visited clients in their home if they did not drive or mobility was an issue for them due to excessive pain. This indicated understanding and respectful acknowledgement of some of the hardships and barriers that clients experienced in making their own community connections. From here, the connector began to learn who the client was, as a person, what was important to them, what challenges they faced and what support needs they required. In the eyes of the participants, it was here that the connector shone above previous support experiences they had encountered in the past.

> *"…her first question to me was 'if there was one thing you would like to do, what would it be?' And I was so shocked and taken back by the question because nobody, no doctor, no specialist, no anybody, other mental health services, never actually ask me that question. 'What do I want?' What do I want to do? I burst into tears. I remember it so clearly and I just said to her, 'thank you'. Because no one's ever asked me that. They all just tell me what to do." C5*

Once there was an understanding of what the clients enjoyed or would like to do, the Community Connector then acted. The connector would offer whatever help was required to help reduce existing barriers. This sometimes took the form of finding information, *'she would always research and email me…C5*'; or speaking to the right people, '*she's got the contacts. She knows people who know people… C2*', or she would seek other supports, *'like the food relief, the vouchers she managed to get through the YMCA*…C5'. Clients expressed that the Community Connector was always responsive to their needs without disrespecting their situation and helping where she could, making them feel valued and worthy of her time. Empowering the clients was also evident, with one client stating, '*she listens to my ideas and says '…what's the next step in that? Let's go do this. Do you need any help in doing that*?' C8. Individual encouragement, flexibility and personalised support were seen as unique and impactful characteristics of the Social Prescribing model and one that made the current Community Connector different from other health providers:

> "*That's probably the biggest thing I've got out of it, is just her encouragement. It's nice to have that moral support there and someone to give me a gentle nudge*." C2

Supporting local connections

By simply arranging meetings in non-clinical settings encouraged people to get out of the house and be within their community. Although very proactive, the connector allowed connection ideas to come from the participants themselves to optimise motivation and compliance. One client commented '*I feel quite supported with the ideas that have been coming to the surface while we're chatting*' C2. Therefore, with continued encouragement and support from the connector, some participants made

> *"I don't think I would have gone if I didn't have her with me…she was very happy to take the lead and ask a lot of questions and speak on my behalf…because I have a lot of social anxiety. It was a really lovely experience*." C4

successful and sustained connections within the community. On occasions, support was provided by physically accompanying the client to a new venue and introducing them to new contacts. The connector was able to escort clients to venues such as the Neighbourhood Houses, food relief, or accompany them during assessments when people felt '*vulnerable*' or '*terrified of being on my own'*, where she could advocate or introduce the client to like-minded people, new activities or gain further supportive contacts.

In addition to addressing travel and confidence barriers, the connector embraced the diversity of interests and desires that clients had discussed and was constantly looking at options to support them. Her willingness to research or find new information was widely praised, with most clients appreciative of the time she spent researching for them and the amount of information the connector could offer. Such information would consist of conversations about where a lonely client could go for a community Christmas dinner, or she would send clients '*a whole envelope of things for me to check out on the internet'* C7. Clients recognised how proactive the connector was in knowing the community and her willingness and effort in promoting successful connections. The Community Connector was open to researching any connection possibilities, including ancestry, hydrotherapy, trivia nights, motorbike enthusiast groups, billiards, multicultural friendship groups, art classes, or further study:

> "*I mentioned I'm going to throw my hat in the ring…and she went, 'right leave it with me.' Bang!. 'I'll go and get some information on it… she came back with three photocopied pages…while we were sitting there talking about it, the other person she contacted, they rang me. She's switched on."* C8

Invaluable Impact

The final major theme highlighted the impact of the program on the clients and how it empowered them to reconnect to their local communities. Through building confidence and having the right information, clients were able to make '*invaluable*' changes in their lives, where statements such as '*…totally changed my life*' and '*…a huge difference'* captures the influence the program had on their mental and social wellbeing. Two subthemes describe both the current impact and future potential of the program: *Confidence to connect and Future suggestions.*

Confidence to connect

For some clients having wholly engaged with the Social Prescribing program, they were proud to share their achievements in rekindling connection with their communities. Having built rapport and trust with the Community Connector, and having her by their side, they expressed how the program had '*helped my confidence'* and they no longer felt '*like a fish out of water*' C1. They recognised the influence the connector's support had on their total wellbeing, and how participation had '*made a really big difference on my mental health as well as my social life'* C4.

> *"I definitely think it has given me more confidence to reach out into the community, even just on my own, now that I know there are things out there. I can do my own research as well, and that in itself is empowering. Empowering me to think 'I can do this. I'm worthy of connection and social interaction. Yes I'm new to this community, I'm now part of this community, I'm not an outsider. I am here and that means that I have equal rights and access to community events and spaces."* C4

With newfound confidence, clients used positive terms such as '*fantastic*' and '*great*' when describing how they maintained new friendships and connections, or how they initiated new adventures such as starting a Facebook page to help connect other like-minded families within their community. One client was very proud of having done over 25 walks with a local walking group, and shared how she now attends regular social outings with these new friends:

> *"I absolutely love it and I've got to know some fabulous people through there, so it has made a huge difference in my life"* C1.

Although some clients did not make ongoing connections with the activities suggested, just having attended venues like the Neighbourhood House, where '*everyone was so friendly'*, meant people had options and would feel more comfortable reaching out to those resources in the future. These experiences demonstrated the importance of first impressions and how the Community Connector enabled these first-time experiences to be supportive, non-judgmental, and welcoming.

> "*And now if I see them in the street, they'll come up and say hello, and I don't feel like everyone's a stranger*." C4

Future Suggestions

Defined as a '*very effective tool'* for helping people within the Latrobe Valley, the clients hoped there was a future for the program. They understood, being a pilot, that the future was unknown, however '*sincerely hope it's always funded, because it changes lives for the better'* C1. They saw real value beyond their own situations, recognising the need for such a program to support minority populations in other areas. Understanding the service may not meet everyone's needs, clients were still supportive of the program that they themselves stated they would support other people in joining or accessing the service, encouraging others to seek out similar supports through their own health services, stating '*you won't know until you give it a try'*.

Amongst the praise the clients gave about the program, they also identified several limitations or barriers, and made suggestions for future improvements or modifications that they felt could further support people within the program. One suggestion was the ability for the Community Connector to have access to a vehicle that could collect clients and help transport them. One client stated the limitation of not being able to travel with the connector made it difficult to engage with the proposed activities, as she used a 4-wheel walking aid and had difficulty with transport. The client understood about insurance and the safety concerns for the connector, but additional client transport access was still recommended.

Another identified challenge was the type of people most commonly using the service. One client explained the barrier of '*depression and anxiety, and the particular mood…how bad they are that day*' C8, as an important consideration. Having a Community Connector who was '*kind', 'listening'* and '*patient*' was paramount to program engagement. Another limitation identified was that one person can't be everything to everybody. The diversity of support offered through the program was restricted to just one person, '*they can't be everywhere at once, they can only do so much'*, and given it took time to work with each individual and address their unique social needs, having more people as Community Connectors would allow more community connection opportunities and social supports to be offered within the area.

One client proposed a slight change in the referral process in regards to who could access the service. As a newcomer to the area, she had identified a gap in services and felt that although she was engaging

in the program as an individual, she felt that '*expanding it (the program) to be family friendly would be great'*, where she saw potential for a role that helped connect families into the community:

> *'I find there are not a lot of places you can go and get that support as a parent or carer, to connect with other families or spaces that meet your family's needs…specific to carers and their families or disabled parents, it doesn't really exist.'* C4.

Finally, for those clients who embraced the support offered and truly valued the program, there was a sense of regret in not having had access to such a program years ago:

> "*Had I have had that (the program) earlier on, at the start of my journey, in being sick, it might have made a huge difference in my confidence. Every major clinic should have some kind of program like this. To me it is invaluable*." C5

4.4.2 Interviews with referring practitioners

The second iteration of the Social Prescribing program was relocated into the Latrobe Community Health Service to improve reach and expand referral pathways. This modification provided opportunity for increased program exposure and diversity in referring practitioners. Individual semi-structured interviews were conducted with seven different referring healthcare workers and personnel from LCHS, including two GPs, a dietitian, two nurse practitioners, and personnel from care coordination and administration; to explore their perceptions and experiences of utilising the program for their patients/clients.

The practitioner/personnel interviews were conducted via MS Teams, recorded and transcribed verbatim. Again, the Braun and Clarke (2022) six-step thematic analysis approach was used, and three major themes identified (Figure 16). These key themes gave insight into the impact of the program on the individual, the health system, and for the Latrobe Valley community. The voices of the practitioners/personnel are again used throughout to support the themes and have been allocated an anonymity code (e.g.: P5= Practitioner/Personnel 5).

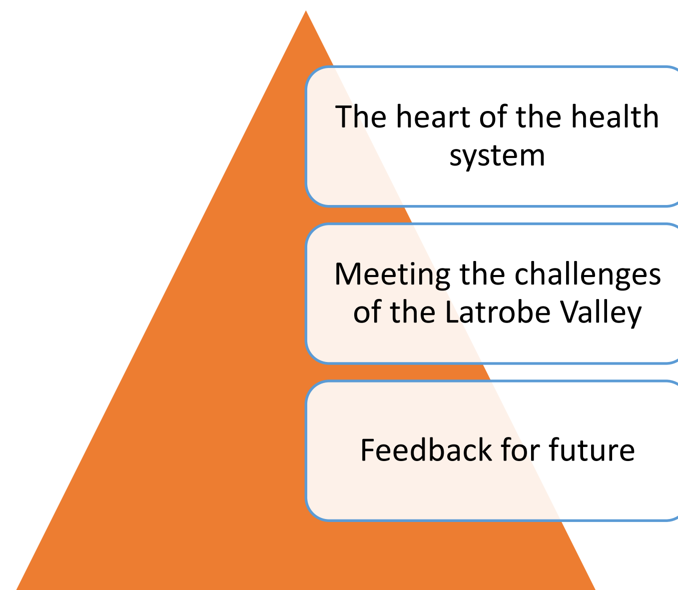


Figure 21: Thematic analysis of practitioner/personnel interviews

From the health practitioners' perspectives, there was full acknowledgement of the influential impact that poor social health has on a populations' physical and mental wellbeing. There was complete consensus regarding the importance of a program such as Social Prescribing, to help address social needs and community connection, in order to maintain and improve health within the Latrobe Valley community. This was especially recognised after seeing an increased demand on health services after COVID, and recent industry changes in the region.

> "*So, if there's anything good that came out of COVID, it is that we, society as a whole and the medical fraternity, now recognise that social isolation and loneliness…impact profoundly on how people perceive their wellbeing*". P6

In addition, the practitioners all conceded that the complexity of health and the healthcare system was good reason for poor community engagement. The psychological and financial burden of health on individuals can in itself, contribute to someone becoming overwhelmed, withdrawn and isolated. With participants discussing the poor health literacy, decreased access, limited transport options, low

socioeconomic status, and high unemployment in the Latrobe area; referring practitioners outlined how it was understandable why such a health burden exists within this particular population:

> "*Health is complex, and if you have multiple comorbidities…by the time you've seen the cardiologists, the diabetologist, the endocrinologist, the renal physician…and then they're seeing you (GP), you're thinking 'well, what difference is it making?' A lot of the times now, it's just another appointment because nobody is able to say 'no, you don't need to see me. Stick with the GP, but if there are problems, he'll send you back.' …I think we all lose that vision sometimes*" P4

It was also evident that the referring practitioners agreed that measuring the impact of a Social Prescribing program was going to be difficult. Although referring practitioner participants maintained confidentially of their patients, they each shared examples and feedback from their clients regarding involvement in the program. One participant clearly articulated that the true success of the program would mean that the referring practitioner would then not see the patient again, and hence could not enquire about the impact or outcomes of their engagement with the Community Connector. They explained that until the patient returns to the doctor:

> "*…six months later because she needs a script filled for her blood pressure tablets*, *the doctor says 'Oh, I haven't seen you for a while'…[patient]'I've been a bit busy'. So, it's going to take time for those things to actually sit in the consciousness of the medical system. To go 'Oh, I haven't seen these people for a while because they're doing this…How has that happened?*" P6

The heart of the health system

The first major theme captured how the referring practitioners valued and utilised the Social Prescribing program in their healthcare practice. Three minor subthemes demonstrated how they saw the program offered *alternative treatment options* for their patients; explained the *importance of the role*; and gave examples of how the *proof in the outcomes* supported their claims. *Alternative treatment options*

The first subtheme highlights how the practitioners recognised how well the Social Prescribing program '*meshes in'* with existing health care services, and despite a sense of primary health being undervalued, claiming governments just '*want to build shiny hospitals*'; participants appreciated the extra scope and service the Community Connector role could offer their patients. The referring practitioner participants used terms such as '*compliments the medical side of things'*, '*another avenue'* and '*useful addition'* to current service delivery; where the inclusion of the program had not necessarily changed their own practice but had '*reinforced, …given that back up, …to keep doing those things*' and offered an alternative treatment option in meeting the needs of their patients.

> *"So, I think it is another option in terms of medicine, not forgetting that medicine is not all just pills and potions. We know that. It really is lots of other things and I think this (Social Prescribing) is filling a role that we as GPs, struggle to provide*." P4

Being offered at LCHS also meant '*Social Prescribing can be linked with all those services'* P2 and having a '*non-clinical focus is helpful'* P3. This collaboration had '*in some cases, definitely taken the load*' P3,

where referring practitioners appreciated the ability of the Community Connector to provide additional supports that go beyond what their own clinical scope or service can offer:

> "*I can try and engage clients into the community better, but my reach can only go so far. I'm limited with time; I'm limited with resources and my appointments go over time now*." P5

The broader scope of practice and support through this additional program meant practitioners felt more confident in knowing patient needs were being met. Participants claimed that when they knew they were unable to provide any further medical intervention or support for their patients, this program provided another avenue to seek support for identified social needs. Recognising that '*the scope is quite different, …we cannot do those things'* P7, the practitioners were pleased that the Social Prescribing program was an attempt at filling some of these practice or service gaps:

> *"…when I get to the point that I've done as much as I can around someone's health needs, and you know that there's still those social needs, I've now got someone. I don't have to go 'I haven't got the time. I know what you really need, but I don't have the time and it's out of my scope to actually take you to the knitting group, or to introduce you to the University of the third age, or to do some research about the particular area of interest for you'. Much as I'd like to…*" P6

The need for such a program was so strongly supported that one practitioner claimed the need for social care as being '*the heart in the system'* P3. They claimed, '*doctors aren't necessarily taught about how to demonstrate that I (they) care'* and hence the need for a role that has the time, empathy, and patience to work with lonely, socially isolated, and disconnected people could only be a good outcome for everyone.

"*It resonates, because that is what we do…that's how it should be done."* P5

The importance of the role

The referring practitioner participants highlighted several key aspects to the role and why it was so important in the broader landscape of providing healthcare in Latrobe community. They identified certain groups of people for whom the program was invaluable, such as '*people who are elderly …bit more isolated'* P7, or '*people who are disengaged from community due to stigma, judgmental things due to drug and alcohol and mental health*', or for those who '*have nothing that's occupying me other than the things that I shouldn't be doing'* P3. One participant stated '*depression is your mind and body's way of saying you want something to be different' P3*, however, existing support services have not always met these needs, '*not everybody is old enough for a planned activity group (PAG)*' nor was there '…*someone who could take them and do that introduction'* P6:

> *"So, it's much better to have a preventative…we need housing support, but we also need people to have belonging. This is part of Maslow's hierarchy of needs, and if we think that we just need a medical service and to fund that, we're wrong."* P3

The distinct focus on '*determinants of health and understanding how the different determinants can impact someone…being a bit more socially active…to improve wellbeing and health outcomes'* P1, was seen as providing a '*holistic approach'* and Social Prescribing was identified as the right role to be reconnecting people when '*things change quickly and it's hard for them to land back on their feet…they just need a little bit of support…*'P7. One practitioner explained:

> *"…for a lot of people, they don't recognise that their repeated visits to the GP are really because they're lonely, and if we can undo the loneliness, then you can reduce the anxiety and depression; so people don't feel the need to be medically orientated, they get on with their life, and happy people don't need to see the doctor so much"* P6

The practitioners appreciated that current Social Prescribing program structure allowed for the connector to have the time required to individually address identified social needs, as GPs were often too limited with time; '*it's giving them (clients) an opportunity to talk about some of those things that are important to their lives, that you're not going to sit down and discuss with your GP…you know (like) 'I miss not being able to go to my quilting group'* P6.

> *"…the more normal you can make your life, the less likely the symptoms are to bother you."* P6

Although aware that all practitioners should be addressing social needs within their care, there was criticism of current practice being '*very robotic and not personalised'* P4. Having up to date knowledge about what community connections were available and individualising supports often went beyond what practitioners were capable of providing; '*it's difficult for us as medics knowing who's still current, who's who in the zoo, what is out there…because we just can't keep up'* P4. Therefore, having the Community Connector continually researching and communicating with community programs, groups and activities was highly valued, as was having this bank of knowledge within the organisation, as it was seen as a very useful resource. The prospect of reconnecting clients back into their community through appropriate referrals and recommendations gave the referring practitioner participants a sense that the service was collaboratively able to support these vulnerable people.

Proof in the outcomes

Participants all reported positive feedback regarding the Community Connector, with consensus that she was '*doing an amazing job in her role'* P2. Both the practitioners and personnel related their clients' outcomes to the connector's personality and persistence in the role, going '*above and beyond'* in her capacity. They acknowledged the work she put into planning successful client interactions and documenting her encounters to keep the referring practitioners '*in the loop'* and up to date with her progress. Appreciating the '*stuff in the background*' and '*the time to take and assist the person to get through the anxiety of not knowing…going there with them*' P3, the participants all knew the Social Prescribing role was making a profound difference to their client's lives:

> *" I could have told him…or given him this number, but even getting on public transport, getting a myki card, just the little things that we take for granted...(the connector) has been able to help."* P5

The Community Connectors' '*knowledge of what is out there'* and her ability to see the broader picture in clients overcoming boundaries was highlighted by the referring practitioners. In addition to providing community connection resources, the connector was able to support everyday challenges that ultimately influence a client's ability to reconnect, such as being '*able to assist her* (client) *in getting her phone in touch, doing a little bit of shopping…and other things around the house*...' meant the client was '*back on her feet again'* P7. This again emphasised the connectors' ability to holistically address client's needs; as '*mental health, social health, physical health, they're all correlated*' P1.

Meeting the Challenges of the Latrobe Valley

The second major theme helps explain the importance of a Social Prescribing service for the Latrobe Valley. Referring practitioner participants described the confounding challenges that contributed to potential social isolation and disconnect for the Latrobe population, how the Community Connector was helping to address these barriers, and how the program was benefitting both the community and their individual clients. As such, two subthemes were identified: *The need for the service* and *Benefits for my clients.*

The need for the service

The participants described the local Latrobe community as '*a very dysfunctional part of the world'* P3. With many social and structural barriers, they empathised with the local population and understood why this populations' health was being influenced through social disconnect. They admitted that mental health was one element that '*we don't do well'* P5, and that the Latrobe community was '*…a lower socioeconomic status area… poor health literacy'* and had *'other determinants that can impact a person'* P1; with additional obstacles identified as contributing factors for why this population find it hard to stay connected; '*transport is an issue… cost is an issue'* P6. Participants explained '*there's intergenerational trauma here'* and that what the Social Prescribing role was achieving was ' *better than what I do really'* P5, in regards to helping people reconnect and overcome many of the challenges they faced on a daily basis.

> *"…this is the place where Centrelink provides the least support, where the job network is the most dysfunctional, where there's just so many layers of mental health that isn't working…and then there's a whole lot of other people who through the cost of housing are being displaced to here. So, they're landing where there aren't good networks and there is not a community that can reach put with open arms and say, 'come and join us'"*. P3

Similarly, although participants valued the continued drive within local health and community services in the area to provide supports, they were frustrated with a lack of sustainability of programs and hence found people were '*falling through the cracks*'. Participants agreed that '*social prescribing is (SIC) really important in the community, especially for people who need connection'* P2, and they hoped this one particular program could be continued, as they had found the Community Connector was addressing a gap in health not being met by other health services. However, due to previous experience working with the various fleeting support programs offered in the area, there was a conscious exasperation amongst referring practitioner participants that this program would just be another valuable idea that was trialled and fizzles out, regardless of the impact.

> *'…we all know what happens…something's set up and a year later it's gone. It was a value, but there's no funding left anymore…'* P4.

Benefits to my clients

Participants valued the individual impact the program was having on their clients, where clients were reporting feeling '*happier*' and '*enjoying*' themselves. The practitioners reported that the '*balance*' of

mental, physical, and social wellbeing, was being achieved for some individuals, through working with the Community Connector. For those people '*in the past, where the client was experiencing anxiety or fear to come out of the house…*', were now reconnecting or linking with connections that fulfill their interests; they were now '*able to give back*' and undertake activities that could '*give them some self-esteem*'. The referring practitioner participants described seeing client changes, using terms such as '*enthusiastic*', '*opened up a huge world…he didn't know existed*' and '*more motivated*'. They claimed those clients who were engaged with the program and have been able to reconnect with their local community.

> *"…are much more inclined to manage their health better because they've got all these wonderful things they want to be able to go and do. So being sick doesn't fit in that plan".* P6

The practitioners proclaimed that their patients '*really love it (Social Prescribing program) because the focus is non-medical*'. By building a trusting therapeutic relationship and working with the connector to address their client's social needs, fears, and barriers, then '*the theory would be, if people are feeling better emotionally, then they may be more motivated to improve, get some exercise, so the diabetic parameters improve*' P4. Engaging with the Social Prescribing program was seen as an effective and sustainable support system that could potentially improve health outcomes, as their client's psychological wellbeing improved, their confidence grew, and they felt empowered and enabled to maintain new connections, friendships, and social networks into the future. Recognising the benefits of engaging with the program made the practitioners and personnel felt they were helping to achieve the best health outcomes for their clients, giving them both personal and job satisfaction; '*as long as the client benefits…that's what I want as a clinician*' P1.

Feedback for future

The final major theme included both feedback and suggestions for future delivery of Social Prescribing programs. This theme highlights the limitations and challenges of the program in its current form, and captures further suggestions made by practitioners and personnel that would continue to utilise the service if it was offered in the future.

One key factor noted was the lack of awareness or understanding of the Community Connector role within the LCHS organisation and clinicians, and what the Social Prescribing program was designed to achieve. One senior practitioner declared he '*perhaps wasn't quite aware of what exactly it entailed*' P4, while another commented '*when you hear social prescriber, you automatically think prescribing medications…coming from a clinical background*' P5. Despite now being fully supportive of the program and its role, in supporting health in the community, many felt better publicity about the role was needed to help improve clinical awareness, for both those referring into the service and for potential clients. Some participants stated '*I've been in this role for 18 months, but I didn't know anything about it*' P5, and it wasn't until the *'(Community Connector) came into a meeting and just said a very brief overview'* P1, that clinicians became aware that the service was available. There was suggestion for '*a bit more information*' about the role and the purpose of the program to therefore encourage practitioner collaboration and increased referral rates.

"it's going to be something that' going to take 5-6 years to really get established and for people to feel confident. …for GPs, and practice managers and practice nurses to understand it…GPs are just so busy trying to get people in and out and manage the medical side of it…so it's how do we promote that it's a really valuable way of addressing the needs for some clients who keep coming in for whom there is no real medical reason…it is this loneliness, ongoing depression, anxiety… this will take time." P6

The location from where the program was being delivered was also seen as an important factor for success. As the current model was located within the GPs setting of the organisation, some saw this as restrictive and suggested it limited access and exposure of the service, '*I mean I sit within the GP world. Nobody else in the organisation knows about it*' P5. Another participant would have liked to see the service '*not linked with a medical facility'* at all, where the program could be run within the community, '*so that it is already dislocated from the medical system'* P6. For those GPs who did work closely with the connector, they felt by having the program located within the same building, they '*feel and see her as part of our team, like she's one of us'* P3. Another limitation in relation to location was regarding the connector not having her own space. Although there was great admiration for the '*knowledge that's in her head'* P3, the connector was not allocated a dedicated consultation space or somewhere she could keep resources. One clinician claimed she would:

> "*…often say to her, 'you come, we'll do a co-consult, I'll sit and chat (with patient), then you can have my room'…because I think that's a little unsettling when you don't have your own space*" P5.

Finally, the referring practitioner participants recognised that the connector was still limited in what support and connections she could achieve, and that this program was not going to achieve success for every client referred. Despite having an admired level of community networks and knowledge for successful reconnection opportunities, and recognising the role allowed time and scope to address individual social needs; the participants still acknowledged that the Latrobe population would continue to face challenges, such as transport, financial and physical barriers, for which the connector had no control. The sustainability of the program, the impact on the community and the health of the population, would therefore, always be in question. Participants knew there would be no quick answer to these community issues and hence, the true impact of the Social Prescribing program would only be seen over time, as people reconnected with community, gained confidence and skills, built support networks, and became empowered to help overcome hurdles for themselves. Such achievement takes time, funding, and community acceptance, and thus evaluating the program after such a short duration may not be ideal and may not necessarily give a true indication of the potential for this pilot.

"I'm sure it will take time for them (GPs) to get their head around the whole social prescribing thing, but my worry is that it'll take them too long". P6

4.4.3 Interviews with community connector

The Community Connector was interviewed on three separate occasions, to capture her expectations, challenges, and highlights of the role. Having already worked in a similar role in the UK, the connector had a preconceived notion of what was required; however, how the program would work for residents in the Latrobe Valley was unknown.

Initial interview- August 2023

The new Community Connector described the role as *"supporting members of the community to gain access to community activity or break down barriers to get access to community".* The Community Connector had previous experience working in a *"Social Prescribing role in the UK"* and therefore provided a new perspective on the role:

> *"My slant is different, the way that I think is different…I'm really interested in people's aspirations…Helping people to find some fun, some pleasure in life"*

The role required providing a *"listening ear"* for clients, some of whom were *"particularly vulnerable, and trying to build their confidence"*. As the Social Prescribing program was still being embedded within the LCHS Morwell site with opportunities to expand to other sites in the near future, the Community Connector stated, *"I'm quite privileged really, because I've got time* [to spend with clients] *and that's one of the beauties of this role".* While appointments slowly increased, as knowledge of the referral process within LCHS spread, the Community Connector was nervous about the impact this could have on their case load:

> *"I am a bit nervous about opening the* [referral] *gates and what that's going to look like because I don't know what a case load should look like".*

To prepare for the potential increase in referrals the Community Connector had set 3 top priorities for the role to increase impact and success.

1. *"Making sure my* [Social Prescribing service] *information is out there."* Increasing awareness of Social Prescribing within LCHS to increase the number of appropriate referrals and clients.
2. *"Streamline referrals."* Ensuring the referral process was easy and simple for practitioners and clients to reduce wait time and increase accessibility to the service.
3. *"Making sure that I'm up to speed with what's out there"* regarding community activities, social services, and referral points, ensuring that all participants receive the best possible service and community connection.

The Community Connector expressed how *"complex"* the clients were in comparison to her previous Social Prescribing role in the UK. This was due to the number of barriers clients must overcome to access community activities and support in the Latrobe Valley. The Community Connector was assisting clients to overcome barriers including *"comorbidities", "transportation", "financial", "mental and physical health", "public housing"* and *"elder abuse".* As the *"barriers are quite widespread"* and each of these *"issues are interconnected"*, connecting clients to activities and support could be a complex task:

> *"That's one of the wonderful things I think about working in the Latrobe Community Health Service is the fact that there are so many other services under the same umbrella that I can refer to."*

As Latrobe Community Health Services offered access to a range of physical, social, and mental health supports, the Community Connector was able to refer to these services and *“get support from others in the teams”.* Due to the complexity of each individual client, the Community Connector expressed angst as she had *“to think on my feet a lot”*. Clients *“have so many issues that I was finding it difficult to navigate”* while also triaging the urgency of their need, *“should I be sending them up to emergency counselling or should I be sending them off to someone who can help with the general stuff?”*

While most health professionals work collaboratively to encourage critical thinking, debriefing and support, the Community Connector worked *“alone”*; increasing the pressure to make the right decision regarding referrals and navigating multiple systems. *“The care coordinator”* had worked with the Community Connector for several clients and provided a *“sounding board”* for potential referrals and community connections. This collaboration *“took the pressure off me because I didn't have to think about medical health needs”.*

“The care coordinator provides all the support that this person could be referred to in the health system … Whereas I'm there when all their support needs are done, then I can work with them…. the clients feel so well supported”.

The Community Connector had been in the role for several months however remained unsure of her scope of practice, as it was *“not defined what I can do and can't do”.* The Community Connector stated that she *“found it really easy to talk those things through with the Care Coordinator”.* Given the complexity of Social Prescribing clients, *“chatting through what I'm doing could be helpful long term”* to ensure the best outcomes for clients.

Progress interview- March 2024

Having now been in the role for just over 12 months, the Community Connector had settled in as part of the team at Latrobe Community Health Service. Although her location in the organisation was quite transient, she believed having the role situated within a centre where several GPs and other health professionals were located influenced the increase in referral numbers. Respectfully recognising the challenges faced by the previous Community Connector at Hazelwood Health Centre, where there were minimal referring doctors available, she believes constant exposure to a variety of GPs and other healthcare workers in a larger, more occupied venue, ensured the program was always present. Her insight highlighted four main themes: a) *Just what the doctor ordered*; b) *Right Place, Right Time;* c) *Prescribing the right medicine*; and d) *Suggestions for future programs*.

Just what the doctor ordered

The first key theme identified was having the right person employed as the Community Connector. The current Connector admitted to being a person who had ‘*a real interest in people*’. Although she had concerns that not having a health background could potentially ‘*preclude some people referring’* to her, she was also aware that confessing this to clients meant conversations could evolve about interests and aspirations, redirecting the focus away from health, which people found ‘*refreshing*’. Her previous counselling experiences and ability in ‘*seeing things from different perspectives’*, allowed her to be creative and flexible ‘*to find something that does fit’* for the diverse range of clients she met with. The connector declared she was ‘*quite persistent’,* repeatedly stating ‘I *will persevere*’ and that

they '*don't give up easily*', indicating she was resilient and determined to be successful in helping the clients reconnect with community. The Connector provided an environment where the client felt comfortable to have a cuppa and chat, have a laugh, and discuss possible connection options. Her empathetic manner was captured in her ability to quickly establish a working relationship and accompany her clients to activities. Her creativity and flexibility allowed her to take her ideas and working connections from place to place, from meeting for a coffee, to joining a client in the swimming pool where the client was free from pain and could have more productive conversation.

> '*I love to see positive results. It makes my day*.'

Such aptitude has produced positive connections with clients and thus she had '*…never had any problems with clients whatsoever*'. Self-awareness was also obvious when talking with the Community Connector, as she occasionally demonstrated self-doubt, and questioned her ability to drive change in the clients. However, she recognised that having access to appropriate health specific support would not only have helped manage some client barriers, but also provided strategies that improved her own skill set. Although *'…often able to come up with the solutions myself'*, the Connector appeared to have a good working relationship within the healthcare team and was confident to seek support from her colleagues or EAP should it be required. The Connector was proud of what she had achieved, but still wanted to see better outcomes. She was passionate and hopeful that the value of this role was recognised, and that her suggestions could help further develop similar roles in the future. She stated *'...if something I have done here helps to develop something that really works, well…*'

> *'I've just loved it. It's been my best job ever!'*

Right Place, Right Time

The second key concept identified in the data was the successful relocation of the program to the Latrobe Community Health Service. Having access to many more GPs across a larger catchment area, had seen an increased referral rate into the program. The initial allocation of space within the GP corridor provided opportunity to '*talk to them* [GPs] *and build relationships'*, which meant the program had a constant presence within the venue. Such visibility created an environment where on occasions '…*the GP has said to me, could you come round and meet this patient?*'

> *'I think that is one of the things that made a difference, because I was walking up and down the corridor and they could see me.'*

The Community Connector had also requested to expand the program by permitting referrals from other healthcare workers within the organisation and had established a good supportive connection with the Care Coordinator. Granted the reach of the program was much wider that the initial pilot at Hazelwood, now receiving referrals from practitioners working in Warragul, Moe, Morwell, Churchill, and Traralgon; but '…*unless we're in this sphere, we* [people] *wouldn't know'* what Social Prescribing was. Hence, although marketing leaflets had been organised to promote the program and client self-referral, the public didn't necessarily understand the service on offer. The current Social Prescribing pilot appeared to still be evolving within the host organisation, attributable to the proactivity of the Community Connector. Flexibility was warranted due to a lack of consistency within the clinical environment where the program was being delivered, where permanent room availability or OHS restrictions limited engagement activities such as displaying interesting connection activities or offering a cup of tea during a consultation.

> *'…it's so different from what you would get if you were going to the podiatrist or going to the GP. It* [cup of tea] *just deescalates everything, doesn't it?'*

Despite these challenges, the Connector felt locating the program within a GP centre was more appropriate than locating within a hospital or other healthcare venues. She recognised the important relationship a patient had with their GP; and declared: *'they're* [GPs] *the ideal conduit because people do have to go and see their GP, don't they?'*

> *'I do think in this setting, it does work pretty well. It just needs the edges rounded off a little…'*

Prescribing the right medicine

Another key theme within the discussion was around the operational aspect of the role. The Connector explained that when she met with a client, she spent time to understand '*what makes them tick…*' But unfortunately, she claimed many clients had underlying concerns that '*preclude them from connecting to their community*'. The Community Connector explained how there had been many instances where these underlying barriers required additional support services such as from a psychologist or Care Coordinator, and she proclaimed that she was often dealing with *'people who've got historical trauma, they're not prepared…it's their life, but they're not dealing with that and it's just so difficult to help them look at other activities.'* Some examples were given: '*one* [client] *includes an irrational fear of identity fraud'*, and for another client '*life is just excruciating pain*…' and so, despite experiencing such difficulties within the role, she admitted that *'…even for that one hour, we often come out laughing…several clients have fed back to the GP that they've loved having that connection with me.'*

> *'…identify with them, their aspirations, things they haven't done for a long time and actually help them reflect on things other than their health.'*

The Connector reports she currently had 22 clients for whom '*the mental health is manageable for them, and for me to manage… and we have actually made some progress…*', but there were another 18 clients who were more challenging. There had also been situations where '*we've had an outcome and then for whatever reason, it's fallen in a heap, and we start again.*' But the Connector carried on, looking for innovative ways to reconnect; '*it's difficult because often they're on their own. I'm talking to them quite bit. It might be a coffee…in the back of my mind, I'm always trying to think to myself, where is this going?*' But it was this adaptability that achieved results. Stepping outside the traditional role for one client and joining her in the pool had meant '*…good conversations when she is not in pain'*.

> *'I think that's where we stand apart. I can actually go along with someone and provide support and get them into it… the peer worker is great, but they don't actually attend with the client.'*

The Social Prescribing program provided flexibility, patience and compassion, allowing the Community Connector to walk alongside vulnerable people, supporting and sharing in their unique journeys, as they each worked to overcome their individual connection barriers.

Suggestions for future programs

Due to the Connector's enthusiasm to see the program be successful, the final theme arising in the discussion was suggestions about how the current program delivery might be improved for future applications. She suggested that '*in an ideal world, it would be great if it was, from the onset, all health professionals*' that could refer, as it had been '*a little messy'* having to keep requesting permission to expand the referral sources to increase client numbers. Similarly, '*it would have been good to have marketing on board right from the onset*', as this was another challenge identified by the Connector, being the lone practitioner trying to promote a new service within this large organisation.

An important gap identified by the Connector was the current inability to collectively support a client in reconnecting to their community, through collegial service support. The suggestion of having a psychologist, or a care coordinator that could help with some of those underlying issues, or even reconnecting with the GP to discuss client progress, was seen as an ongoing challenge. Appreciating the role was designed to help relieve some burden from the GPs, working in isolation was also not ideal; '*the GPs are very busy…sometimes it would be nice to just chat through a little bit more about what's going on, but they are so busy*'. The Connector understood that including more practitioners takes time and money, however, the suggestion of '*maybe just once a month, talking through clients with perhaps a psychologist, I think would be really good.*'

> *'…its extremely hard…it might not be the psychologist talking to them [clients]… it might be me perhaps, having the support from a clinician, like a care coordinator, who's got the background of Social Prescribing, to help me see the bigger picture.'*

Supporting both the role, and the person in the role, was essential. Practitioner and client safety were paramount, along with privacy, confidentiality, and access to appropriate resources. Hence, having a permanent and private location within the organisation was highly recommended. The current Connector, suggested an ideal space would be on the main corridor, where she *'…could actually just put out a sign saying Community Connector's here, come in and have a cup of tea with me…*' She felt being more visible, would mean you could potentially have people popping their heads around the corner saying '*what do you do*?' She envisaged a future where something similar to the existing Alcohol and Drugs hub could operate, potentially a *'hub of social prescribers'*, but where Social Prescribing functioned within a '*support network'*, all working together to reduce the barriers to client connection.

Final interview- June 2024

The final interview with the Community Connector provided opportunity for reflection and recommendations, being able to highlight both the successes and challenges of serving the Latrobe Valley population for the past 17 months. Identifying this role as '*the best job I have ever had'* the connector was eager to explain why she has so enjoyed '*communicating with clients…I mean really insightful conversations*' where she had spent time finding out '*their inspirations, their interests…*' and '*talk about things that are (SIC) not health related'*. She now stated, '*I admire the client's attempts to overcome barriers'* and had gained appreciation for the struggles this population sometimes faced in connecting with community. She stated, '*I have worked with vulnerable people in the past'* but claims that '*once you get people talking about things they like to do, the conversation is easy'*.

As time has passed, she now recognised that not having a medical background was perhaps a positive aspect to the role. People opened up because they felt comfortable. '*They've been referred by someone who trusts the social prescriber',* and because these people have recommended meeting with her, and clients have often spent a lot of time in health clinics, '*this is perhaps refreshing, to talk about things other than their health*'. However, not having that health background has potentially contributed to challenges with her own welfare in some instances. '…*there's some issues that clients have brought to meetings…there's definitely been an effect on me…*'. Because the Community Connector works '*alone*', not having fellow colleagues to help manage, discuss or debrief means, had there been a larger team, she *'…wouldn't have gone home a few nights really worried about things*'. Although the connector did engage with a community of practice, and '*will always reach out to others' and 'will seek advice',* other programs appeared to be dissimilar to the model provided in Latrobe.

'*Others are specifically working with elderly and putting groups together*' where she feels '*being embedded in quite a large health service*' had '*worked really well*'.

In addition to reflecting on her own personal growth in the role, three key topic areas were discussed in the final interview, where the connector provided explanation and rationale for some recommendations she had for future program delivery. These topics included: the importance of adequate research and the time required to gather appropriate resources; workload and the ability to meet individual client needs; and the importance of promoting community connection opportunities through Social Prescribing.

Research and Resources

The connector declared that although she had not formally documented the time used for researching connection opportunities, it was a pivotal component of her role. She explained that she was constantly having to learn about new connections as well as create resources that could be drawn from in the future; '*but of course, it only takes a few months for things to change'*. Keeping current with what programs were still funded and being offered in the community was also a constant issue. She provided an example, where not only was she '*ringing the op* [opportunity] *shops, finding the name of the person, whether they need volunteers…*' but she was compiling relevant information to ensure there were minimal barriers for clients in making the connection.

> *"…three pages of different activities, including how to get there. And some people are on public transport, and some are using cars, so it's finding the best route public transport wise, …all those things take time*".

Workload and meeting client needs

Although the connector admitted to time being wasted on occasions due to client non-attendance, she explained the time required and lengths that were needed to minimise lack of engagement with the program, *'I'll try to encourage people to meet close to home, at a place convenient to them…so they don't have to travel very far'*. She also discussed the '*calls, writing notes, the administration'* involved, that helped plan for a positive encounter or first experience with a community connection.

> *"I'm really trying to make that first experience, a really good one… because that sets the tone for the rest of the future activity…just trying to make the experience as easy and fun as possible"*

To do this there had been a high engagement required by the connector: '*it comes down to the research and finding out who's leading the group, who might be there on the day…and I might go to an activity to check it out…I attend with the client, I observe what's going on, and I might manage the meeting…we do coffee afterwards…'*. Because of this dedication to individually supporting the needs of each client, there had been many successful connections made; '*…had I not gone, had I not said I will be there at 10, I don't know if the client would have attended'*.

...one of the most enjoyable parts of it has been the fact that I've been able to leave my desk and participate with the clients. That's been really enjoyable, and it's enabled me to really close the circle... talk about an activity with the client, do the research and then go along and then see how the client reacts.

The connector recognised that she had been very '*privileged*' in the current role with the number of referrals being made, which had allowed her time to practice as she had. Although she declared '*I could work harder*', she implied '*I might spend 2 days in total on a client before they're ready to move on*'. She then suggested if referral numbers were to grow, careful time utilisation would still be required to not lose the key features of the service. She suggested a potential increase of daily client contact from 2-3 client meetings a day, to a hypothetical 4 clients a day for three days, with one day allocated for research duties, could be a sustainable possibility in building capacity for the current program. She went on to suggest that '*maybe 6 new clients and follow ups with other clients*' would make up the 12 clients per week workload, accounting for all the administration, travel and research associated with each client.

Promoting connection opportunities

The final point discussed was around recommendations that could potentially support further use of the Social Prescribing model. The connector felt the transient nature of the current role provided great flexibility in how she could attend to client needs, however, she would love to have her '*own room*' where she could keep her resources and '*promote some activities*'. She was pleased about the uptake and current organisational support and '*the fact that other health professionals, other than GPs are referring; dietitians see the value... care coordination see the value...it's really exciting*'; however, felt a more permanent, central position would '*be great to be a point of contact for things like volunteering and all community activities*'.

The final concern expressed by the connector was regarding the community programs or volunteer organisations utilised for community connection; '*me encouraging a new member to come into a group is fine, but say Social Prescribing really took off and I was referring 6 people to a group, I wonder whether some organisations might feel they don't have the capacity... some might welcome new members with open arms, but some might find it really challenging*'. With local organisations '*looking for grants all the time to run programs*', it highlighted a wider need for organisational support and community partnership in the future.

Overall, the Community Connector was grateful for the opportunity to work within the program; *'I love being part of this organisation and the fact that other health professionals other than GP's, are referring. It feels good.'* She recognised the fact that referral numbers may not have been as high as anticipated but was proud of what she had achieved and the impact she had on the lives of many of her clients; '*one particular client hasn't missed a group. She absolutely loves the group'.* Knowing the program was not for everyone, yet each success was one less person who was socially isolated and lonely in Latrobe.

5. DISCUSSION AND RECOMMENDATIONS

5.1 DISCUSSION

Although the Social Prescribing pilot program was relocated into LCHS to maximise referral pathways and client numbers, results did not improve as anticipated. In comparison to the previous delivery in Churchill, data has shown that the second iteration of the program did see higher referral numbers in a shorter time period, however the delay in program exposure within the organisation contributed to the slow uptake and limited clinician awareness of the service. The relocation and proactivity of the new Community Connector has seen a more diverse range of practitioners referring into the program, and an increased GP referral rate from just one GP referral at Churchill, to 67% referrals coming from GPs within LCHS. However, this took the Connector additional time and effort to promote the program whilst working as a sole clinician in the Social Prescribing space. Such time allocation has not been documented nor considered when analysing expenses of the program. Exposure of the role has been reported as inadequate due to organisational structures and communication limitations, suggesting inappropriate planning and information distribution occurred during the relocation of the service.

Another key component of the Social Prescribing program and Community Connector's role that is highlighted throughout this evaluation, is the time spent conducting research and building connection resources. Again, not formally documented or analysed, yet it is recognised by both the clients and referring practitioners as vital to the success of the program; the Community Connector is valued for her knowledge of local community contacts, existing support programs and up to date information about projects and services. The time spent building relationships with community contacts and maintaining up to date contact details, has been highlighted as a trusted resource within the organisation, one that reassures clinicians that their clients are being given appropriate and helpful information.

The pilot has not resulted in sustained connections for every person who was referred into the program, yet many successes have been seen. Referring to the research questions underlying this evaluation, the following outcomes have been achieved:

1. *What was the impact of the Social Prescribing model on primary health providers in the Latrobe Valley?*

The health providers interviewed during the evaluation spoke very positively about the program and the Community Connector, however, this did not truly measure the impact of the program. Practitioners appreciated having someone they trusted to refer clients to when they could no longer address persistent health issues with medical interventions. They valued having a service that allowed time and resources to help clients overcome social barriers and challenges, something they outlined as not having time or scope within their own practice to do. They all recognised the connection between social connectivity and how it impacts mental and physical wellbeing and reported positive feedback from many of their patients. The healthcare providers did not report the Social Prescribing service has changed their practice, nor reduced client attendance within their clinics, however, they were grateful for the additional non-medical intervention option available to them as practitioners.

> *"…it's nice to be able to offer something which isn't just a pill or a potion". P4*

The evaluation also demonstrated that there was still room for improvement regarding providers' awareness of the service and the Community Connector role. Data were limited, as only a small range of practitioners were currently utilising the service, with reasons unknown. Interviewed participants

all declared the referral process was very easy and straightforward to use, but their knowledge of what the service entailed was delayed due to limited publicity or the physical location of the connector within the organisation. However, those practitioners who were utilising the service, acknowledged that a successful intervention with a program like Social Prescribing, was changing their client's confidence, self-esteem and giving them a sense of purpose, which in turn had the potential to improve both mental and physical health. One practitioner explained how client's:

"…are much more inclined to manage their health better because they've got all these wonderful things they want to be able to go and do. So being sick doesn't fit in that plan." P6

There was recognition that the program was also supporting those people who were '*falling through the cracks'* of the current healthcare system, and that there was a great need for the service specifically within the Latrobe community, *describing the area as 'a very dysfunctional part of the world'* P3. There was appreciation for the holistic nature of the program and how the service was able to '*reinforce*' the type of support and healthcare practitioners wanted to deliver in an ideal world.

"*It resonates, because that is what we do…that's how it should be done."* P5

The practitioners were so supportive of the program and the potential impact the service could have on social, mental, and physical wellbeing in the local community, that one practitioner referred to the concept as being '*the heart in the system'* P3, where they imagined a future healthcare collaborative system that managed to truly meet the diverse needs of this vulnerable population.

2. What was the impact of the Social Prescribing model on referral recipients?

From the small sample of clients who completed the participant surveys, 90% (n=9) stated they were satisfied with the recommendations given by the Community Connector and that they would recommend the program to others. Although not everyone established sustained social connections, there were many success stories shared through client interview discussions and practitioner feedback. Clients used strong descriptive terms such as '*invaluable*', '*life changing'* and '*made a huge difference',* as they reported new confidence, new connections and new friendships as a result of their interactions with the Social Prescribing program:

> *"…because I was ultimately just sitting at home and not engaging with anything within the community. So, it's very much opened up a whole new world for me, which I'm very grateful for*." C1

Not only have some clients' emotional health and sense of purpose improved through these connections, but it has led to increased physical activity, also inadvertently benefitting their physical health:

> *"I have done over 25 walks with them now. Absolutely love it and I've got to know some fabulous people through there. So, it has made a huge difference in my life."* C1

Having a connector who was able to accompany the clients to new activities also contributed to some successful connections. For those clients who have embraced the opportunities to try new things whilst being supported by the connector, new connections have been possible. For others, simply leaving the house to meet the connector for a coffee catch up has still been a positive encounter and something they look forward to attending. Whilst for others, they are happy to remain within their own comfort zone and do not wish to pursue the new social networks or interactions that are suggested. For some, the physical barriers are just too great to overcome, and although they are

unable to turn their ideas and ambitions into actions, they truly appreciate having the connector as an empathetic ear. This has provided opportunity for them to have a voice and to be heard.

> "*I definitely think it's given me more confidence to reach out into the community and make those connections, even just on my own, now that I know that there are things out there. I can sort of do my own research as well, and that in itself is empowering."* C4

Measuring the impact of the pilot on the clients who have engaged with the program is nuanced and complex. Success and failure are measured differently for each individual and each client has their own challenges and barriers to work through. On this occasion quantitative data has not been able to capture this impact, where qualitative story telling has provided examples of both positive reconnection, negative social engagement and personal growth.

3. What were the perceived benefits and challenges to introducing a program for Social Prescribing in the Latrobe Valley?

The Latrobe Valley was widely identified as being an area of great need for such a program, due to the many social challenges facing the local population. Current social determinants of health were seriously contributing to poor social connectivity, community disengagement and high levels of isolation and loneliness. Both client and practitioner participants highlighted barriers such as financial insecurity, the lack of transport, high unemployment, and limited access to healthcare services in Latrobe, has led to poor mental and physical wellbeing, including poor sleep, unhealthy diet and limited social interaction. All these factors are therefore contributing to a vulnerable population with increased risk of chronic disease and complex health needs.

Relocating the pilot program into a large community health organisation such as LCHS was seen as a way to expose this vulnerable population to additional non-medical social supports, where client focus could shift from poor health to what would bring a person joy, where the Connector was able to:

'…identify with them, their aspirations, things they haven't done for a long time and actually help them reflect on things other than their health.'

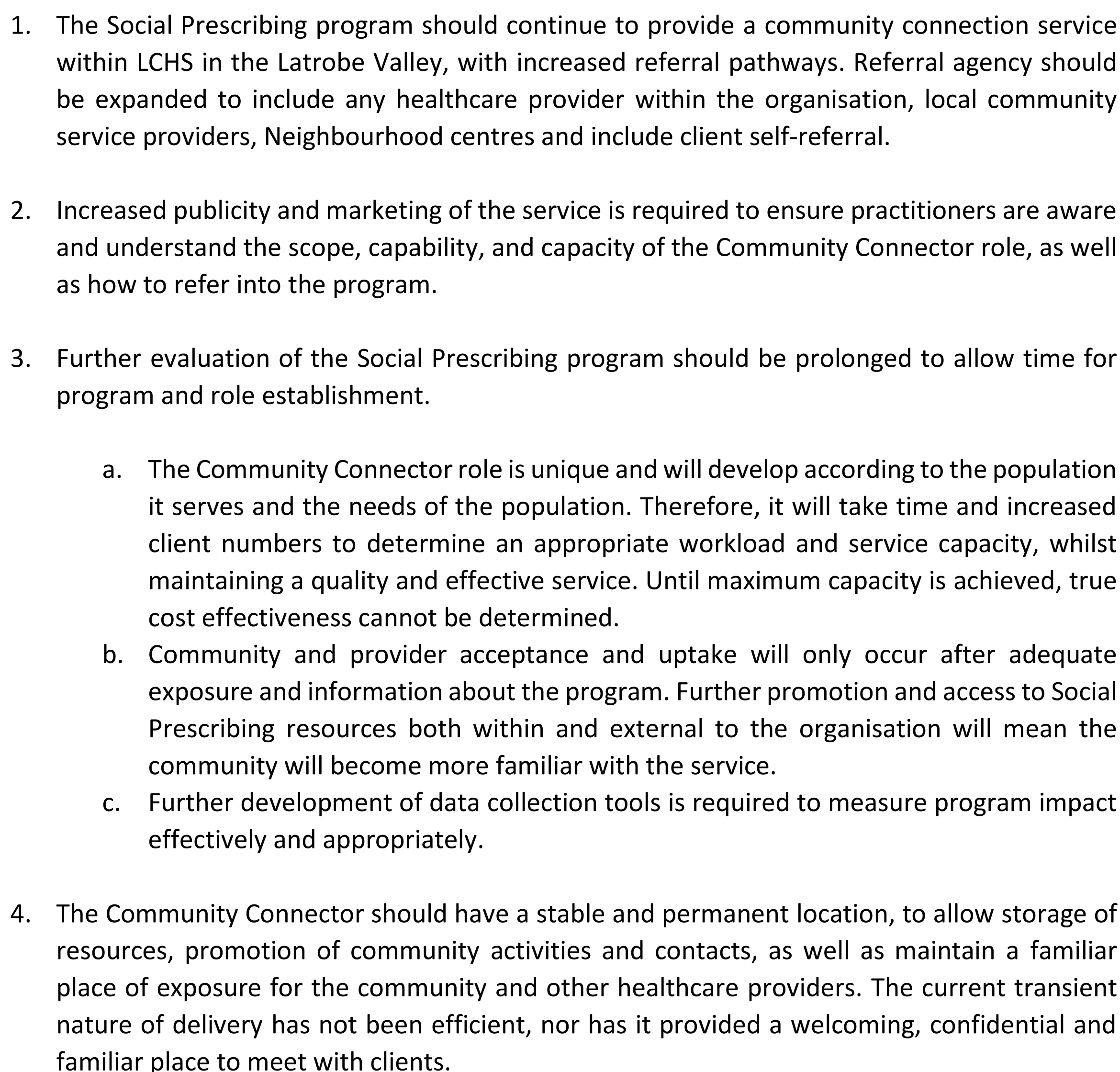
The Social Prescribing program was seen as a unique opportunity to work with positive emotions and thoughts rather than focusing on the challenges and barriers in a person's life, which would then increase happiness and connection with others. It was deemed '*…refreshing, to talk about things other than their health*', which then also led to the opportunity for a personalised, holistic approach of meeting client needs. Compared to various other social connection programs, the LCHS Social Prescribing model offered a full cycle of support; from identifying social needs or barriers, researching appropriate connections options, instigating initial connections, potentially accompanying the client for introductions, and building confidence, and then following up and supporting sustainable connections. Being able to '*close the circle*' was one unique factor identified by the Connector that made this model unique and why it worked well.

It was acknowledged that there are many support services already available to the Latrobe population, however they are often transient in nature, regardless of their impact or value, due to short term funding or community engagement. Effective marketing has been flagged as a contributing factor for program uptake, both within the community population and by referring practitioners. This was again seen at LCHS with the Social Prescribing pilot, where awareness of the program and connector role was delayed due to inadequate planning and promotion during the early implementation period.

The cost effectiveness of this pilot demonstrated that although client contract had increased, the model as it stands was not necessarily a cost-efficient solution to providing social support. Evaluation participants however alluded to the potential of increased referral capacity with improved publicity and program awareness, and therefore as the number of clients and contact hours increase, the cost per client and client contact hour would decrease. Role efficiency was impacted by lower than expected referral numbers.

When identifying challenges associated with the program being delivered in Latrobe, two key concerns were raised by the Connector and the practitioner participants. The first was regarding an ideal role capacity, as it was important that the quality of the service was not compromised by increasing referral numbers. It was recognised that the current limited capacity was a vital key to enabling the level of engagement with each client and thus, impacted the level of success for each reconnection opportunity. The second challenge was the potential impact an increased Social Prescribing capacity would have on the connection organisations within the community, and how they too may need supporting should they receive an influx of volunteers or new members through the Connector successfully reconnecting clients. Subsequently, it appeared the social connectivity within the community was reliant on social organisations also having adequate connection capability and capacity.

5.2 KEY RECOMMENDATIONS



1. The Social Prescribing program should continue to provide a community connection service within LCHS in the Latrobe Valley, with increased referral pathways. Referral agency should be expanded to include any healthcare provider within the organisation, local community service providers, Neighbourhood centres and include client self-referral.

2. Increased publicity and marketing of the service is required to ensure practitioners are aware and understand the scope, capability, and capacity of the Community Connector role, as well as how to refer into the program.

3. Further evaluation of the Social Prescribing program should be prolonged to allow time for program and role establishment.

    a. The Community Connector role is unique and will develop according to the population it serves and the needs of the population. Therefore, it will take time and increased client numbers to determine an appropriate workload and service capacity, whilst maintaining a quality and effective service. Until maximum capacity is achieved, true cost effectiveness cannot be determined.
    b. Community and provider acceptance and uptake will only occur after adequate exposure and information about the program. Further promotion and access to Social Prescribing resources both within and external to the organisation will mean the community will become more familiar with the service.
    c. Further development of data collection tools is required to measure program impact effectively and appropriately.

4. The Community Connector should have a stable and permanent location, to allow storage of resources, promotion of community activities and contacts, as well as maintain a familiar place of exposure for the community and other healthcare providers. The current transient nature of delivery has not been efficient, nor has it provided a welcoming, confidential and familiar place to meet with clients.

6. LIMITATIONS

There were limitations related to this evaluation that must be considered. These include:

1. The quality of data submitted was variable, with not all clients having forms completed for each visit/consultation. A lack of formal documentation of time spent when not engaging with clients has meant analysis of role efficiency has been limited.

2. Surveys were completed by only 10 Social Prescribing clients after they had engaged with the program. Given the very small number of surveys, it has not been possible to undertake any meaningful statistical analysis for this measure.

3. Client and practitioner participation in the data collection has been from people who have embraced the program and wanted to provide feedback. Data from those who did not want to use the service has not been obtained and thus, participant selection bias is acknowledged.

Despite these limitations, the evaluation is considered to present a credible assessment of the project.

7. METHODOLOGY

7.1 CONCEPTUAL FRAMEWORK

A Participatory Evaluation and Co-Design Framework is the approach used in this evaluation conducted by the CERC.

Participatory evaluation

A participatory evaluation framework puts people from the community and those delivering the programs, projects, and services at the centre of the evaluation. Participatory evaluation is a distinctive approach based on the following principals:

- That evaluation should be a co-designed, collaborative partnership through 360° stakeholder input including project participants and project funders.
- That integral to evaluation is an evaluation capacity-building focus within and across projects.
- That evaluation is a cyclical and iterative process embedded in projects from project design to program assessment.
- That evaluation adopts a learning, improvement, and strengths-based approach.
- That evaluation supports innovation, accepting that projects will learn and evolve'.
- That evaluation contributes to the creation of a culture of evaluation and evaluative thinking.
- That there is no one or preferred data collection method rather the most appropriate qualitative and quantitative methods will be tailored to the information needs of each project.

Co-design

Co-design is a process and approach that is about working with people to create 'interventions, services and programs which will work in the context of their lives and will reflect their own values and goals'[12]. Co-design can be done in many ways but is about collaborative engagement that is

[12] VCOSS (2015). Walk alongside: *Co-designing social initiatives with people experiencing vulnerabilities*. V. C. o. S. Service. Melbourne.

bottom-up, creative, and enables a wide range of people to participate and importantly to steer decisions and outcomes. Co-design is not a consultation process but a partnership approach where 'end-users' actively define and shape strategies and outcomes. The role of the 'expert' is to facilitate this process.

7.2 EVALUATION METHODOLOGY

The evaluation of the project utilised a variety of data collection tools in a mixed methods approach providing information about process, outcomes, impact, and capacity building. No identifying information was included in analysis or reporting of results.

Data collection strategies

1) Process data - Process data included how many referrals were received, the resources expended, and a cost analysis. Process data was provided to the CERC by the SP project manager. The CERC was not involved in the collection of this data. All data provided by the SP project manager was de-identified and anonymous.

2) Referral data - GPs were given a referral template to record information such as type of referral, reason for referral, and relevant medical history. The research team did not have access to this referral form until the patient accessed the Social Prescribing program and gave consent for use of this information which was obtained by the Community Connector . Referral data was provided to the CERC by the SP project team.

3) Audit of Community Connector case notes - The Community Connector engaged with participants of the Social Prescribing program to connect them with appropriate community services or activities. They kept detailed case notes of each appointment. At the initial consultation, participants provided consent for their de-identified case notes and GP referral to be used by the project team and CERC research team, including for use in research. Case notes were provided to the CERC by the SP project team.

4) Survey of participants - The survey was designed by the CERC in collaboration with LHA during the initial phase of the pilot, to measure the quantitative response of community members who participate in the Social Prescribing program. Participants or people who engage with the program were invited to complete the survey by the SP project team at the end of their engagement with the program. The survey was able to be completed online via a secure survey platform QR code or in paper form. Survey response numbers were dependent on how many people participated in the program.

5) Interviews of key stakeholders - The interviews of key stakeholders were used to inform the LHA about the process and experience of referring to, or delivery of, the Social Prescribing model. Key stakeholders were invited to participate in an interview by the SP project team and by the research team.

6) Semi-structured interviews - Semi-structured interview questions were designed to guide the researcher to capture all desired information while providing flexibility for the participant to elaborate on their experience.

Data Analysis

A thematic analysis technique was used for the qualitative data with findings presented under theme headings together with participant quotes. The thematic analysis utilised Braun and Clarke's six step process which included familiarisation with the data, generating initial codes, searching for themes, reviewing themes, defining and naming themes and producing the report (Figure 17)[13].

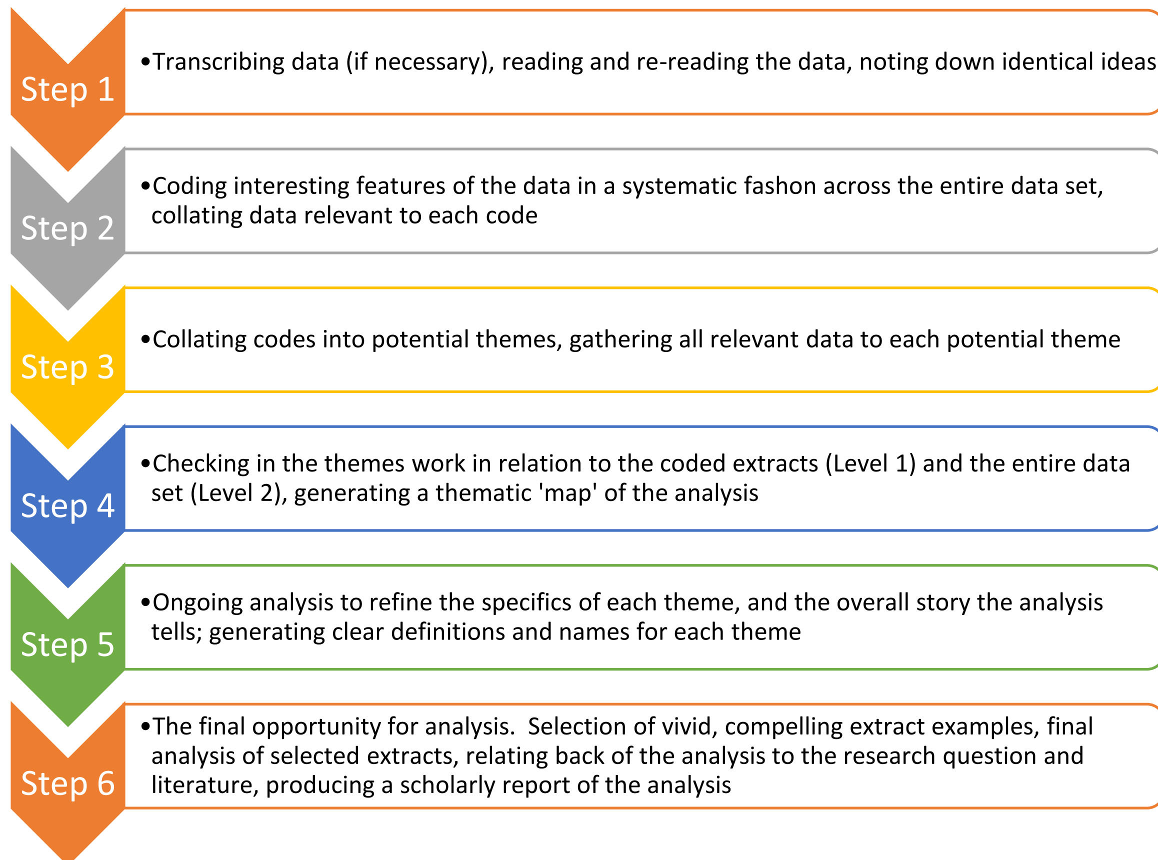


Figure 22: Six Step Thematic Analysis

As qualitative analysis is an inductive process, some interpretation of the data was required to create the thematic map. It was actively acknowledged that the researcher's interpretations would inform the results of this study, hence, any prior conceptions of the topic were reflexively bracketed to the best of the researcher's abilities[14].

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[13] Braun, V., & Clarke, V. (2022). Conceptual and design thinking for thematic analysis. *Qualitative psychology*, *9*(1), 3. https://doi.org/10.1037/qup0000196

[14] Berger, R. (2013). Now I see it, now I don't: Researcher's position and reflexivity in qualitative research. Qualitative Research, 15(2), 219-234. https://doi.org/10.1177/1468794112468475

8. ETHICAL APPROVAL AND PRACTICE

Federation University aims to promote and support responsible research practices by providing resources and guidance to our researchers. We aim to maintain a strong research culture which incorporates:

- Honesty and integrity.
- Respect for human research participants, animals and the environment.
- Respect for the resources used to conduct research.
- Appropriate acknowledgement of contributors to research; and
- Responsible communication of research findings.

Human Research and Ethics application, *"Piloting of the Latrobe Social Prescribing model"* was approved by Federation University Human Research Ethics Committee (Appendix 2) prior to data collection and analysis (A21-082). Consent to participate in the study and for participant's de-identified transcripts to be used for research and evaluative purposes was obtained via signed informed consent forms before commencing the interviews. Participant anonymity was maintained by removing any identifiable information from the evaluation.

9. ABBREVIATIONS

AHPRA	Australian Health Practitioners Regulation Agency
AMA	Australian Medical Association
CERC	Collaborative Evaluation & Research Centre
GP	General Practitioner
GOVT	Government
LCHS	Latrobe Community Health Service
LHA	Latrobe Health Assembly
LRH	Latrobe Regional Hospital
LV	Latrobe Valley
NP	Nurse Practitioner
PAG	Planned Activity Group
SP	Social Prescribing
AOD	Alcohol and Other Drugs
YMCA	Young Men's Christian Association

10. LIST OF FIGURES AND TABLES

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11. APPENDICES

Appendix 1: Returning client summary table

Client #	# return visits	Connection options offered	Successful ongoing connections at final meeting with CC	Contributing factors
1	5	U3A, fishing, Moe Neighbourhood House, Rock ‘n Roll, Traralgon pool/gym, cooking classes, motorbike chat group, volunteering.	Foodbank volunteering (3-4 days/week) Croquet squad	
2	13	Terrarium making for market stall Churchill market, public housing application support, walking group.	Planning second stall at market	Financial situation/living with ex-partner/unstable housing
5	6	Various home care companies- sending untrained disability carers.		Elderly mother as carer
7	8	Pool/water aerobics- with carer support, St Vincent de Paul, chair dancing, choir		Rare disease- NDIS appeal
8	1	Gipps Chorale, Men’s Kitchen, financial counselling, Gippsland Community Legal service (Family law)		
9	3	Busking, writing workshop, pool, walking, Reclink activities	Has found new partner	Youth space lessons -not funded.
11	18	Financial support services, Disability support pension, public housing application, Multicultural Friendship Group- Moe, Morwell women only movement session, English classes	Disability pension approved. Client moved to Springvale- being supported by new GP.	Language practice while walking. Has refugee nurse. ? Unsafe- neighbour abuse.
13	10	Knitting groups, financial services (Anglicare), St Vincent de Paul (heater), Orange Door, LCHS Family Violence Advisor, Quantum		Client safety issues. Mobile phone support provided.
15	1	Skills and Job Centre, childcare services		Carer for child
16	6	Local primary school volunteering, Men’s Shed, Gippsland GateWay Group- Moe RSL, Care Finder’s referral		Very active but isolated in current housing. House flooded.
18	2	Buddy Bears volunteers		
19	10	Multicultural Friendship Group (Moe), Financial Capability Worker, Refugee Legal Centre (RLC), Traveller’s Aid	Continued attendance at Friendship group. Interprets for Indian women at group	Burmese- interpreter sometimes required. Over 60

				calls to RLC before contact
20	2	Jobs and Skills Centre		Anxiety ++
21	15	Aquarobics, care coordination, Traralgon Neighbourhood Learning House- art group, Taxi card, Stroke support group, Heart Smart walking group, guitar lessons, exercise group LCHS	Continued participation (25+) walking group- plus coffee and social outings	Traumatic dental work (AHPRA complaint made)
22	5	Motorbike enthusiast coffee group (new idea), walking group, Trivia night, Repair café (Morwell Neighbourhood House)		
24	1	Borrow Box (Library), golf		Bought new car- improved own access
25	2	Community garden, Food Bank		
26	5			Wanting to move away.
28	12	Multicultural fitness group for women, supported playgroup for children, English classes- TAFE/Gippsland Employment Skills Training	Attended English class, enrolled children in kinder.	Language/cultural barrier
29	1	Pool, jewellery making		pain
31	5	Op Shop, TAFE, U3A, exercise group, resume assistance, mystery shopping, completing surveys (paid)		Focused on moving house and finding work
32	5	Volunteering, Mens Shed, Multicultural friendship Group (Moe), Bootscooters	Started Ballroom dancing classes, looks up local newspaper for community activities.	Autism diagnosis, doesn't like going out at night, or driving outside Morwell
33	8	Multicultural Friendship Group (Moe), Morwell Neighbourhood House Repair café, Morwell Senior Citizens Club, cards, bowls	Made friend at Multicultural group, cooking for neighbours	
34	2	Jobs and Skills, Gippsland Accoustic Music Club	Jamming session (sings and plays bass) may continue into something regular.	Broke her arm skateboarding!
35/36	6	Tai Chi, Volunteering Neighbourhood House (supervising Yooralla -cooking community lunch), practice sending/receiving emails, St Vincent DePaul Soup kitchen, Meals on Wheels, career counselling, Lobs and Skills Centre	Client booked ancestry course (Moe Neighbourhood House)	
37	5	Pool and cards		Client distressed over financial and other social issues (council rates etc)

38	3	Patchwork/Quilting (Moe and Churchill Neighbourhood Houses)		
40	4	Volunteering -Lifeline, Knitting group, Richmond supporters' group, Poppy creators group		Ceased medication- feels energised.
42	2	Small business advisors- Business Victoria, resume and police check, career counsellor, volunteering, working bees, Friends of the Reserve (Traralgon)		
43	5	Volunteering, Moe Multicultural Friendship Group, International Women's Group, Heart Foundation walking Group, driving lessons, Op Shop	Continues to volunteer once a week	
44	1	Walking group, water aerobics, career counsellor		Client moved house- Melbourne
45	7	Knitting groups (Traralgon), Financial counsellor	Client initiated volunteering in Op Shop, sits with elderly neighbour once a fortnight	Wants to work, but elderly.

Appendix 2: Human Research and Ethics Approval

Federation University

Amendment Approval

Human Research Ethics Committee

Principal Researcher:	Professor Joanne Porter
Co-Researcher/s:	Natalie Bransgrove Kaye Borgelt Megan Simic Mrs Nicole Coombs
School/Section:	**Collaborative Evaluation and Research Centre (CERC)**
Project Number:	**A21-082**
Project Title:	**Piloting of the Latrobe Social Prescribing model**
For the period:	16/07/2021 **to** 31/12/2026

Quote the Project No: A21-082 in all correspondence regarding this application.

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Amendment Summary: N/A
Extension: N/A
Personnel: Michelle James, Valarie Prokopiv, Dr Vaughan Reimers, A/Prof Karen Missen and Christopher Mesagno have been removed from this project. Natalie Bransgrove, Kaye Borgelt, Megan Simic and Mrs Nicole Coombs have been added to this project

Please note: Approval has been granted to undertake this project in accordance with the proposal and amendments submitted for the period listed above. Ongoing ethics approval is contingent upon adherence to the Standard Conditions of Approval

COMPLIANCE REPORTING TO HREC:

Annual reports due:
16 July 2022
16 July 2023
16 July 2024
16 July 2025
16 July 2026

Final project report due:
31 January 2027

The combined annual/final report template is available at:
HREC Forms

Fiona Koop
Coordinator, Research Ethics
13 February 2024

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