# Peace Plus Proposal: Theme 4.1 Collaborative Health and Social Care

A FAMILY BASED SOCIAL PRESCRIBING PROJECT

## The Problem

There is a high prevalence of mental health issues amongst families (both adults and children) cross our target area. These issues are caused by or compounded by a range of factors including (not exhaustive)

- Loneliness/isolation
- Addictions or hidden harm in the family home
- Trauma/Adverse Childhood Experiences
- Challenging behaviour in children
- Caring responsibilities for both children and adults
- Bereavement
- Social Determinant of health related issues such as unemployment, poverty, low education
- Underlying depression and anxiety

## Evidence

- High levels of waiting lists of CAMHs
- Recent evaluations of partner projects such as Beacon FSP and Mind Matters
- Research reports such as Bunting et al
- Tacit knowledge of partners
- Consultations with statutory and VCSE providers in the area

## The Intervention

To address the identified problem, partners are proposing the development and delivery of a family based Social Prescribing Project targeting **10,000** participants from across the SEHSCT, SHSCT and Community Healthcare Organisation 7 (comprising the Counties of Monaghan, Cavan and Louth). ***By family we mean the wider family unit in all its diversity, that this can include parents, children, siblings, grandparents and guardians. The project will work with participants across the life course.*** Our Social Prescribing Project proposes to achieve the following key outcomes:

| People Based Outcomes (primarily adults) | Family Based Outcomes | System Based Outcomes |
|---|---|---|
| 1. Participants are empowered to better manage their own care<br>2. Participants improve social connectedness<br>3. Participants improve mental and emotional wellbeing | 1. Improved overall family wellbeing where children and families are supported to thrive<br>2. Improved family cohesion | 1. Reduced pressure on mental health waiting lists (adult and children) |

We will measure change using a combination of validated evaluation tools including e.g. SWMWBS, WHO-5, Family Star, Social Connectedness Scale and through qualitative engagements with primary and secondary care waiting lists.

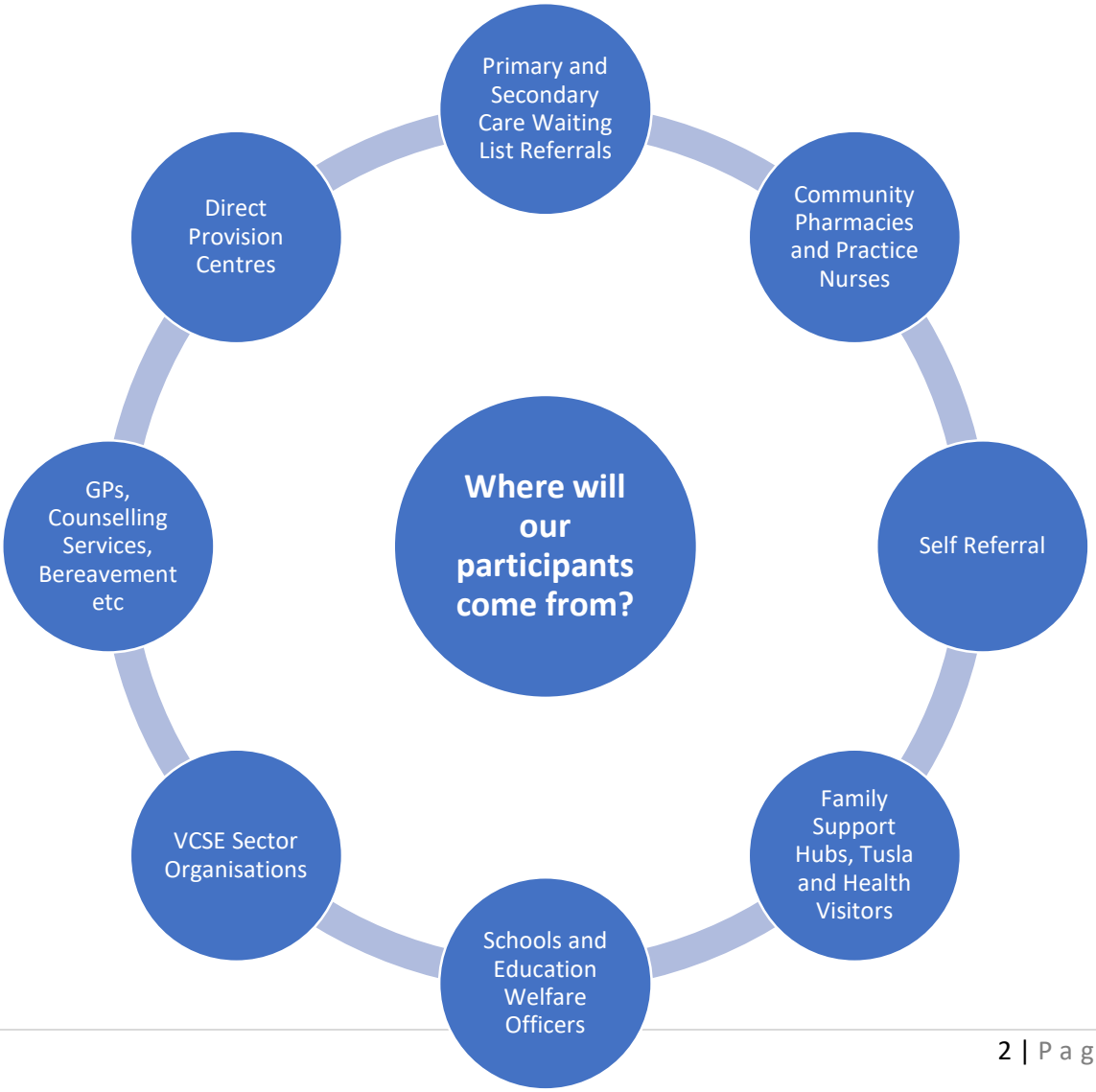
## The Participants

The project will target 10,000 participants over a 4 year period. Multiple individuals can be engaged from 1 family, we anticipate that the project will engage a minimum of 4000 families over the 4 year period. Examples of family composition include:

a) An adult, single parent with 2 children who is struggling to cope with a child's challenging behaviour linked to ADHD and where there is hidden harm/trauma in the household resulting from an adverse childhood experience. This impacts the other sibling.

b) An adult who has caring responsibility for their elderly parent who is living with a disability and/or chronic pain. The individual has struggled to sustain employment as a result.

This reflects engagement of 148 participants per Social Prescriber per annum. Participants will be referred to the project from a wide range of sources, building on the existing relationships between the project partners and various referral agents across the target area. The focus on the entire family unit provides the flexibility to focus and refine our support on specific ages where there are strong existing services, ensuring that we complement rather than displace services in each area.



# The Project

The project will be delivered by a network of [XX} partner organisations who collectively will employ the following staff:

a) **{XX} Social Prescribers** – responsible for directly engaging participants, carrying out person centred baseline assessments, developing family centred plans, facilitating direct interventions with families as well as signposting to additional community services.
b) **{XX} Community Connectors –** responsible for maintaining a network of cross border peer support groups. These groups will be developed thematically based on the emerging needs and interests of participants (i.e. bereavement, trauma, isolation). Community connectors will facilitate online and in-person engagements for participants post their interactions with the Social Prescriber to sustain long term, cross border connections.

### Step 1 – Baseline Assessment by a Social Prescriber

On referral to the project, each participant will engage in a baseline assessment with a Social Prescriber. This baseline assessment will explore needs, interests and challenges. It can be delivered in a persons home to encourage uptake, or online. The baseline assessment will have a therapeutic component and will result in the development of a family centred plan aligned to emerging needs.

### Step 2 – Family Centred Plan

The family centred plan will be developed around 2 distinct components:

1. **Component 1 Direct Delivery by Social Prescriber** – each participant will have up to 4 engagements with the Social Prescriber (including the baseline assessment). These engagements will be person centred but are likely to include: mentoring, goal setting, confidence building, stress management and personal development.

2. **Component 2 Interventions delivered by a network of specialist facilitators** – the partners will procure a framework of delivery agents across the themes of: parenting support, physical activity & healthy eating, counselling, family support, social inclusion. Each participant will engage in at least 2 interventions from the menu of available support services. These will be delivered on a group and cross border basis.

**steps 1 and 2 comprise 2 distinct 'episodes of care'. Episode of Care 1 is up to 4 direct engagements with the Social Prescriber including baseline assessment. Episode of Care 2 is the 2 interventions by specialist facilitators**

### Step 3 – After Care Support: Referral and Sustainable Support Networks

There are 3 key routes to sustainable ongoing support:

#### Onward Referral

Each participant will be supported to engage in an existing community based service, aligned to their specific areas of interest and to address their person centred challenge. This onward referral will represent the completion of the initial Social Prescribing Process

#### Locality Based Peer Support

Organised by individual Social Prescribers, this may include local walking groups, chatty benches and regular arts and crafts groups that will continue to meet – organised, led and facilitated by Social Prescribers

#### Cross Border Peer Support Groups

Organised by {XX} specifically appointed Community Connectors, this groups will be based on communities of interest, or based on emerging needs of families. For example, the establishment of a cross border bereavement support group, a cross border carer support group, a cross border trauma support group. The community connectors will organise meetings, invite guest speakers and experts, coordinate in person engagements and maintain a connected community to ensure sustainable peer support.

**participation in an after care peer support group represents Episode of Care 3**

## Key Outputs

The project will achieve the following key outputs:

1. 10,000 participants engaged over 4 years, representing a minimum of 4000 families
2. 10,000 participants receive at least 2 'episodes of care' comprising up to 6 interventions = 20,000 episodes of care and up to 60,000 interventions
3. Approximately 2,500 participants will participate in Locality Based Peer Support Groups or Cross Border Peer Support Groups (a 3rd 'Episode of Care) = 2,500 Episodes of Care
4. Total of 22,500 Episodes of Care delivered by the Project.

Comhairle Ceantair
Lár Uladh
Mid Ulster
District Council

<insert date>

Clanrye Group
Drumalane Mill
The Quays
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Dear Liam,

**RE: - Letter of Support**

Mid Ulster District Council are aware of Clanrye Group's plan alongside partners County Down Rural Community Network and Family Resource Centre Monaghan for the development and delivery of a Social Prescribing project targeting participants from across the South Eastern Health and Social Care Trust, Southern Health and Social Care Trust and Community Healthcare Organisation Ireland (Comprising Counties Monaghan, Cavan and Louth).

We are aware that the project will follow a family-based approach, meaning the wider family unit in all its diversity, to include parents, children, siblings, grandparents, and guardians. The project will work with participants across the life course to tackle the high-prevalence of mental health issues across the target area.

Mid Ulster District Council understand some of the project outputs will include –

- 10,000 participants engaged, representing a minimum of 4,000 families
- participants receiving up to 6 interventions of care
- participation in Locality Based Peer Support Groups or Cross Border Peer Support Groups.

The outputs identified will contribute to improved social connectedness, improved mental and emotional wellbeing, and improved overall family wellbeing and family cohesion.

We participated in the consultation process to inform a funding submission to the SEUPB. Mid Ulster District Council endorse the need for this project in the target area and believe that the proposed approach can deliver the anticipated outputs and results.

We pride ourselves on our continued support of local initiatives that tackle health inequalities whilst championing our residents to embrace lifelong healthy choices that improve wellbeing and their quality of life as residents of the Mid Ulster District. The proposed project dovetails with our strategic objectives and as such, we would welcome the development of a project of this nature and we will support the referral of participants annually onto this programme.

We would like to wish Clanrye Group and project partners County Down Rural Community Network and the Family Resource Centre every success with the project and are hopeful that the project application is looked upon favourably by the evaluation panel.

Yours Faithfully

<insert name>



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