



SOCIAL PRESCRIBING PROJECT – CONNECTING COMMUNITY

Referral Information for Health Professionals and those referring patients/clients

This program has been funded by a grant from Equity Trustees. It is managed by the Community Houses Association of the Outer-eastern Suburbs (CHAOS) Network. The volunteer community connector model of social prescribing was trialed in 2020-2021 following an ageing innovation grant from Equity Trustees. The successful program is now being expanded across the outer-eastern suburbs.

Essentially the program aims to reduce social isolation and loneliness for people aged 60+ by linking them into social activities with the assistance of a volunteer connector. It has been inspired by the achievements of the Mendip Health Connections model in the UK and Bromley by Bow Centre in London. The key feature of the program is the recruitment and training of volunteer community connectors. The focus is on linking people to social and peer support activities across the community.

The volunteer community connectors complete training that includes:

- Data about loneliness and social isolation and its health impacts
- Barriers to participation and possible solutions
- Tools and resources for linking (online directory and other agencies)
- Boundaries of the role, health and safety for yourself and your client
- Record keeping, evaluation
- Completion of the World Health Organisation social prescribing online short course

Volunteers are police-checked and attend regular team meetings with the program leader. The referral process we have devised is quite simple and is regularly evaluated for improvements:

- 1 Health professional refers patient to the program using LOBL referral form
- 2 LOBL program leader makes contact with the patient within two working days to explain the process and let them know who their community connector is so that they recognise the name when they phone them.
- 3 Volunteer Community connector phones patient within five working days and discusses what they feel they'd like to do and what their barriers to participation may be. They let them know that they will do some research and get back to them within a week with some suggestions.
- 4 Community connector contacts patient (will meet in public place when and where it is safe to do so) and take them through the available options, providing details such as venue, cost, dates, how to get there, etc. If the patient is anxious about making the initial contact themselves the

community connector will offer to make the call while the patient is with them to arrange their attendance.

5 If the patient feels they need support when they first attend the activity the community connector will offer to meet them outside the venue and take them in to meet appropriate people who will be assisting them to engage in the activity.

6 Follow-up:

- The community connector will contact the participant a few days after the first session (even if they attended with them) to check that they were happy and are returning and determine if they are confident to attend alone. Alternatively they will make new arrangements if needed.

- They will contact them again after a further two sessions to make sure they are still attending and are happy. If not, they will offer to help them try an alternative activity or speak to the contact at the organisation if they have any issues

- If they are happy to continue and are settled in, the community connector will let them know that their relationship ends at this stage but they are welcome to contact the Program leader again any time in the future if they require further assistance with connecting to other activities.

Other features of the project:

- Drop in Talking Cafes.

Once per week patients are able to attend a social meetup, Talking café, which operates as a drop in at a local café where participants can meet in person and access more information about social activities in their community.

For further information, and to receive a referral form, please contact the Program Leader, Maureen McLaughlin

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