UNDERSTANDING WHAT OUTCOMES ARE RELEVANT TO MEASURE IN SOCIAL PRESCRIBING SCHEMES FOR CHILDREN AND YOUNG PEOPLE.

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As part of the consultation during April 2020 on the guidance for social prescribing for children and young people, participants were asked what areas they thought were appropriate to measure. The responses were free-text, to allow people to express themselves without having to make any prior choices.

This was answered by 82 people who responded to this question, near the end of the survey. The free-text responses were analysed using content analysis and the summary is presented below. To understand which groups of participants were and were not represented, the participants characteristics were also analysed.

What are the characteristics of the people who responded to this question?

Participants represented all regions of England and reported the following for the status of children and young people's social prescribing schemes in their area.

- 26% reported schemes re in some stage of set up or already running
- 25% didn't know the status of the schemes
- 30% stated there were no current plans for children and young people's social prescribing
- 19% provided other comments.

The responses represented the following sectors:

- VCSE 36%
- Local Authority 28%
- NHS service providers 14%
- Clinical commissioning groups 9%
- Early years, primary and secondary schools 4%

The remaining 9% comprised: consortium and networks; business and consultancy; Trusts; Parent and carers; public bodies.

It should be noted therefore that key sectors including further and higher education, police and faith organisations have not provided responses to this section.

OUTCOMES AND AREAS TO MEASURE

Many participants stated several areas to measure, pointing out how areas were inter-related or improvements in one area had knock-on effects into other areas of children and young people's lives. This is an important aspect to note as some outcomes measured may occur quickly, others may take a longer amount of time to manifest or be demonstrable within data reported in sectors outside of health for instance.

There was a very strong feeling that the voice of children and young people should be involved in co-producing what outcomes are relevant to them as opposed to only adults deciding on what outcomes they think are relevant.

Some participants also reflected that the outcomes need to be ones that also work for commissioners of services, to enable funding to flow.

Similarly, several participants highlighted that improvements in children and young people carry through to the parents, carers and families. It was suggested that these parents, carers and families also be involved as a distinct group, when schemes and researchers are trying to understand the benefit of the social prescribing for children and young people. Young carers were also highlighted as a distinct group of stakeholders.

The main categories elucidated from the data are shown in Figure 1 will be further discussed below.

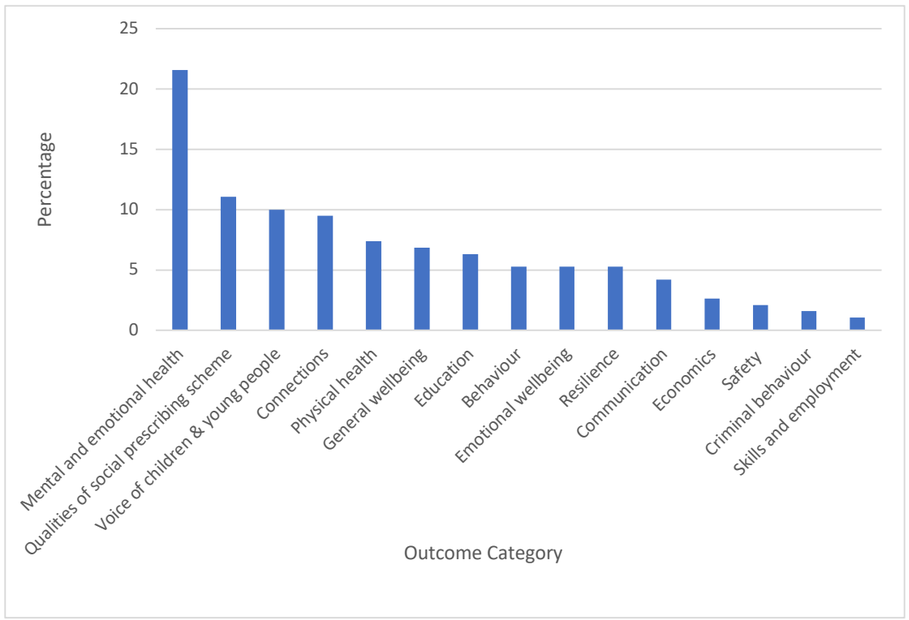

Figure 1. What areas do you think should be measured in social prescribing schemes for children and young people? 190 suggestions from 82 people were analysed.

Mental and emotional health

The predominant focus of people's comments related to mental health and emotional wellbeing. There are different thoughts on whether these terms are interchangeable or distinctive in meaning.

It was clear that whilst some people referred only to mental health as an overarching term, other people qualified this using terms such as stress and anxiety or self-harm, therefore, indicating the ill-health aspects of mental health. The term emotional wellbeing was also often used generally but was also associated with positive indications of mental or emotional wellbeing such as improved confidence, improved self-esteem, hopefulness, aspirations, sense of belonging. This indicated a positive take on the situation. This approach to interpreting the data was in line with research by Patalay and Fitzsimmons (2016)[1] and more widely consistent with the literature on salutogenesis (Antonovsky, 1979).

This category of data was further broken down in Figure 2 below, to understand the nuances in people's reporting and to see if there were any specific aspects of mental or emotional health and wellbeing that were frequently identified.

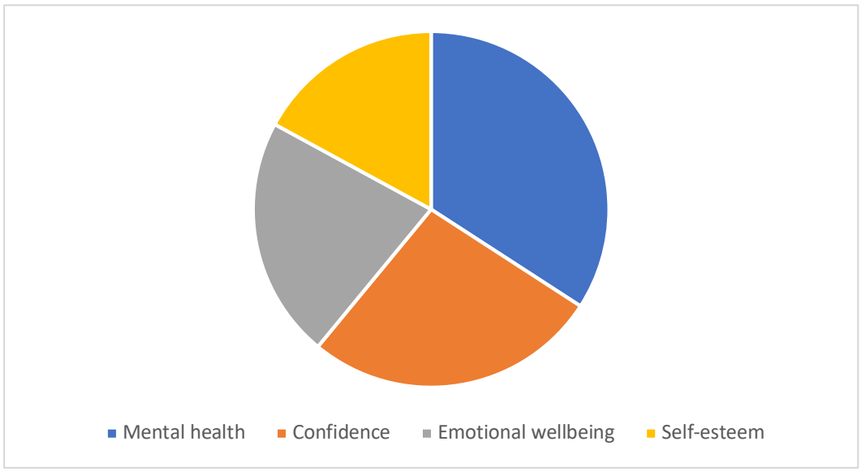

Figure 2. Breaking down the contents of mental and emotional health category.

34% of responses referred to mental health (with a more negative slant) and 21% of responses referred to emotional wellbeing generally. 26% of responses specifically referenced changes in levels of confidence of a child or young person and 17% referred directly to changes in self-esteem.

[1]*Patalay P, Fitzsimons E. (2016) Correlates of Mental Illness and Wellbeing in Children: Are They the Same? Results From the UK Millennium Cohort Study (PDF). Journal of the American Academy of Child & Adolescent Psychiatry, 55(9), 771–783.*

Qualities of the social prescribing scheme for children and young people

This category identified a range of things to record including the number of referrals, where referrals come from, what activities children and young people are referred on to, the progress in relation to the action plans (devised by the children and young people, with their link worker) and levels of engagement and satisfaction with the scheme. People also highlighted the need to understand how inclusive and accessible the scheme is and to what degree it addresses inequalities.

Voices of children and young people

This category had 2 distinct parts. The first was to state that children and young people should be equal stakeholders and included in co-producing what is measured to ensure it is meaningful and relevant to them. Secondly participants repeatedly suggested using qualitative methods e.g. case-studies that allow the words of children and young people to be captured directly.

Connections

This category reflected the ways in which children and young people increased the number of connections they had. This included changes in the level of interaction with peer and professional groups; the number of new activities taken up as a result of the children and young people's social prescribing scheme, and additional activities that the children and young people were not referred to. Increasing connections is also a theme seen in research undertaken on adult social prescribing schemes[2] which is under reported in traditional social prescribing literature. Importantly, this is an area of evaluation that is often neglected as it is very difficult to capture the number of new activities effectively attended by social prescribing users, both young people and adults.

Physical health and general wellbeing

In both of these categories, participants made reference to physical health or general wellbeing without there being much further explanation. A few responses referred to diet, weight, BMI and dental health for the physical health category.

Education

Many participants suggested the changes in school attendance is monitored as well as a changes in academic attainment. Other points relating to the school environment related to gaining feedback from the multidisciplinary teams in schools and the SEND needs outcomes.

It is noted that this data is up to secondary school. The further and higher education sectors were not represented in this data and further research should be carried out to understand outcomes that are relevant to young people between 18-25 years old.

Behaviour

Many participants suggested changes in the behaviour of children and young people could be used to understand the impact of the social prescribing schemes. Examples of behaviours ranged from the ability of a person to get out of bed and out the house or stick to a routine or make a decision through to risk-taking behaviour, use of alcohol and recreational drugs and the use of prescription drugs. It has been reported in the adult social prescribing research2 that over time and with social prescribing support, people take more pride in their appearance and decrease their reliance on prescription medication. Whilst examples of behaviour in adults are understandably different to the examples given here for children and young people, it is of interest and of note that some behaviours may act as simple indicators of positive change, but are not used in traditional research measures.

Resilience

Participants referred to improved levels of resilience in general, some people gave examples of aspects of resilience in children and young people, such as the ability to cope with situations or manage practical issues and the ability to self-regulate.

Communication

This category may seem similar to the ''connections' category. This category specifically highlighted the ability of a person to communicate more clearly whether with their friends, peers, teachers or other professionals. Some participants also highlighted the ability of children and young people to express themselves without fear. The other aspect to this category related to relationships at home with the family.

Safety, criminal behaviour, skills and employment

The final categories have a small number of responses but still highlighted some important aspects. In terms of safety, participants suggested capturing how safe or secure a person feels, it was unclear sometimes in what sense this was meant. There was also a category around criminal behaviour, suggesting reductions in rates of offending, crime and antisocial behaviour may result from children and young people's social prescribing schemes. Finally, a few participants referred to increased levels of skills and employment. These three areas are all in need of further investigation as it is likely that responses relating to 18-25 year olds are not very well represented in this data. These are outcomes that were recently reported in research on outcomes in adult social prescribing and are typically under-reported in existing social prescribing literature[2].

[2]Polley et al (2020) What does successful social prescribing look like? – mapping meaningful outcomes

Economic benefits

Very little was reported relating to the ways of measuring the economic impact of children and young people's social prescribing. This is in contrast to adult social prescribing schemes, where the economic impact of healthcare usage, reduction in attendance at A&E or unplanned secondary care admissions are frequently cited.

It is likely that the approach to establishing economic impact will need to be carefully considered as only 20% of referrals into existing children and young people's social prescribing schemes come from GPs – demonstrating a distinctive difference between adult social prescribing and children and young people's social prescribing. Looking forwards, it is important to understand that the changes to children and young people may manifest in improved outcomes in life chances and therefore economically are hard to quantify accurately in the immediate future.

Using education as an example, the impact of not attending school or gaining qualifications is profound and lifelong, in terms of a persons' ability to earn money and therefore on their health. It is likely that any changes to children and young people that improve mental health, confidence, self-esteem, resilience will all support increased attendance and attainment at school, college and university. This will have a direct and positive impact on a young person's life chances, particularly for employment in the future. Moreover, the Mental Health Task Force (2016) showed that half of all mental health problems are established by the age of 14, and three quarters of all mental health problems by the age of 24. Thus, the economic benefits of supporting young people to address mental health problems early are significant.