



The impact of social prescribing on children and young people's mental health and wellbeing

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Introduction

Three quarters of mental health difficulties occur before the age of 25, and half before the age of 14 [1]. Early intervention can have positive effects on outcomes [2], yet children and young people are less likely to seek support from mental health services than adults [3]. Social factors are acknowledged as contributing to and maintaining difficulties in both physical [4] and mental health [5]. As such, there is increasing interest in how community approaches, such as social prescribing, may be used to help support individuals with health difficulties [6].

Research has found that social prescribing is linked to a wide range of benefits, including improvements to both mental and physical health [7-10], reducing pressure and saving costs in primary care [11], and demonstrating a favourable

return on investment (ibid). However, despite social prescribing being described as an ‘all age offer’ [12], a recent review concluded that only a small proportion of Link Workers were working with young people aged 16 and under [13].

A review in 2020 exploring the impact of social prescribing on child and youth mental health did not identify any studies or grey literature which met inclusion criteria [14]. To progress this area, the authors suggested that further work should be undertaken to understand how best to implement social prescribing with this group, including exploring different pathways to access, and understanding any barriers around delivering social prescribing with children and young people. Subsequent work to identify these barriers suggested that further training and support for Link Workers was needed [15]. Since the last review, specialist Link Worker roles with an emphasis on children and young people have been created both in the National Health Service (NHS), as well as in the voluntary, community and social enterprise sector. There has also been the development of the NHS social prescribing toolkit for children and young people and funded research studies, including CHOICES [16] and INSPYRE [17] which aim to better understand how to implement social prescribing with children and young people.

The aim of this review was to conduct an updated rapid evidence review of the impact of social prescribing for children and young people’s mental health and wellbeing.

Method

- For a full overview of the methodology, including the search terms and inclusion criteria, please refer to the supplementary methodology section at the end of this document.
- A Rapid Evidence Review [18] approach was used to provide this evidence synthesis. Rapid Evidence Reviews streamline the steps of systematic reviews under an accelerated timeframe to produce evidence in a shortened timeframe. We searched PsycINFO, EMBASE, Medline, and Social Policy and Practice until 24th February 2022.
- Search terms were established using the PICO (population, intervention, control, outcome) method. To be eligible, an individual with a social prescribing (linking) role would have to refer the child or young person to any social or community intervention, such as singing, arts or sports activities.
- Outcomes included psychological wellbeing, general health, mental health, and quality of life.
- Studies were included if they explicitly assessed the relationship between the specified interventions alongside one of the identified outcomes, if they pertained to child or youth populations (aged 25 years or younger), and were written in English. All other literature was excluded.

Results

- A total of 587 studies were identified during the search. Four met inclusion criteria [19-22].
- Population: Studies focused on young people with an average age of at least 15 years old. Presenting difficulties included: anxiety and loneliness, emotional difficulties, being socially isolated or at risk of social isolation, general mental health difficulties, and young mothers who were classified as vulnerable.
- Included studies all comprised of pre/post designs [19-22]. Two included qualitative components [19,21] and one an economic component [19].
- One pilot evaluation investigated Social Prescribing across three sites in England [19]. Increases in personal wellbeing and mental wellbeing were found at six month follow up, particularly for those with the lowest levels at baseline. Significantly lower GP consultations and attendance at A&E were observed. An economic analysis, conducted only at one site, demonstrated a return of £5.04 for £1.00 spent. Qualitative interviews identified that social prescribing was seen as acceptable and filling a mental health gap. However, the following challenges were identified: a) inappropriate referrals, b) a greater than expected mental health need, c) the need for greater co-ordination with agencies and parents/guardians, d) worries about the sustainability of Voluntary and Community Sector organisations, and e) the prohibitive costs and journey times associated with activities.
- A second evaluation [22] explored the impact of social prescribing on mental wellbeing and goal-based outcomes. This was at a site involved in the above pilot study. All sites found the majority of young people reported increases in mental wellbeing and being able to achieve their goals.
- The third included evaluation [20] explored a social prescribing service for those aged 16-25. The majority of young people involved reported increases in both personal wellbeing and mental wellbeing, and decreases in loneliness and perceived level of support required.
- The last evaluation explored social prescribing for vulnerable first-time mothers aged between 17-25, whose stress may impact their child's development [21]. No change was observed on wellbeing, as it was high at baseline. Despite this, interviews with young mothers identified that Link Workers helped increase their wellbeing, self-esteem and confidence. Interviews with Link Workers identified interagency joint working was challenging, due to difficulties with information sharing, as well as some confusion around referral processes.

How reliable is the data?

- Strengths of included studies involve the use of validated measures for this population, such as the SWEMWEBS [23].
- However, all studies lacked any control group making it difficult to directly attribute the impact of social prescribing to any outcomes.
- All included evaluations that consisted of small samples, which may not be representative of the wider target population. The largest evaluation involving three sites was heavily skewed towards data collection at one site [19].
- The majority of evaluations did not report significance levels on quantitative findings, meaning any increases may not have reached the threshold for statistical significance.
- Based on above, findings should be treated cautiously.

Recommendations

- There is emerging evidence around the benefits of social prescribing for young people, particularly for those aged over 17, on personal and mental wellbeing.
- There is also preliminary evidence to suggest there is a potential favourable return on investment.
- Whilst small, the evidence base has increased in two years from no published evidence to four published studies. To strengthen the evidence base, more robust research is needed, including: a) larger samples, which are representative of the target populations being studied, b) more detailed reporting on quantitative data, including means, standard deviations and significance levels, and c) the use of control groups to be able to accurately infer the impact of social prescribing on children and young people.
- Qualitative data suggests that whilst social prescribing can be of benefit to children and young people, barriers remain, particularly around interagency working, information sharing and incorporating multiple stakeholder perspectives. To effectively roll out social prescribing for children and young people, further exploration of these barriers, as well as concrete suggestions to any encountered obstacles, is also needed.

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Supplementary information

Search strategy

Four research databases were searched until March 2022: PsycINFO, EMBASE, Medline, and Social Policy and Practice. The search strategy included three concepts: ‘child/young person’, ‘social prescribing’ and ‘mental health/wellbeing’

Title, abstract and keyword search

Concept 1 - child terms

1 Child*

- 2 Adolescent*
- 3 Young*
- 4 Student*
- 5 youth*.
- 6 teen*.
- 7 pupil*
- 8 1 or 2 or 3 or 4 or 5 or 6 or 7: 7,495,516 hits

Concept 2 - mental health terms

- 9 Mental Health/*
- 10 Anxiety*
- 11 Depression*
- 12 Stress*
- 13 Psychological distress*
- 14 (mental adj2 health)
- 15 (mental adj ill*)
- 16 (mental adj well*).
- 17 (mental adj2 stress*)
- 18 (mental adj2 distress)
- 19 (psycholog* adj2 health)
- 20 (psycholog* adj ill*)
- 21 (psycholog* adj well*)
- 22 (psycholog* adj2 stress*)
- 23 (psycholog* adj2 distress*)
- 24 Wellbeing
- 25 Anxious
- 26 9 or 10 or 11 or 12 or 13 or 14 or 15 or 16 or 17 or 18 or 19 or 20 or 21 or 22 or 23 or 24 or 25 4,445,565 hits

Concept 3 - social prescribing terms

- 27 (social* adj2 referral*)
- 28 (communit* adj2 referr*)
- 29 (communit* adj2 prescrip*)

30	(communit* adj2 prescrib*)	
31	(social* adj2 prescrib*)	
32	(social* adj2 prescrip*)	
33	(Care adj2 navigator*)	
34	(Wellbeing adj2 coordinator*)	
35	(Link* adj2 Worker*)	
36	27 or 28 or 29 or 30 or 31 or 32 or 33 or 35 or 35	9846 hits
37	8 and 26 and 36	
38	Deduplicate	587 hits

Methodology

A team of individuals with a knowledge of a) children and young people’s mental health and wellbeing, and b) social prescribing, were convened. The primary inclusion and exclusion criteria were agreed upon by two of the authors (DH, KH) and shared with the wider group for refinement. These are outlined below:

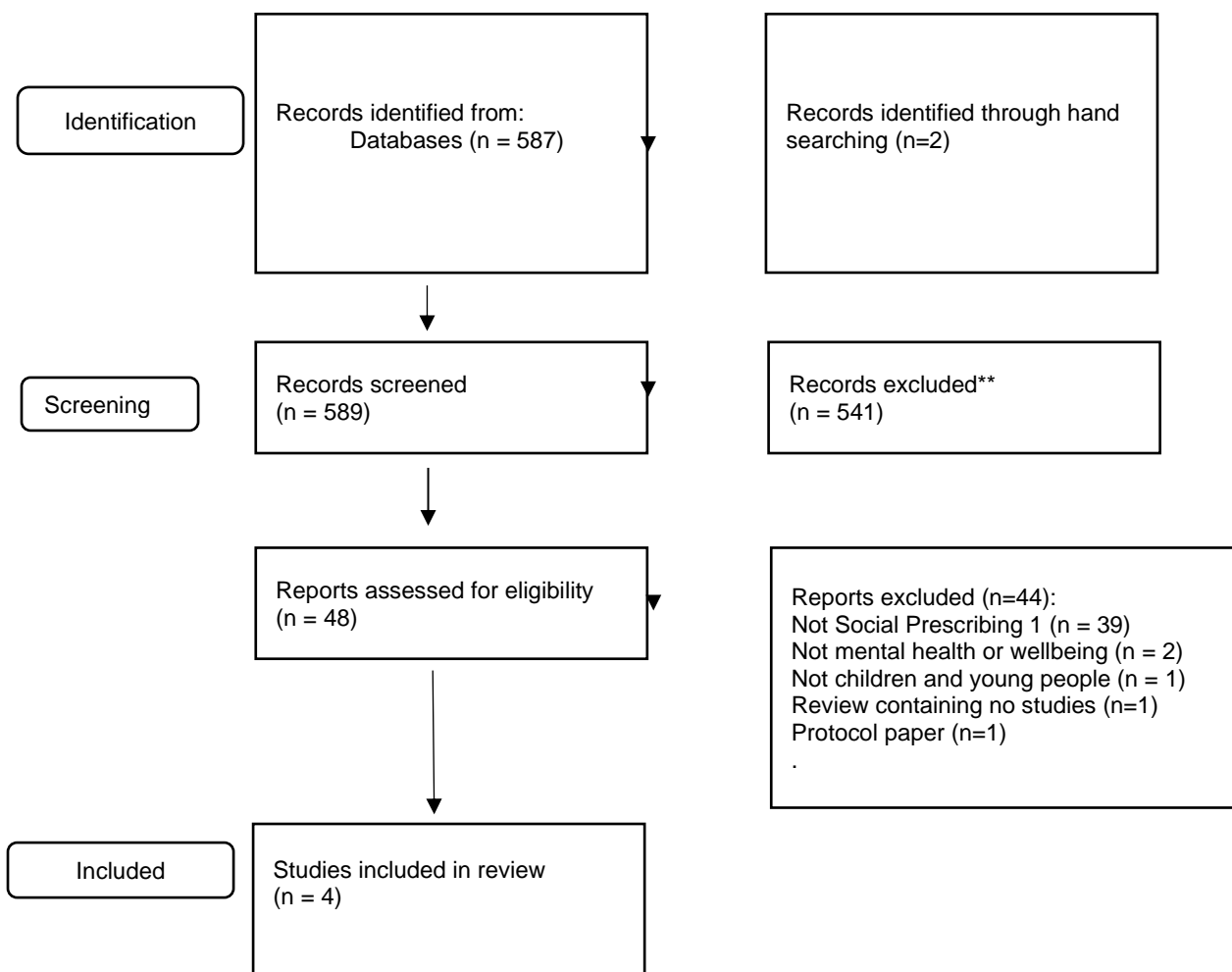
1. **Participants:** Included a child, adolescent or young person (up to age 25)
2. **Intervention:** Any social prescribing intervention, which includes the use of a Link Worker, referring on to any community activity
3. **Comparator:** Any study design is eligible
4. **Outcomes:** Focuses on mental health and/or wellbeing, including quality of life and loneliness

Additional points

- Record must be in English.

Record selection was completed using a two-stage process. The first stage involved two researchers (DH and KH) independently screening all titles and abstracts. Those that were not relevant were excluded and any discrepancies were resolved via discussion. The second stage consisted of full-text screening and included the same two authors and again, any discrepancies were resolved via discussion. Figure 1 outlines the process for exclusion at each stage. A data extraction template was created to obtain the following information from included records: author, year/publication date, participant details, study design, sample size, constructs measured, outcome results, and any child and young person characteristics.

Figure 1: PRIMA flowchart outlining the search strategy for the review



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