SOCIAL PRESCRIBING FOR BETTER MENTAL HEALTH REPORT

Overview of Social Prescribing for Better Mental Health

One of the biggest challenges facing Ontario's health system is addressing social isolation and loneliness. Social isolation occurs when individuals are disconnected from family, friends, social groups, support, and spaces in the broader community, increasing the risk of loneliness. Social connection is a key determinant of health, and research shows that people who are isolated for extended periods are more likely to face serious health issues[1].

Social isolation and loneliness are significant risk factors affecting people's physical and mental health. During the COVID-19 pandemic, the prevalence of major depressive disorder (MDD) doubled among Canadians aged 18 or older[2]. For adults over 50 who lack social connection, their risk of developing dementia increases by 50% and their risk of stroke increases by 32%, among other increased physical health risks[3]. Sense of belonging to the community and especially the overall sense of community are the most vital mitigating factors against loneliness[4].

Social prescribing is a holistic approach to healthcare that combines social, medical, and wellness models of health to address social isolation and loneliness. It provides a formal pathway for health providers to address diverse determinants of health, using the familiar and trusted process of writing a prescription.

Social Prescribing for Better Mental Health (BMH) was an 18-month project funded by the Public Health Agency of Canada to support people whose mental health was most affected by the COVID-19 pandemic. Building on the Alliance for Healthier Communities' previous social prescribing work, the project's goal was to scale up social prescribing at 28 pilot sites to organizations across Ontario to improve social connection and overall well-being.

[1] Social isolation, loneliness in older people pose health risks
[2] Symptoms of major depressive disorder during the COVID-19 pandemic: results from a representative sample of the Canadian population
[3] Social Isolation and Loneliness in Older Adults: Review and Commentary of a National Academies Report
[4] Exploring the determinants and mitigating factors of loneliness among older adults

Objectives

The project had five key objectives: train service providers to implement social prescribing with a health equity lens; identify individuals at risk of poor mental health; navigate individuals to the most appropriate services; co-design locally responsive mental health promotion/illness prevention programs; and engage, evaluate, and share impacts and lessons learned throughout the project.

The BMH team initially worked with 28 Alliance Member Centres to implement a sustainable social prescribing pathway. Each centre also received funding and focused coaching to implement social prescribing initiatives tailored to their local communities. An additional 13 centres participated in a 12-week Scale and Spread Learning Collaborative to build and improve upon their social prescribing pathways.

Training materials, resources, and knowledge products were shared across Ontario to support this work. These included electronic medical record (EMR) custom forms that collected client loneliness and wellbeing data and client and team surveys to assess overall client experience and team collaboration at each participating centre. In addition to the site-specific work, an online learning course with nine modules was developed to support the continued spread and scale of social prescribing across Ontario.

Evaluation Findings

The project used a mixed-methods evaluation that combined qualitative and quantitative research approaches to examine how social prescribing was implemented, clients' and providers' perceptions of their centre's social prescribing initiatives, its effects on clients' health, and its impact on systems within healthcare organizations.

During the year-and-a-half pilot, the project engaged 80 providers in monthly social prescribing implementation coaching and hosted almost 2800 attendees at various learning events. Through the work done with member centres and a partnership with 211 Community Connection, over 2900 clients were provided social prescriptions during the project.

Highlights

- 90% of participants reported improved wellbeing after attending community programs and activities;
- 91% of clients reported that the programs they attended were meaningful to them after being referred through social prescribing;
- 79% of participants who reported improved wellbeing as a result of attending programming also stated their mental health is better;
- 72% of clients who experienced barriers when accessing community programs reported that they received support to help them attend programming

- 88% of healthcare professionals and service providers agreed that social prescribing is worthwhile for clients and improving interprofessional staff collaboration;
- 84% of providers agreed social prescribing helps address clients' complex needs;
- 89% of providers agreed that they will continue to make social prescribing referrals for future clients.

Throughout the project, essential components for the success of social prescribing in a healthcare setting emerged. These included:

- Receiving coaching support (from the Alliance): "The social prescribing program and our new CONNECTYOUTH program would not have been possible without the Alliance grant AND the coaching support we received." - Lakeshore Community NPLC
- Support and training for data collection and use: "Working with the Alliance allowed us to find new ways to capture the data to help prove the important work being done in health promotion." -North Lambton CHC
- Focusing on social connection for clients experiencing mental health challenges: "Having the option to offer social prescribing has been a huge asset for counselling as I often see improvements within my clients at a faster rate knowing that they are now connected to something social." - Chigamik CHC
- Focusing on client-centred care: "The most important thing learned along the way is...that social prescribing is not solely about providing information but working alongside the individual. This relational process helps facilitate outcomes desired." - Grand River Community Health Centre
- Deepening and expanding community relationships and using an asset-based community development model: "We've forged many great relationships with program participants and had many empowering discussions about looking at our community through an Asset Based Community Development model, encouraging participants to think about what's STRONG in their community instead of what's WRONG in their community." - ConnectWell Community Health Renfrew

Participating centres identified the following as significant, common challenges:

- Staff capacity and funding. The BMH project offered many resources and focussed coaching supports to participating centres, which could not be fully expanded to other Alliance member centres interested in implementing social prescribing. As such, centres that were not funded as part of this project regularly attended monthly learning events.

- Managing staffing changes or challenges. 68% of centres experienced staffing changes or challenges which impacted their ability to implement the project.

- Project sustainability was a significant concern. With the project's funding limited to 18 months, many centres were unable to continue this vital work, including their social prescribing initiatives and the maintenance of vital link worker roles, without renewed funding.

The BMH project was an opportunity for Alliance member centres to rebuild and improve programs, social connections, and client accessibility supports. This was crucial after many centres effectively shut down during the COVID-19 pandemic. Looking forward, these programs and supports rely on sustained funding, particularly long-term investments in the community, to continue promoting better mental health for all of Ontario.

Client Feedback

- "Attending the course helped because it gave me something to look forward to. I could be surrounded by like-minded moms going through the same thing."
- "I moved here from Wyoming, and I didn't know anybody, but now I've got a lot of friends. They make me feel welcome here. I was so depressed, but now I'm not."
- "It got me in touch with people in my neighbourhood that I probably wouldn't have met if I hadn't gone to the community health centre. It was lovely; it was all women, and we talked with each other and shared everyday stuff, experiences and knowledge about other things available in the community. It was wonderful."

Provider feedback

- "Collaboration was a cornerstone of the project, emphasizing the importance of partnerships between our organization's primary care team, healthcare providers, community social service teams, and various stakeholders. By promoting integrated and coordinated care delivery, the project sought to address individuals' diverse needs comprehensively. This collaborative effort ensured that individuals received holistic support tailored to their circumstances." – Pinecrest Queensway CHC
- "Providers were surprised at the social prescriber's knowledge of community resources and activities. Providers learned a lot more about their clients that they would have otherwise never known about, found new ways to support clients." – Carlington CHC
- "The work is so much more than just Social Prescribing – also involves asset mapping and gap analysis, process development, program creation, community engagement and capacity building." – Grand Bend Area CHC
- **"**One of the main lessons learned was in the structure of our referral pathway. Our project's focus on Primary Care as the main referral source constrained its scope. Adopting a multi-directional referral pathway early in the project's

implementation would have significantly enhanced accessibility to services for a broader range of clients. The imposed limitations were a result of the restricted utilization of PS Suites throughout the organization." – Pinecrest Queensway CHC