North Cork Social Prescribing FAQ

What is Social Prescribing?
Social Prescribing is new term for a very old concept, that people are healthier and happier when they are connected with their communities. Social Prescribing links people into sources of support within the community to help them to improve their lives and take greater control of their health and wellbeing.

Who is the North Cork Social Prescribing Link Worker?
Eithne Foley, based in the Le Chéile Family Resource Centre in Mallow. The catchment area is Community Healthcare Network 04 (Mallow, Charleville, Kanturk, Buttevant, Millstreet, Newmarket).

Who is Social Prescribing Suitable for?
Social Prescribing is suitable for people who want to improve their quality of life. In particular, those who are lonely, socially isolated, living with a chronic illness, living with mild or long term mental health challenges such as anxiety or depression.
The service is suitable for people who are in a state of readiness, who have arrived at a point where they are ready to make a step forward with support. It is crucial that those referred to the service are willing participants - if they are not yet ready for change, physically or mentally, they can be made aware of the service with the goal of working towards engagement in the future.

How do I make a Referral?
Fill out a referral form and post or email it. Download from here https://thewellbeingnetwork.ie/community-referral/mallow/ or email for forms linkworker@lecheilefrc.ie or 087 7193257. Address: Eithne Foley, Le Chéile FRC, Fair St., Mallow, P51 F344.
Referrals are welcome from GPs, Practice Nurses, Public Health Nurses, Mental Health teams, addiction practitioners or other health care professionals.

What is the Social Prescribing Process?
When a referral is received, the Link Worker phones the person to explain the service and if they are happy to proceed, make an in person appointment. Then the Link Worker meets the person and sits down for a relaxed consultation (60-90 mins, including a wellbeing assessment). Together a simple plan is agreed to meet the person's needs. The person is supported to get involved in the group/support and followed up with up to six phone meetings/calls. When the person is established in the group/support, another wellbeing assessment is completed at the final meeting.

What might the person be linked into?
Social groups: for example, Men's Shed, Support groups: for example, mental health support meetings, Counselling, Physical activities: for example, a walking group, Hobbies: for example, a craft group, Information services such as MABS (Money Advice and Budgeting Service).

What are the benefits to the patient?
Improved health and activity, improved mental wellbeing, more socially connected, support with finances and information, living better with a long term health conditions, lifelong learning opportunities. This is a free service and the community resources discussed would be free or low cost.

What are the benefits to the GP or other Health Care Professional?
Improved patient outcomes, physically and mentally and a potential reduction in medical appointments in a case where the person's real needs are social or community related.

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