Connect. Create. Play

Social Prescription Pilot Project July 2020 - April 2021

Innovative solution to address isolation and loneliness in our community

In 2020 Highett Neighbourhood Community House and Hampton Community Centre received funding to pilot a Social Prescription (SP) project – an innovative approach to community health and wellbeing. The following is a summary of our findings:

Program Overview

Total Staff time per week: **Paid Staff member (8 hours)**, one Social Work student placement (6 hours) and two MSc Counselling Student Placements (5 hours).

Total Funding: **$29,000** (3 grants)

Total Clients Participated: **32** participants

Average time spent with Community Connector Team: **4 hours** (includes initial meet/collection of data scales/preparation of health/well being plan/supporting people to attend activities/closure from program and 3 month follow up session.)

Referral Process: **60%** referred by 5 GP/Practice Manager with remaining self-referred via our Lonely Need to Chat campaign counsellors or the Bayside Council connection program.

Health and WellBeing Plans: **50%** of participants engaged in new activity

Feedback from participants: **81%** had a positive experience in the program and felt socially connected through our Community Connector.

The timing for our pilot program could not have been more challenging. We implemented a program about reconnecting at a time when the need was greatest and the means to do it were the most restricted, limited and difficult.

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Process:

We started the SP program without external funding which gave us great flexibility in the design and delivery of the project and allowed us to tweak when required.

We initially cold called (emailed) 80 local GP clinics, allied health and a number of other organisations we thought would have solid engagement with a cohort who would typically not come through our doors and who may be experiencing social isolation, loneliness or health issues which SP may address. This also included local faith groups, Men's Sheds, RSL's - places where people have small amounts of social connection but might be open to greater engagement.

Initially we had no extra funding for staff but we rejigged staffing arrangements so a member of our team could begin to devote up to 8 hours a week as a Community Connector.

One of the more common queries we receive is who do you employ in this role/what skills do they have. Our first Community Connector (CC) had a Social Work background and our second CC is a long time team member, skilled in engagement, extremely knowledgeable about local services and has an Art Therapy/Counselling background.

Data collection:

We created our own templates using a combination of questions from data templates used in the UK such as the Warwick Edinburgh Scales, UCLA Scales and questions taken from the Patient Activation Measures (SEMPHN).

The data collection proved to be extremely time consuming and difficult to obtain, particularly gathering someone's initial history over the phone. Our team felt that after establishing an informal relationship with a client, often via phone, it then felt decidedly clinical, awkward and intrusive to get more data from them. We had one example where a participant whose health (Dementia) was not getting better reported back that completing the health and well being scales made them feel worse. We also had a few clients who were reluctant to meet face to face once Covid restrictions had lifted.

Social Prescription Wins:

- SP team overcame Covid restriction difficulties by safely engaging community members via Zoom, telephone and appropriate safe distancing in full PPE kit;
- We were able to extend our reach to local community members who were not aware of our services;
- We developed a series of free activities and programs tailored to the needs of participants e.g. walking group, followed by coffee and conversation and then a community lunch. This program was designed with SP participants and has now grown to include other community members. This program started in February 2020 with 8 people and after 10 weeks in operation we plated 40 meals;
- Data we received back from participants confirmed the need for more social connection programs in our communities.

Social Prescription Challenges:

- Difficult to engage GP's/ Allied Health. GP's not understanding what we do/offer, time poor, limited response to our mail out to participate in the program;
- COVID19

- Ability for clients to engage in programming/activities was almost non-existent until 8 months into project, particularly those with technology challenges including hesitancy and resources;
- Staff were restricted to phone calls as the demographic of the clients being referred were not confident with Zoom. The team felt that rapport building and conveying empathy over the phone was difficult and not all participants were comfortable with communicating over phone lines. There was a greater time commitment required to invest with clients to keep them engaged over phone. Whilst the overall duration of each case was drawn out, approximately 3- 6 months, we believe we would have spent as much time with each client meeting face to face but in a shorter period of time.
- Difficult to form relationships over the phone and ask for personal information/reluctance from clients to share personal details with Community Connector.
- COVID meant the length of a participant being in a project extended beyond 3 months which resulted in multiple placement students per client; thus interrupted the opportunity to build a strong relationship for some clients.

Overall clients completed the pilot program with a positive experience and outcome. Whilst not all clients engaged in recommended activities, they were connected with new services relevant to their needs e.g. My Aged Care, Council services, Dementia Australia.

Where to from here

Having completed the project what are the things I would ask for going forward.

- More funding to sustain programs like these. Community Centres are not funded to provide the full-time administration required to address the level of demand for social inclusion by the community and deliver this type of programming.

- Greater awareness raised within the health sector both GP Practices and Allied Health professionals.

- More work to include the community sector as a relevant module within the Continuing Professional Development program and that University's and all higher learning institutes include the community sector in their health curriculums.

- Advocacy supporting the recognition of health and well-being programs offered by community centres be included in the PBS and by Health Insurers.

- When PHN distributes funding to private GP practices they embed a requirement for the GP's to engage with local community centres and for GP Practices to clearly demonstrate they have.

If you have any queries please don't hesitate to email me - manager@highett.org.au

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