Addressing the crisis in child mental health: the feasibility of primary prevention through social prescribing as the missing link

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Abstract

Background

The mental health (MH) and wellbeing of our children is in crisis. Increasing prevalence of disorder and need is placing extreme stress on under resourced and over stretched services. Most at-risk are those living in areas of social deprivation who experience multiple adverse effects of poverty and inequality in health access and care. Within the health sector Social Prescribing (SP) as a provision to target mental health and wellbeing has gained in popularity in adult MH, yet there is little exploration of SP practice addressing children's MH or the value of embedding SP into education as well as the health sector. This study explores the feasibility of SP for children within an at-risk community, utilising cross-sector collaboration to design and implement a SP programme with health and education referral.

Methods

Taking place in the West End of Newcastle, SP programme design involved community consultation with 60 primary school children, 38 cross-sector professionals, and 9 parents. Implementation involved a hierarchy of three governance groups of cross-sector stakeholders.

Results

'Zone West' (ZW) was designed in response to a gap in the provision of support for children with MH needs below clinical thresholds but generating repeat attendance at primary care or poor educational engagement. Referral pathways for health and education sectors were defined, and the value of implementing SP into education were highlighted. Key to implementation was 'buy-in' from cross-sector partners and embedding ZW into community services.

Conclusions

SP offers the opportunity for early identification and intervention of child MH difficulties. Success requires cross-sector collaboration which presents unique challenges; unclear processes for information sharing and separate funding streams. More work is required to ensure these are streamlined and to evaluate evidence of impact to provide sustainable and replicable models in the future.

Background

There is an overwhelming public health crisis facing children, mental health. One in six 6- to 16-year-olds in England have a probable mental disorder (1), a sharp increase from one in nine in 2017. This is likely to have been exacerbated by the COVID-19 pandemic. Most at-risk, are children from deprived backgrounds who are four times as likely to have serious mental health difficulties than their wealthier peers (2). Such an increase is placing extreme stress on under resourced and over stretched mental health services. Only a third (32%) of children with a probable mental health disorder are able to access treatment (3). One in four mental health referrals from primary care are rejected, and for those accepted for treatment there are

waiting times of up to six months (4). NHS ambitions to increase service access to 40% of children with a diagnosable condition pre-pandemic, means over half of children do not receive appropriate support. NHS resources were not equipped to meet the pre-pandemic needs of children's mental health and the resulting increased need has exacerbated this crisis (5). With over half of mental health disorders having an onset before the age of 14 years (6), there is a clear need to address this problem promptly through early identification and intervention to improve outcomes.

The factors impacting on child mental health are multifaceted, meaning they require input and collaboration from cross sector agencies across the children's workforce (7). The effects of the mental health crisis are seen daily across the health, education, and social sectors. Some presentations are self-evident, with a rise in self harm and eating disorders and younger age of presentation (8, 9), while some are more subtle, manifesting as poor school attendance, poor engagement and repeat attendance at primary care. Even children themselves are telling us they want 'easier access to support' and 'someone to talk to when they are worried or upset' (3). Traditional health models are reactive, with significant delay for services. Early intervention models focussing on wellbeing and resilience, provide an opportunity to prevent the development of more significant problems.

Social Prescribing (SP), a key component of Universal Personalised Care, is an approach that may provide this early intervention and support for children, reduce the burden on mental health services, and offer a valuable opportunity for cross-sector collaboration. Involving the integration of patients into community-based resources supported by a Link Worker (LW), the SP approach has gained in popularity in adult health. There is however little practice of SP for children, no established model or framework for delivery, and a lack of evidence base to support its effects. There is a need to explore the feasibility of implementing a SP concept for children that utilises cross-sector collaboration within an at-risk community. The current paper addresses this by exploring the following question:

What is the feasibility of a link worker social prescribing service that delivers early intervention and prevention of mental health problems in children aged 7–11 in schools and primary care?

Methods

Design

The feasibility study took place between April 2019 - September 2020 and was led by charitable organisation North East Wellbeing (NEW) based in the West End of Newcastle. The study involved 2 phases: design and implementation.

Participants

The design phase involved community consultation with 60 primary school children aged 7–9 years, 38 professionals from health, education, and social sectors, and 9 parents/carers in the West End of

Newcastle. Both design and implementation involved 3 governance groups: 'Advisory'- senior representation from health (primary care, secondary care and mental health trust), education (the local community West End Schools Trust, WEST) and voluntary sector (NEW). 'Steering'- colleagues from community voluntary sector organisations (NEW, Healthworks, Action for Children) and the local authority, and 'Impact'- NEW and primary care colleagues.

Materials

Listening questionnaire

Community consultation involved a short listening questionnaire created by the research team which was distributed to the West End community. The questionnaire was designed to capture key strengths and concerns of the community, and priorities for future intervention and services from the perspectives of professionals, parents, and children. The questionnaire included 4 free-text questions, took approximately 10 minutes to complete and was hosted online by Survey Monkey and available as a paper copy.

Social prescribing programme documents

Information sheets and referral forms were developed for schools and GP practices, as well as parent/carer information and consent forms, and information forms for children about their Link Worker.

Strengths and Difficulties Questionnaire (10)

Teacher-report Strengths and Difficulties Questionnaire (SDQ) aided identification of appropriate children for participation in the SP programme. The SDQ is a standardised questionnaire which measures social-emotional wellbeing across 5 scales: 'emotional difficulties', 'conduct problems', 'hyperactivity', 'peer difficulties' and 'prosocial behaviour'. The first four of these are summed to provide a 'total difficulties' score. Scores may be categorised to represent 'close to average', 'raised', 'high' and 'very high' degrees of difficulty. The SDQ is a well-established measure frequently used in clinical and research with an overall internal reliability of .73 (11).

Procedure

The early buy in from cross-sector partners in both governance and implementation was an inherent catalyst to the study's progression. All partners approached ZW with a child-focussed and developmental lens, meaning they understood the need for and saw the value of early identification and intervention for children. In addition, partner organisations clearly understood their own unique role in the community and in relation to the project, as well as the role of their collaborative partners.

An advisory group meeting at the start of the project marked the inception of the project at which point strategic and funding commitments were outlined. Following this initial meeting a steering group meeting was held to share sector priorities and concerns for children in the West End community. The listening

questionnaire was distributed to the local community via email to professionals (facilitated by steering group contacts) and paper copies were handed to schools for staff and parents/carers to complete. Children's responses to the questionnaire were collected during small-group workshops in 2 schools, led by an education practitioner. Questionnaire responses were collated by the impact group and results were shared with all governance groups. Link workers were then recruited to the project through formal interview and were employed by Healthworks, a voluntary sector organisation in the West End community. Schools were recruited through WEST, and one PCN was recruited through existing contacts of the impact group.

Results

Designing 'Zone West', a SP programme for children

The SP programme 'Zone West' (ZW) was designed in response to the results of the community consultation, key outcomes of which included the identification of concerns from the WEST and local GP practices about the increasing numbers of children who did not meet threshold for mental health services or special educational needs (SEND) support. These children were experiencing difficulties significant enough to impact their quality of life and wellbeing, resulting in repeat attendance at primary care, and/or impacting on school attendance and attainment. Community consultation also indicated that the existing community partnerships between organisations and sectors, as well as the local community organisations themselves, were considered key strengths of the West End community.

The design of ZW was a collaborative process between NEW and Healthworks, with input from the advisory group. Designed to be a primary prevention initiative, ZW addresses the population health and wellbeing needs found in primary school aged children, and the targeted health needs of children repeatedly attending primary care. Both these groups of children are those who are at greater risk of poor life outcomes due to deprivation, and who are not in receipt of clinical services.

Children recruited to ZW complete a developmental plan with the LW at the start of the programme where key aims and goals for their learning, physical health, social emotional development, and school engagement are defined. This developmental plan is reviewed at regular intervals throughout the ZW programme during 1-1 sessions between the LW and child. ZW children receive weekly individual and group-based therapeutic support with a LW, either in school, GP practice or home, and the LW supports them to attend community assets and meet their pre-defined individual developmental goals. Provision is long-term until developmental goals are achieved. Throughout provision LWs maintain contact with parents/carers, and where appropriate, signpost to external resources if additional needs specific to the parent/carer are identified. This may include welfare rights, housing, adult LW, Early Help, parenting support programmes.

Implementation of Zone West

Implementation of ZW involved 'buy-in' from partners across education, health and VCSE sectors through the formation of 3 governance groups: Advisory, Steering and Impact, outlined below:

- Advisory group- included key senior stakeholders from health, local authority, voluntary, mental health and primary care organisations. This group were responsible for overseeing decision making about strategic and funding commitments and met every 3 months.
- Steering group- included colleagues from voluntary sector organisations within the community and the local authority. This group advised the practical implementation of ZW in the community and met every 2 months.
- Impact- included a small group of NEW and health colleagues who led the project at the community level, meeting weekly.

Governance groups take on a hierarchical structure reflecting membership size and involvement perspective of stakeholders, i.e., overarching (Advisory) – place-based (Steering) - community level (Impact). These governance groups ensured ZW was embedded into the wider network of organisations across the region, the network of organisations in the West End of Newcastle, and the community. Feedback and communication between all three groups remained open, frequent, and consistent. The embedded nature of ZW into the existing landscape of community services at these three levels allowed for the outlining of referral pathways into the ZW programme.

Zone West partnerships with other services

The ZW programme and its LWs work in a system and network of other community services for children and families. Crucially ZW defined to existing community services what the aims of ZW were and worked in partnership with the community. This allowed ZW to establish itself amongst existing services for children in the community and specifically alongside the Newcastle Inner West Family and Community Hub, which was fundamental to successful delivery of complimentary models of service provision.

These partnerships and the employment of LWs by Healthworks (a local charitable organisation central to the Family and Community Hub), allowed for the LWs to be embedded into core health, education, and social service groups for families in the community. This included child protection and early help services and allowed for active referrals and signposting for parents/carers. With consent from families, LWs were able to share information about specific children to these wider community services, ensuring efficient support was implemented for the family and/or child, and that support was not duplicated in any way. LWs also provided scaffolding whilst a child/family was waiting for further assessment or specialist intervention, and the outcomes of this scaffolding work were fed back to the specialist services with consent from the child and family. Embedding LWs in the existing network of community services has been an essential component to providing integrated cross-sector support for children and families.

Referral pathways and data sharing

In response to local concerns and needs from the education and health sectors about many children not meeting threshold for clinical services, two referral pathways were developed to identify these children for inclusion into Zone West (Figure 1).

Outlining these referral routes required considerable discussion within the advisory group, whereby differing needs, operational methods, funding streams and outcomes goals from the education and health sectors were identified. The education pathway allowed for a population and long-term approach to SP through the screening of all children in a target age range, i.e., school year groups for appropriate inclusion in ZW. Teacher-completed SDQ's allowed for the identification of children across multiple year groups who were at-risk of SEMH difficulties, and these results were considered alongside a discussion with education staff to identify appropriate children for inclusion in ZW. This discussion allowed for a broader view of children's difficulties, considering the dynamics of the child's school engagement and home circumstance and the potential engagement of the parent/carer to support their child's inclusion. This process was supported by teachers who appreciated and recognised the benefits of a data-led approach to identification. The education pathway's identification of children at a year-group level enabled group-based as well as individual SP work with children in school, and long-term provision that transcended school years.

In contrast, GPs see children on an individual basis and mainly observe them in specific contexts and snapshots of time during clinical attendance, therefore it was not possible to screen cohorts of children in the same way as the education pathway, nor was it possible to engage in in-depth discussion with GPs about each child. For these individuals and the GPs involved in ZW, there was a greater need for more rapid and measurable impact that would satisfy the child and family, GP, and funding arrangements. GPs were asked to refer children to ZW who had poorly controlled long-term health conditions or presentations suggestive of emotional distress, who were not in receipt of clinical services. LWs worked with these children primarily in either their GP surgery, at their home or in a community space. In cases where a GP-referred child attended a school which referred children to ZW, the LW was also able to work with that child in their school. Children referred through education, or who attended a ZW referral school, were grouped as ZW 'Warriors'. Children referred through health who did not attend a ZW school were grouped as ZW 'Seekers'.

Procedures for sharing data between referring education and health staff, children, families, LWs, community services and the research team, were ethically approved through the Integrated Research Application System (IRAS) and Newcastle University. Data sharing was governed by parental consent at various stages of the referral to recruitment pathway as well as the allocation of unique ID numbers (Figure 1). It was noted when implementing referral pathways that there was a lack of shared knowledge and communication between the education and health sectors, for example many GPs were unaware which school a child attended and vice versa. In addition, there was no infrastructure for schools and GPs to share information about children's school engagement and health related behaviours even when consent was provided from the child and family. The linkage of this information was however important

for the ZW programme to allow LWs to work with children in the most efficient way and location (i.e., their school if their school was taking part in ZW).

Discussion

The study has identified a need for the provision of support for children with MH difficulties that do not meet clinical thresholds but generate repeat attendance at primary care settings and/or poor educational engagement. In response, we have demonstrated it is possible to harness the power of cross-sector collaboration and infrastructure to design and implement a successful SP programme, 'Zone West', for children that is embedded into an at-risk community and allows for the identification and referral of children that meet the needs and systems of education and health sectors.

Although SP is well-established in the health sector and growing in popularity in adult mental health, despite a mental health crisis facing our children, there is very little practice applying the principles of SP to children's mental health and wellbeing to create a preventative rather than reactive model of health. Moreover, factors impacting children's mental health are multifaceted, and the impacts of poor mental health are clearly and significantly felt across health, education, and social sectors.

This study has therefore filled a gap in existing SP practice and offers hope for proactively addressing the child mental health crisis. We have learnt that there is a place for SP in the landscape of child services in at-risk communities and that such support it is needed and advocated for across sectors and services. In addition, where many existing SP models are embedded in the health sector, the current model highlights the value of schools referring children for SP, and the opportunity for direct, regular, and consistent work to take place within the school grounds. Education referrals can be supported using standardised tools such as the SDQ to aid the identification of appropriate children, a process which is advocated for by teachers. The current study has also brought to the forefront the flexibility required to implement SP across both health and education sectors; that each sector has different referral process requirements, operational methods for LW provision, different funding streams and outcomes goals.

As the focus of this study was exploring research in practice, specifically the feasibility of designing and implementing a SP service for children, it is is limited in the extent to which we can learn about the impacts of SP on children's mental health or provide a defined framework for delivery which we know produces robust outcome data. Furthermore, this study is specific to the West End community within which Zone West was designed and implemented therefore the extent to which this exact model may be replicated is less understood. However, there are lessons learned here are likely to be universally applicable. Establishing ZW has demonstrated that effective collaboration requires strong cross-sector relationships, a shared vision and clear understanding of the unique and complimentary roles of each organisation. Setting-up collaborative ways of working takes time to develop partnerships and undoubtedly collaboration presents unique challenges; for example, the lack of information sharing between sectors presents a challenge to providing children and families with an efficient and effective service. Information sharing facilitates practitioners to support children holistically across contexts. Clear

pathways for information sharing across health, education and voluntary sectors are required to provide a holistic and efficient service, pathways which, in the current study, were not defined at the time of inception. Cross-sector collaboration, strong relationships and information sharing are therefore vital components of SP models for children, and it cannot be presumed these already exist within a community. Collaboration may also bring about separate funding streams generating competing outcome goals and time frames. This highlights a need for future funding to be integrated and long-term, to ensure that the primary focus of provision remains child centred and longstanding.

Conclusions

The provision of SP for children offers a unique opportunity for early identification of and intervention for SEMH difficulties, as does collaboration between sectors providing for a holistic perspective of, and approach to, the child's needs. The pressures of long wait-times for clinical services and/or children not meeting clinical thresholds that we see in the current climate can result in resources being directed towards a reactive approach, but we believe this work highlights the need to maintain focus on early intervention through a public health model.

SP for children meets calls from children to have 'easier access to support' and 'someone to talk to when they are worried or upset' (3), but there is much work to be done to further define frameworks for delivery and understand the wider impacts of SP for children. It is anticipated that like adult SP, we will see a sharp rise in SP for children nationally. However, provision must be built from the ground up, take on an embedded approach, and be accompanied by evidence of impact if we are to understand the extent to which provision may begin to address the nations mental health crisis, and ensure provision may be effectively maintained long-term.

Abbreviations

LW- Link Worker

MH- Mental Health

PCN- Primary Care Network

SP- Social Prescribing

WEST- West End Schools Trust

ZW- Zone West

Declarations

Ethics approval and consent to participate

This work was granted ethical approval from the East Midlands-Leicester South Research Ethics Committee via the Integrated Research Application System (IRAS; ID 266176) and the Faculty of Medical Sciences ethical review board at Newcastle University (Reference 1824/15352). Written informed consent was obtained from a parent or guardian for participants under 16 years old. The study was carried out in accordance with the Data Protection Act 2018 and principles of the Declaration of Helsinki.

Consent for publication.

Not applicable.

Availability of data and materials

The datasets used and/or analysed during the current study are available from the corresponding author on reasonable request.

Competing interests

The authors declare that they have no competing interests.

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Authors' contributions

JC is the main author of this manuscript and led on quantitative and qualitative data collection and IRAS ethical approvals and contributed to programme design and implementation including development of referral pathways.

AB contributed to the writing of this manuscript and led Newcastle University ethical approvals. AB also contributed to data interpretation, programme design and implementation including development of referral pathways, and led collaborations with the health sector.

CD contributed to the writing of this manuscript and was a key facilitator of the project set-up which included the arrangement of governance structures, and contributions to programme design and implementation.

MM contributed to the writing of this manuscript and was a key stakeholder in project governance and programme implementation.

TQ contributed to the writing of this manuscript and led on project set-up, design and implementation and led collaborations with the health, education, and social sectors.

All authors have read and approved the manuscript.

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Authors have additional affiliations and roles that are relevant to this work. Dr Jenna Charlton is the Impact Lead for North East Wellbeing charity who led the delivery of the current work, and Inequalities Advisor to the North East and North Cumbria Child Health and Wellbeing Network at the Great North Children's Hospital who supported this work. Dr Alexandra Battersby is a Clinical Lead for Healthier Together North East within the Child Health and Wellbeing Network. Professor Chris Drinkwater is a Voluntary Sector Advisor for the Child Health and Wellbeing Network, and Patron of Ways to Wellness, a charitable service delivering social prescribing across the North East and North Cumbria. Dr Mike McKean is the Clinical Lead of the Child Health and Wellbeing Network. Dr Toby Quibell is the Director of North East Wellbeing.

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Figures

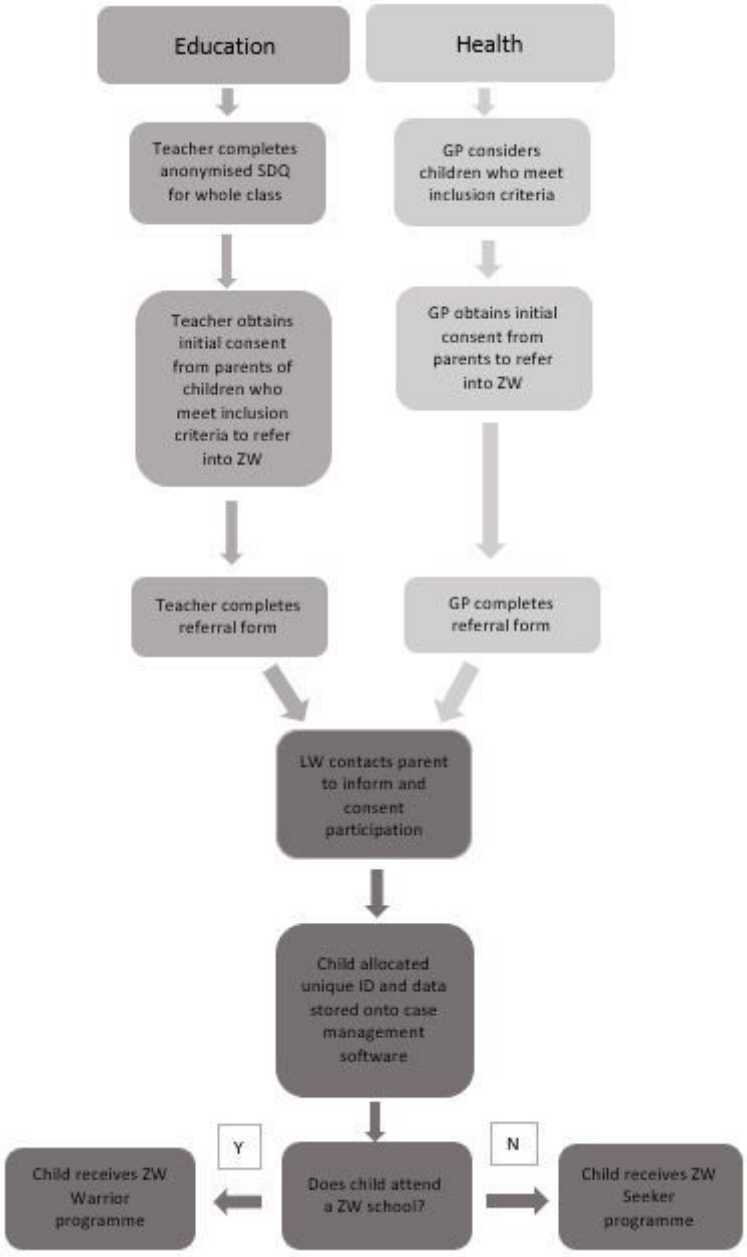

Figure 1

Zone West referral pathways for health and education