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CHILDREN & YOUNG PEOPLE'S SERVICES COMMITTEES
COISTÍ NA SEIRBHÍSÍ DO LEANAÍ & DO DHAOINE ÓGA
Dublin City South
Cathair Bhaile Átha Cliath Theas

Ballyfermot Chapelizod Partnership
'Building an inclusive community'

Dublin City South CYPSC
&
Ballyfermot Chapelizod Partnership
(Family Matters)

Children & Young People's Social Prescribing Scoping Study

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An Ghníomhaireacht um Leanaí agus an Teaghlach
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1 Executive Summary

It is clear that there is scope for social prescribing as a preventative intervention in terms of health and wellbeing and particularly in relation to mental health. It is equally clear that the groundwork is in place and that support for this approach is locally widespread amongst stakeholders.

Though there are important initiatives underway throughout the country, targeted at varied groups, there is a gap in provision of social prescribing in terms of young people for whom this approach may align well with development stage and changing patterns of personal and social engagement.

Considered reflection on the part of the sponsors and main partner stakeholders as to the detail of the task should be undertaken. A rigorously planned initiative that addresses barriers identified in research and practice as well as anticipating the unique needs of the target population is required, with organisational commitment, capacity and sufficient resources to ensure a successful learning project.

The 'pilot' initiative must have a clear strategic vision, objectives and strategy, that are jointly understood by all participating groups. Success should lead to the transfer of the model throughout the area. A project that is deemed not viable should provide significant learning on both the approach and process that will inform the practice of working with young people and the particular approach. A well organised and managed pilot project can be instrumental in determining this.

Four key questions can be explored in a pilot initiative that will provide invaluable information in research and practice:

1. Does the model address parent concerns with a clear focus on anxiety, isolation and self-esteem issues that may have secondary impacts in terms of physical health, weight health, addictions and mental health.

2. Does implementation take place after a systematic, well planned approach based on developing clear patterns of shared understanding and agency among all partners and stakeholders with respect to the scope, operations and outcomes of a social prescribing service.

3. Is there evidence of adapted case management, social prescribing style, that fosters a referral serviced continuum between medical services, link workers, a secondary 'link' level in existing positions[1] and *prescribed* community services.

4. Is there evidence that this is a learning project with appropriate record keeping, monitoring and evaluation?

1 Home-school liaisons, after-schools coordinators, sports development officers, key workers in youth organisations

2 Introduction

The fundamental question

This scoping study is undertaken for the ABC Family Programme in Ballyfermot Community Partnership to explore if and how a social prescribing (SP) pilot project for young people might yield positive outcomes within the community and voluntary sector, particularly youth services.

The structure of the report is shown below:

2.1 Review

A literature review (Appendix 1) conducted previously in the community set out the context of social prescribing in Ireland, and in the UK. To this work we have included an update on activity in Ireland, and scoping considerations from reviewing a specific youth focused project in Rochdale in the UK and an independent evaluation of a significant project in Glasgow, Scotland.

The key focus of the review is social prescribing for youth, for which there appears to be limited research and practice.

2.2 Consultation

For this project the voices of stakeholders in various contexts assumes greater significance as in many cases the consultees will be needed as champions and advocates, if not more directly linked in terms of organisations or as workers, or service users. Their opinions and understanding of social prescribing and its possibilities, of the limits and barriers to use in particular circumstances is important within existing service and target group conditions.

A common questioning framework was used with each group to ensure consistency. There were four key questions:

1. Is there a need?
2. Is there capacity in the community?
3. What about the medical profession?
4. How will referrals happen?

Beyond it's implied meaning the question of need seeks to test if social prescribing can fit within current community and voluntary sector/ youth services infrastructure and resources. The capacity of the community to be the point of referral (the prescription) is an important question in the context of resource challenges brought about by significant budget and programme cuts over the past ten years. The medical profession is a key, and in many examples in the literature, the only source of referrals into social prescribing. The focus in this context recognises the challenges inherent in asking doctors to consider non-medical solutions beyond CAMHS/ Primary Care Psychology Services in situations where a parent brings their child in because they are 'anxious' or 'depressed'. Among the considerations is the extent to which social prescribing may be a benefit in that it formalises for all concerned the networking between parties in the care of a child or young person. Finally the role of the link worker has been shown in research to be very important in determining the effectiveness of social prescribing initiatives.

2.3 Analysis

The intent of the scoping study is to critically interrogate the research evidence and the feedback from the stakeholders to assess whether the project is worth taking to the next (pilot) stage. In recommending the next course of action the analysis will seek to contextualise within the current service infrastructure and to highlight where further investigation is important with key questions in terms of the pilot being a 'learning' project.

2.4 Report

The Report captures and presents the main learning from the literature review (Section 3) and consultation among stakeholders (Section 4), culminating with Analysis and Recommendation (Section 6).

3. Literature Review

3.1 Introduction

Social Prescribing introduces the concept of non-medical interventions through linking referrals with a range of social, sports and community services. It can include a wide range of interventions from healthy eating (cookery, nutrition advice) to drama and arts activities. It is often related to physical activity involving referral to a range of traditional and non-traditional recreation, leisure and sports activities. It has been declared effective in reducing the dependence on the health system (less prescriptions, less GP visits) and facilitating positive health outcomes, though there are few systematic, wide-ranging studies of effectiveness. A HSE review in County Donegal of a six community pilot project for adults (18+) found that

'Social Prescribing has shown very positive results for participants and other stakeholders. The structured way of supporting partnership between clinicians and the community has the potential to harness and nurture the good will that already exists between these partners. (*Donegal Social Prescribing – Evaluation Report 2015. HSE*)'

A recent news report (*What is social prescribing and how it can benefit your health. Cleary C Irish Times. April 2019*) provides a useful overview of social prescribing in this country. The main focus of the article is on the experience of a Dublin 6 resident who attended the GP services with health concerns and was surprised that the 'prescription' was a referral to a local community services organisation. He had not long retired from and was suffering from identity loss, stress and isolation The wellness benefits were noted as well as the Doctor's appreciation that there were more options than medication or referral to mental health services in a situation where the ailment was feeling low as a result of isolation and lack of activity options after retirement.

In addition to the Dublin 8 Social Prescribing Project that was the main feature, the report referenced social prescribing projects in Donegal, Waterford, Mayo, Kerry, Wicklow and two others in Dublin (Dún Laoghaire and Tallaght).

The Scoping Study is looking at targeting the model specifically at young people, which would reflect a first in this country. There is little in the literature on social prescribing for youth; one of the few examples from Rochdale, England is explored in the next section.

3.2 Social Prescribing, Rochdale, England

In the UK a social prescribing project for youth in the Rochdale Area (*Link4Life Rochdale Thrive, Young People's Health Partnership 2018*) has developed a prescribing model after consulting widely with young people. The service features a dedicated phone line to access services, online support, and a physical hub (youth cafe model) among other interventions.

The focus is on improving general lifestyle and there is an underlying recognition that social care can help in reducing isolation.

#Thrive is an early help, mental health service for children and young people (CYP) between 0-19 years. The service is about building social resilience and confidence; trust in adults; a peer support network and, access to counselling and therapy. The #Thrive service started in July 2016 but the physical expression of the programme, a café opened in 2017.

The report noted an unexpectedly high level of referrals with anxiety, low mood and behavioural difficulties the top presenting problems for children and young people accessing the service. In terms of referral, children, young people, and families can simply drop in; the organisers are currently seeking to encourage this form of access over formal referral. There are weekly referral meetings with CAMHS. Before this process referrals might not have met the threshold for specialist CAMHS. The Thrive programme has gone some way to fill this gap and it is working to link together different parts of the system so schools are feeling much more supported.

A number of providers aim to target services side by side with the parents to help build the relationship between children and parents, which is seen as key to promoting resilience.

3.3 Social Prescribing, Glasgow, Scotland

(Delivering a primary care-based social prescribing initiative: a qualitative study of the benefits and challenges. Skivington K et al. British Journal of General Practice: 2018)

The project provided 6 link workers in a social prescribing programme in deprived areas of Glasgow. The aim of the study was to investigate the benefits of and challenges to implementing a social prescribing programme to improve inter-sectoral working to mitigate the negative effects of the social determinants of health.

The evaluation was based on analysis of data from individual interviews with the six link workers and 30 representatives of community organisations. The topics covered were: participants' views on the programme; relationships between primary care and community services; relationships with link workers; the referral process and appropriateness of referrals; and organisational capacity.

Benefits

Community organisation participants suggested that, before the programme efforts of workers or community organisations to get a forum with GPs was very difficult.Most participants viewed the role of the link worker as engaging patients with a network of community resources and providing continued follow-up and support, rather than simply being a referral point.

Link workers were perceived to carry gravitas, authority and credibility with GP's that facilitated initial contact, bypassing traditional routes.

Link workers were seen to have an understanding of both primary care and community organisation structure and function, and therefore could help negotiate between these sectors. Importantly, they were seen to be in a position to champion different approaches.

The location of link workers in GP practices provided the opportunity to become a trusted member of the GP team, where they could share information about community organisations. Co-location facilitated easier referral, and engagement with the link worker for vulnerable patients.

Challenges

For this project the increase in need for services was occurring concurrently with austerity cuts, where organisations were expressing uncertainty about sustainability.

Link workers noted issues with patient referral to organisations that they believed did not have sufficient capacity to support patients but also hesitant to admit any lack of capacity. In a sense this was confirmed by community organisations noting that they would not turn people away though funding and sustainability was an issue. This can lead to a 'fire-fighting' approach not best suited to support individuals with enduring and complex health and social challenges.

The capacity of link workers was expressed as a concern given that theirs almost became a case management role. They were seen to have taken on a 'fixing', rather than solely 'linking' role. This hands-on approach was welcomed by community organisations but there were concerns about the sustainability of the position. It was felt that link workers were arguably filling gaps created by budget cuts elsewhere.

Moving beyond individual rather than organisational relationships and continuity was a challenge. Collaborative relationships were clearly valued but the parties found it difficult to progress them to a more lasting collaboration between organisations independent of the specific individuals involved.

3.4 Learning Points for the Project

- Link worker
  - Fundamental to successful outcomes
  - Understanding of both medical and community services
  - Location is a consideration
  - Risk of it becoming a ‘fixer’ rather than ‘referrer’ role.

- Community Capacity
  - Unable/ unwilling to say ‘no’ to referral can be both positive and negative
  - Moving beyond individual connections to organisational relationship
  - Credibility with medical profession provided by Link Worker

- Need

- Youth presenting with anxiety, low mood, depression.

4. Consultation

A key part of the work involved seeking views of the range of stakeholders who will ultimately be responsible for successful implementation. The core purpose of the engagement was to gain participants' views on what a social prescribing programme might look like in a pilot project in Ballyfermot, before considering a wider community implementation.

In addition to interrogating needs, barriers and potential implementation pathways community engagement informed and sought consensus on the value of the approach and started initial discussions with different stakeholders on collaborative ways of implementing elements of a social prescribing plan.

Where it was not possible to organise a focus group, a simple online survey was circulated to stakeholder groups. Thus the Youth Services Sector feedback is survey based. A similar intent was taken with GP's though with this sector, the possibility of a telephone interview was explored first.

The groups included

Stakeholders	SP Function	Engagement	Participants
Young people	Target group and ultimate beneficiaries	Small focus group	3
Medical profession	primary referral source for social prescriptions	Selected key activists	3
Youth Services Sector	primary referral destination	Online survey	10
Community Services Sector	Secondary referral source and destination	Stakeholder focus group	9
Community Partners	Governance, Strategy and Funding	Key Stakeholder meetings	5
Parents	Stakeholder/ Activists	Meeting	15

4.1 Youth Meeting

The notes for this meeting were recorded by the facilitator in the immediate aftermath of the meeting and are written in the form of a narrative. This approach was explained to the group and allowed for a fuller discussion among what was a small group.

Definition

Social prescribing was quickly defined with the simple explanation of it being a social prescription that took the place of medical prescription. The scoping discussion was timely for the young people as they are involved in developing a volunteer-led arts and music programme to deal with young people with potential co-morbid mental health issues, for whom it is felt that the only recourse is medication and that this is not always appropriate. ASD is seen as a primary target group for social prescribing. The volunteer-led project has been set up to fill a gap in services.

The role of parents was discussed as they bring the children to the music and arts programme. They too can become part of the process, with some level of group activity required for when their children are engaged in activities.

What about the doctors

There was considerable discussion about the role of the doctor and psychological care services, some based on personal experience. In some cased referrals to counselling and organisations had occurred on a once-off basis. The approach of medical services was noted as playing an important role. If there is a rush to prescribe then it is less likely that any of the social determinants will be explored. Examples of a number of doctors (female) having a more holistic approach were put forward as the way the system should work.

Community Capacity

Many elements of community capacity were discussed. The young people were very strong that that system would have to be 'open' for referrals. When this was teased out further in terms of limits, a recent example of a local arts programme was brought up as being one of unsustainable practice. There were 60 involved in the service creating issues of overload, and service quality. Finally, a maximum capacity was established, which had the effect of sudden reduction and a gradual building back up of the service. A smaller group was set up to take the overflow; in this way no one was turned away.

Cross referral among the youth services would be needed if capacity issues were to be addressed. Organisations would require good systems and these were not in place at present. A youth worker present with the group noted that there are many good organisations but there that communication between them can be a challenge. The capacity of services would be an issue, as there was already pressure on services. Nonetheless social prescribing may work to formalise informal work that is already in progress. The referral system was discussed as having the potential to facilitate a common referral system for youth services, replacing the individual form that often attaches to each organisation.

Appropriate training of workers was pointed out as being very important by the young people, fresh from their experience of gaining that experience in the ASD programme. If capacity is needed from the start, then that training would have to be in place.

Referrals

The general consensus was that the referral system is key. If doctors had a central position to refer to it would make their job easier and also facilitate trust in the system. It would however also place big pressure on the link worker as the only channel for GP's to refer. An example from the UK was discussed where self and parent referrals could also be made. This may help alleviate the choke point issue but the role of the link worker or social prescriber would still be crucial. The qualifications for this position was discussed and it was agreed that some medical background would be helpful but that the main qualifications should relate to social or youth work. The position would need to have a good knowledge of the local infrastructure. The position was acknowledged as being important to success.

Comparison of the link worker model with that of key workers in youth services was made, even if the scale of the involvement was seen to be one of less attachment to the file. However the experience of Glasgow was bought up where the capacity of the six workers became the issue as they became 'case managers' of every referral and the focal point of all communication and issue resolution.

Online engagement based on the UK model was brought up as a way to ease access to the service. A number of online tools are available to the young people.

4.2 Agency Stakeholder Meeting

The notes for this meeting were compiled from participant comments, the main points of which were recorded on Flip Chart as the discussion went on.

Definition:

A number of different ideas, that feature in the research, came out of the discussion. As a base definition social interventions (prescriptions) are appropriate in addressing non-medical needs, an additional option for doctors, linking clinical and non-clinical practice. In terms of mental health the need for 'wellbeing' options is important as in the current context the only non-medical referrals are to CAMHS or Primary Care Psychology Services. Isolation creates a social need where community network solutions can help. An example was cited of the transition from traditional 'going out to play' play model that was the experience of many young parents to the pattern of organised play that may be the apartment living experience of new immigrants. The concept of social prescribing changes for different age ranges with parental focus more prevalent in the younger age groups (ten and under) than among the 11-18 group.

Need

The need has already been expressed in terms of social / participation interventions to add to the 'crisis' interventions associated with CAMHS/ Primary Care Psychology Services. In addiction services the fall-back to substance solutions is in some case not as effective, or indeed appropriate, as referral to a social or networking solution. This is a model that supports the medical model, the GP refers the patient to a social prescriber/ link work in the same way as a referral is made to a social worker or mental health services.

The practice goes back, if not in name, to an example cited from the North Inner City, where GP's developed a book referral scheme in league with the ILAC Centre to address wellbeing needs.

What about the Doctors?

Research suggesting that for 20% of GP visits (adults), non-medical solutions are more appropriate was noted. There is an incentive for the Doctor to get involved as there is a time and money saving. GP's receive a limited annual amount per child referral (medical card). So if a child refers 3 times in a year, their fee is used up. If it is a visit per month, that may amount to 9 free visits. Within the system a new scheme addresses a financial incentive to prescribe less. The awareness and model training could be part of the mandated CPD sessions that doctors have to attend.

4.3 Parents and School Sector

The point was made during the meeting, that although each of the school workers present had attended in their role, their presence also attested to their status as parents with children in the same schools. The questioning format followed the format used in each of the meetings, though the discussion generated by the question of need was central to the overall discussion. This allowed for a comprehensive consideration of the 'new' online world and the link with mental health and social prescribing.

Need

Concerns about new technologies, social media and cyber bullying framed much of the discussion throughout the meeting. The group wished to continue talking about this issue despite the opportunity to broaden the discussion. This gives some indication of the strength of concerns expressed primarily about the difficulty to control the amount of time that young people are spending online.

The surge in online 'friends' gives rise to concerns that young people are hiding behind the screen and are not learning the social tools that start within the family and progress through play, early years, school and sports/ cultural activities. This gives rise to confidence issues about something as basic as talking to friends etc.

Cyber bullying is an invasive demeaning of the person and its effect is heightened the greater the role of social media in a person's life. Though the effects have been well documented with a number of high profile tragedies, it remains a significant issue.

Anxiety has become the new and very real illness caused in large part by having to be constantly turned 'on' in the social media environment. It is a 'captive' environment and the constant checking into social media platforms adds to stress and anxiety, adding to the 'pressures' of young adulthood in the adult world.

Privacy is a big fear of parents. Beyond the increased pressure caused by social media is the danger that when their children are in their rooms on social media with their friends, that they are also engaging with strangers on different platforms.

Social media is shaping how children and young people are presenting their 'public' face. So called 'beauty' blogs are instrumental in 'helping' them develop a public (airbrushed) face for social media purposes that can be at odds with how they actually feel about themselves. This public image can then become an unrealistic icon that they have to live up to.

In terms of learning, research was cited that shows the very real and negative impact of smart phones on reading, writing and communication skills.

An associated concern is that this may be the first generation that are not culturally attuned to 'playing outside'. Whereas for most people in the room playing outside was an automatic rite of passage growing up, now the whole concept of play has to be planned and implemented. Participants noted a number of organised play initiatives. The links with obesity and poor fitness levels was noted.

4.4 Youth Services Sector

The online survey featured ten questions that reflect the main themes in the focus group sessions. Many of the questions invited a positive-negative rating across a number of indicators. One question used feedback from the focus group sessions to establish a hierarchy of preferences. In the online survey this was the only opportunity that respondents had to build on the feedback/ thinking of others to develop a consensus position common in focus group situations. This feedback is the sum of individual responses a different type of feedback that is useful and allows interpretation of majority responses, without understanding necessarily the context of responses.

Rating Scale Indicators – Need and Capacity

There were significant majority positive responses as shown in the table below:

Indicators	Rating	Score
First Reaction to the introduction of Social Prescribing	Very Positive	80%
How important is the model	Very Important	70%
Can it add to existing services	Yes	100%
Capacity of your organisation to engage	Very Positive	40%
Willingness of your organisation to engage	Positive	50%
How likely is it that your organisation will engage?	Very Likely	50%
	Likely	50%

Two broad themes are evident within the questions, one relating to the need for a social prescribing model in Ballyfermot and the other relating to individual organisation capacity to engage. In terms of need the positive response is almost universal, even where it is set within the context of current service infrastructure. Responses are similarly positive in terms of organisation capacity though it should be noted that there was greater balance on the scale even if between the two positive scores. This perhaps reflects positive regard leavened by concerns in the midst of service pressures.

Ranking Question – Most important elements

To the question relating to ranking various characteristics of success noted in the research and refined in the focus group sessions the ranking produced more uniformity than difference with almost equal positive ratings for Link Worker, Dedicated Contact Point and Long-term Commitment. Least important in terms of ranking were Training and the need for more resources.

Comment Questions – Positive and Negative reflections

Responses to the two comment questions in the survey provide the opportunity for greater nuance, even if the responses are generally positive.

To the question *What are the things that you least like about social prescribing* there is little by way of negative responses. However a number of concerns arise that reflect the experience of projects cited in the research. The *need for dedicated contact points* is a challenge in a sector with high rates of staff turnover. *Increased workload* is also noted and a number of respondents note challenges in terms of *'long-term commitment'*.

To the question *What are the things that you like most about social prescribing* the majority of responses reflect on the benefits for young people of a more holistic approach. Linking the community sector with medical services is noted as providing many more options for the young person and can serve to distract from the current impetus toward 'crisis' solutions. Such a service would be preventative and help many young people from developing mental health issues. Having a link worker and a dedicated contact point can help to provide clarity and stability in terms of services.

4.5 Survey of Doctors

There was a relatively poor take-up of the survey among doctors to the online survey. In the short-term this is less of an issue as a pilot project requires a smaller cohort to facilitate a learning project. It is worth noting that the responses among those that took part were very positive.

Rating Scale Indicators – Need and Capacity

In terms of need and capacity to engage the positive tone is set with all responses in the most positive scores. In terms of willingness to get involved the positive trend continues and all respondents comment that it is very likely that they will engage with service.

Ranking Question – Most important elements

In terms of ranking, responses are individual to the respondent and there is little by way of shared views, perhaps reflecting different disciplines. The top priorities relate to resources and long-term commitment and among the top three priorities there is a level of agreement on the need for a dedicated contact point and the importance of a link worker.

Comment Questions – Positive and Negative reflections

To the question: *what are the things that you least like about social prescribing* a concern is noted, not against social prescribing but rather relating to the current ad-hoc basis of the practice and the consequent need for a more systematic approach.

To the question: *what are the things that you like most about social prescribing* the responses reflect the general positive for social prescribing in the consultation phase.

Linking the medical sector with community services is noted as broadening the level of support for young people in the community, beyond the relatively narrow scope of medical services. This approach opens up the opportunity for young people to have agency in terms of their help, creating a level of independence.

4.6 Learning Points for the Project

The views shown below are selected and not intended to reflect the full discussion in each meeting. In particular, points of common concern are presented once though they will have been brought up at each meeting.

- **Selected views of young people**
  - *Gap in community services for ASD children and young people*
  - *Parents bring their children and alternate programming will be needed to cater for their needs.*
  - *Referral must be open.*
  - *Planning must take into account capacity*
  - *There is a comparison between the Link worker and key workers in the Youth sector*
  - *Training is required for all workers/ volunteers engaging in this activity.*
  - *Cross referral and collaboration between youth organisations will be required*
  - *Social prescribing may formalise existing work of youth workers.*

- **Selected views of Community Stakeholders**
  - Wellness options among more serious mental health diagnoses
  - Isolation
  - Different age ranges will engage with the services differently and there is an important distinction between 'parent' led services (10 and under) and youth services.
  - Addiction services require treatment options beyond substance solutions
  - There is a financial/ time-saving incentive for doctors to get involved

- **Selected views of Youth workers**
  - Link worker, contact point, and long-term commitment ranked highest in terms of importance in setting up a service.
  - The high rate of staff turnover is a concern when considering dedicated contact point
  - Increased workload and long term commitment
  - Social prescribing provides for a more holistic service to young people.
  - The service continuum between the link worker and the dedicated contact point provides stability for the young person

- **Selected views of Parents/ School Workers**
  - Social Media creates an online world that can be 'easier' to manage (control) than the life lived among family and peers in home, school and community.
  - Play patterns have changed with this generation and this is compounded by the advent of the smartphone.
  - Friends is now an online phenomenon that distorts the social properties and dynamic that are more traditionally associated with the term.
  - Anxiety is a very real condition that has sprung to prominence, and for which the current options are medication or mental health services (CAMHS/ Primary Care Psychology Services). Social Prescribing is a viable alternative treatment.
  - Education levels are impacted negatively by overuse of new technology and in particular smartphones among young people.

5. Analysis and Recommendations

The literature review notes the lack of systematic review in terms of social prescribing, despite the recent proliferation of projects. One such study from 2018[2] came to light light at the end of this research process and though full review is beyond the scope for this work it is helpful to reflect some facilitators and barriers that are noted in the document. It is clear that many of the challenges noted in the review section and remarked upon by those that contributed to the consultation are validated in this review. The assertion of lack of systematic review is itself validated with the methodological finding that only eight review documents from 213 considered were considered sufficiently rigorous to warrant inclusion. This should demonstrate to the sponsors that if a pilot project is to be an outcome of their preparatory work it must be a learning project, with systematic monitoring, review and evaluation contributing to on-going reporting.

In terms of facilitating factors, the review notes *implementation approach* including the need for a phased approach based on a realistic 'lead-in' time. For *organisation and management* all-stakeholder workshops and training are touted as facilitators, contributing to *shared understanding and attitudes*. *Shared understanding* between sectors (including service users) is considered critical as is facilitating *relationships and communication* between partners so as to build trust and reciprocity. *Organisational readiness*, *GP staff engagement*, *support and supervision* and quality community *infrastructure* complete the list.

It is not surprising the barriers (*shared understanding, leadership and organisation, implementation approach, GP staff engagement, infrastructure and quality appraisal*) broadly represent the absence of what have been shown as facilitators. To these are added barriers noted earlier in the report relating to *staff turnover* and the *economic climate and funding*. A barrier *patient engagement* is noted relating to a lack of understanding among patients and consequent distrust of social prescribing as a viable practice.

The detail of the review should give rise to considered reflection on the part of the sponsors as to the comprehensive nature of the task. It is clear that there is a fit for social prescribing as a preventative intervention in terms of health and wellbeing and particularly in relation to mental health. It is equally clear that there is a gap in provision of social prescribing in terms of young people for whom this approach may align with development stage and changing patterns of personal and social engagement. It has to be established that the appetite, capacity and resources of the sponsor and main partner stakeholders are appropriate to the task. A well organised and managed pilot project can be instrumental in determining this.

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[2] *Facilitators and Barriers of implementing and delivering social prescribing services: a systematic review. Pescheny et al. BMC Medical Service Research. 2018.*

5.1 Analysis

Need

In the example from the UK the needs that were addressed related to issues pertaining to angst, low mood and behavioural difficulties. These 'symptoms' of need relate clearly to parents express concerns about the effect of social media and the ubiquity of new technologies. At the moment the sole 'prescription' option is to refer to CAMHS or Primary Care Psychology Services (PCPS) where for many the child will not meet the threshold for specialist input. Furthermore in the changing living cycle of young people in which issues arise and fall away, the length of time it takes for referral, the waiting list, negates the 'natural flow' into which an issue might emerge and a common sense timeline where effective intervention might be brokered. Even in cases where ultimately these services may be required there can be need for an intermediate process where the ebbs and flows of the symptoms can be acknowledged/ supported and where 'social' referrals can be tried.

A 'progression' path can be part of an appropriate reporting mechanism which can add to the information available to CAMHS/ PCPS (with relevant permission). In the local situation social referral has been expressed as a much needed option for those on the ASD spectrum and in addiction services where the only solutions available at present are substance related and it is felt that in some cases these substances can be as harmful as they are helpful.

Some outcomes noted in the literature reflect the intermediate step on the path from referral at one end to 'clinical' mental health services at the other. Building social resilience and confidence, fostering or increasing trust in adults, supporting young people in the intricacies and emotions of engaging among their peers have been observed as outcomes in Rochdale. Wider research into social networks suggests that there are clear health benefits from multiple networks and that correspondingly the lack of social networks, associated with isolation can be negative in terms of mental and physical health.

Referrals

This service is all about referral. It is important to ensure that referral pathways and outcomes are strong and that the service addresses the risks associated with poor practice. Consider the risk first. For doctors or other education, social or family referrers, there has to be a level of certainty that the 'prescription' is effective. In any situation where this is compromised, referrals will dry up and more established prescriptions will be reverted to. It is not difficult to imagine the reputational damage that could result. Misdiagnosis is a risk. Capacity is a risk, where the organisation to which the client is referred does not have the capacity to provide consistent levels of service and support in the course of what is a medium to long-term commitment. This is a very real risk, and made more so by the almost systemic belief that no client can be turned away.

The link between this type of programme and community and voluntary youth services is interesting to consider. The potential for the referral pathway to formalise, and perhaps further legitimise the role and function of the youth worker is persuasive. The approach can foster positive networking and collaboration between relevant parties in the care of the client. The joined-up approach might be a powerful validation of the client, providing a more systematic path to positive outcomes. Where the added formality includes referral forms and intervention notes a more complete service can be added that becomes the common standard among and between organisations. The importance of this in terms of service consistency, ensuring that no one is falling through the cracks, and worker support cannot be overlooked. It will be challenging to overcome GDPR and confidentiality issues in all cases but there are definite benefits in considering this approach. It was noted in a number of sessions that youth services can be defined more by fragmentation and less by coordination or collaboration. In a situation where the situation of young people is very fluid, this can be detrimental to positive outcomes.

Capacity

The issue of capacity is at the heart of developing a service that will result in positive outcomes for young people. Pre-planning must ensure that all potential risks in terms of the capacity of organisations that becomes the point of referral to carry out the prescription. Capacity challenges are legitimate and should be expected in a sector which took the brunt of service cuts in the aftermath of the crash, and to which funding levels have made little if any recovery in the intervening period. The feedback from within the sector acknowledges this, and accepts that this contributes to high levels of staff turnover. This introduces a level of instability in terms of one characteristic of successful projects, namely the availability of dedicated contact points. In a situation where trust relationships can be a challenge for vulnerable young people stability is required. In the section above, the potential of a social prescribing service to positively impact the sector is recognised. While this is acknowledged, the beginning point must be a level of certainty for the young person that consistent service and support is available through the period of need. This has to be non-negotiable. It is telling that the most important requirement for doctors in the survey is new resources. As this sector is going to be a primary source of clients it is important that this feedback is kept in mind.

Two further elements, noted in the youth services survey and in discussions, are the need for cross-referral and collaboration and the potential for a common referral form. Feedback suggests that collaboration and partnership between organisations has not been a feature of the sector to date. This is not surprising where the focus of scarce resources is on the clients that show up looking for services. The potential for cross-referral can be useful or even vital in situations where capacity is an issue. Prior work will be required to ensure that the strength of ties between groups is strong enough to facilitate cross referral. A common referral form can serve to assist the cross-referencing process. It will also be an important element of comprehensive monitoring and reporting that will add to the learning outcomes associated with this being a model-testing process.

Link worker

The importance of the link worker is noted in the research and has been noted by all stakeholders in the consultation phase. An understanding of both primary care community organisation structure and function is a requirement of the position, particularly in a situation where referrals are made from multiple stakeholders. The capacity for the position to work comfortably, and to create an effective referral pathway between, medical services, and the community and voluntary sectors is important to success.

Potential secondary link roles exist with the key worker positions (community and voluntary youth services), community liaison and school completion positions in schools, and sports development officers in a variety of sports clubs. These positions could play an important function in both referral and support for the client and help redress the ‘choke-point’ pressure on the link worker. It has been envisaged that the position will be to ‘link’ but the reality of many projects is that the link worker becomes part of the ‘fix’. In the situation of vulnerable youth it is difficult to see how a more restrictive linking role might work where the beginnings of a trust relationship with the client are in place. This is hardly going to be a one or two session relationship. A stable service continuum can be envisaged linking the link worker, dedicated contact points and prescribed service organisations, that can add to the level, and perception, of consistency and commitment.

Parents

The target group, youth, is not uniform and age range is an important distinction that will impact on both referral and successful outcomes. For the younger age groups (up to 10years) parents are going to accompany their children through all stages of the process.

Their role was discussed as they bring the children to ‘prescribed’ services. They too are part of the process, and some level of group activity may be required when their children are engaged in activities. In some cases, or at some stages their involvement might be required, where for example there are issues in the relationship between parent and child.

Training

Training was considered more important to success by youth, parents and stakeholders and not as important among youth workers and doctors. The issue of training does not feature to a significant degree in the literature, either because it is assumed or not considered necessary. In the context where community and voluntary youth services are fragmentary in terms of coordinated services it would seem critical to provide training on the systems, procedures and reporting processes that are put in place. Training can also have an important function in signifying the service (objectives, outcomes, target population) and the importance of using reporting tools together with monitoring and evaluation.

5.2 Recommendations

The evidence from the review, consultation and analysis suggests that a systematic, well planned approach is required based on developing clear patterns of shared understanding and agency among all partners and stakeholders with respect to the scope, operations and outcomes of a social prescribing service.

Environment

Service name is an important consideration, right from the start. Social prescribing may the service type; it should not be the name. (Ballyfermot) Community Youth Referral Service is one to consider. Whatever the final choice, the name should strive to achieve common level of understanding among community members and stakeholders. Confusion about what is being offered constitutes a setback from the outset.

Referral service

It should be clearly communicated from the outset that this is not another programme for young people. This is referral. The doctor, primary care psychologist or other is going to refer to a 'link worker', social prescriber etc.

The literature suggests, and the consultants concur that the link worker, particularly in a service for often vulnerable youth will be a 'fixer' rather than just a 'referrer'. With this in mind and to avoid the potential for a damaging 'choke-point' issue, we suggest a system of designated secondary referral sources involving a selection of community facing positions in a number of sectors.

It was apparent in the consultation that many were of the view that it had to be more than a medical system referral service. For the pilot project it is also important to be mindful of the experience in Rochdale, where the level of service demand right from the start was unexpectedly high. Managing expectations is going to be important.

The meeting with parents established high levels of concern about social media related anxiety, and it is not hard to see that any service that engaged with this issue would be overrun with demand. For this reason, we suggest that direct parent referral be excluded from the pilot. Indirectly, parents may be able to make a case through a secondary referral option or if they are already patients of the selected doctors.

Secondary referral options should be limited and include designated community-facing positions:

- Schools: Community Liaison or School Completion (2-3 sites)
- Addiction Services (most locally appropriate service)
- Sports Partnership/ Organisations - Sports Development Officers (2 sites)
- CAMHS/ Primary Care Psychology Service

Referral Source: Medical Services

GP engagement with the scoping study has been patchy. Anecdotal evidence however suggests that there is growing awareness and acceptance of the model. With this in mind, a limited number of doctors or primary care/ medical services centres should be engaged for the 'pilot' project.

Link Worker

The link worker/social prescriber role is key. The credibility of the link worker is central to success. The referral service points to the need for the person to have knowledge of both the medical services and a youth or social services. The position should be based in medical services though with easy access to secondary referral sources.

Youth Sector Capacity

Questions of community capacity are legitimate in the context of resources available, and not a reflection of will or professional capacity. Lack of planning in this regard constitutes risk and places the client at greater risk.

A 'friendly' audit of community capacity of relevant organisations should result in the selection of a limited number of pilot sites, for which there is capacity. A level of diversity is required to address the diverse prescription needs.

If resources allow, a small (equal) allocation should be made to each site to help address administrative (reporting) and additional cost (additional hours). To this allocation should be attached a contract requiring full participation in reporting and monitoring/ evaluation.

Management and Reporting

With youth (perhaps more so than adults) there may be a need for a quasi 'case-management' approach. Case management, social prescribing style, can create a referral continuum between medical services (link workers), a secondary 'link' level in existing positions (home-school coordinators, after-schools coordinators, sports development officers, key workers in youth organisations), with 'prescribed' community services. There is every chance that some of these positions might be both point and source of referrals, and clear mechanisms and reporting systems should be in place.

It is not the intention with this recommendation, to start up another form filling bureaucracy. Case or referral management may involve the adoption of existing forms (so long as they are not ruled out by GDPR), or the replication of existing forms with confidential data redacted. However it is achieved, a simple, clear reporting mechanism is an essential requirement.

In terms of monitoring and evaluation it is worth considering links with third level bodies, both in terms of practical resources (projects, placement and theses) and validation.

Key Contact Workers (prescribed services)

A 'designated' key contact worker position should be identified in each community organisation that is signed up for the service and into which the link worker could share the case management/ reporting function.

The consultant recommends that Training is an essential consideration for all workers engaging with the model from the very outset. In addition to the shared skill-set that it will demand and facilitate, training can signify the service as a different approach. For workers who are busy, this is key. There are examples of training programmes in the UK (eg. Enhanced Care Navigation Training for Social Prescribers and Link Workers*) and while these can inform the training curriculum, it will be necessary to develop or adapt modules to the local/ Irish context.

Parents

The function/ role/ attachment of parents will have to be addressed. A strategy is noted in the feedback from young people; in the (youth) volunteer led arts/music programme for ASD children, the parents will also attend but will be offered an alternate space in the venue, for a cup of tea, or perhaps an informal support group function.

* The Social Prescriber Plus™ Program https://dnainsight.co.uk/social-prescribing