

READY STUDY – Wave 1a short summary report 2020

Introduction

The **READY** study (Recording Emerging Adulthood in Deaf Youth) is a 6-year study funded by the National Deaf Children's Society and led by the Universities of Manchester and Edinburgh. It follows up to 300 deaf young people over a 4 to 5 year period who were first recruited when they were between 15 and 19 years old. The aims of the study are to investigate in depth this period in the life course, a time when deaf young people face many changes including the transition to new educational environments, entering the workplace, independence from parents, and choices about how they want to shape their future. For all young people this is an intensive period of identity development, exploration and new challenges. How deaf young people fare in comparison with their peers, what enables them to overcome obstacles and what promotes wellbeing are important aspects of the study.

In this summary report, we highlight some early findings from the first wave of data collection. This was severely interrupted by the outbreak of the coronavirus pandemic. We chose to halt data collection in early March 2020 because we were concerned that some of the online questions and assessments may cause undue distress during a time when deaf young people were out of school/college/workplace and may be experiencing unprecedented levels of isolation. Therefore, this report is based on 9 months of data collection only and presents results from 92 deaf young people. The number of deaf young people who are now in the study has exceeded 120 and we are extending our initial recruitment phase

up to June 2021. Those who have already contributed will be re-contacted for the second annual wave of data collection in due course. **We are still looking for participants. Please encourage deaf young people to explore the study website** at <https://sites.manchester.ac.uk/thereadystudy/> or **to check eligibility and sign up directly** at <https://is.gd/ready2020>

How are we collecting data?

Participants complete an online annual survey which is automatically re-sent to them on the anniversary of their enrolment in the study. It is available in multiple languages and formats and participants can even switch languages/formats on a question by question basis to support understanding and access preferences. The survey collects data on their lifestyle, education, current circumstances, identity and support. In addition, there are three standard assessments: a 5-question health assessment (EQ5D-5L), a 7-question wellbeing assessment (The Short Warwick and Edinburgh Wellbeing Scale - SWEMWBS) and a 21 item self-determination questionnaire (the Self Determination Inventory Self Report - SDI:SR). Participants can stop and start at any time or do the whole thing at once. All parts of data collection are available in Written English, Written Welsh, Sign Supported Spoken English, Sign Supported Spoken Welsh and BSL with the exception of the SDI: SR which is not available in Welsh/SSSW.

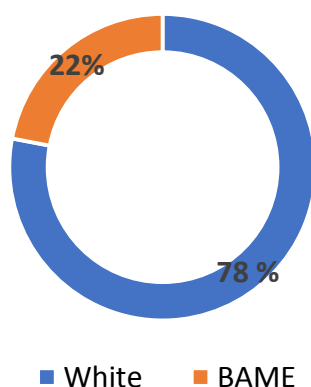
These formal assessments were chosen because they have been previously shown to work in signed languages and be suitable for deaf people. Using them will mean we can compare our findings with general population data.

Who has taken part so far?

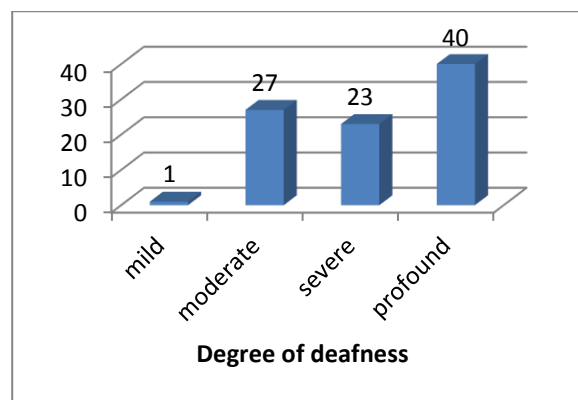
Between June 2019 and March 2020, 143 young people were screened and found eligible.¹ Ninety-two completed the online questionnaire and 83 the online standard instruments.



Of the ninety-two participants, 87% (n=80) described themselves as having bilateral deafness, with twelve (13%) confirming unilateral deafness. We are still seeking more people from BAME backgrounds.

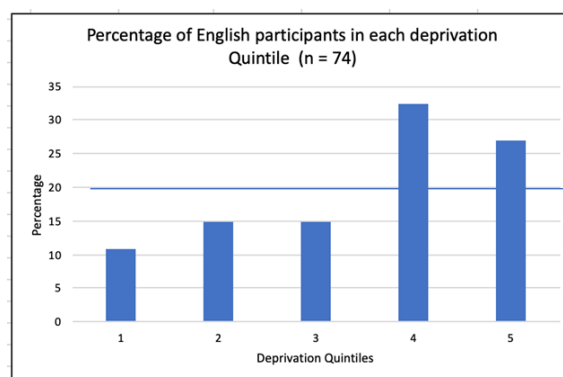


So far we have adequate representation in the moderately deaf group, under-representation in the mildly deaf group and over-representation in the severely and profoundly deaf groupings.



Of the 82 who answered the question, 30 said they had at least one 'additional need' or 'disability' separate from being deaf.

The sample is slightly over represented in the higher groupings of socio-economic status.



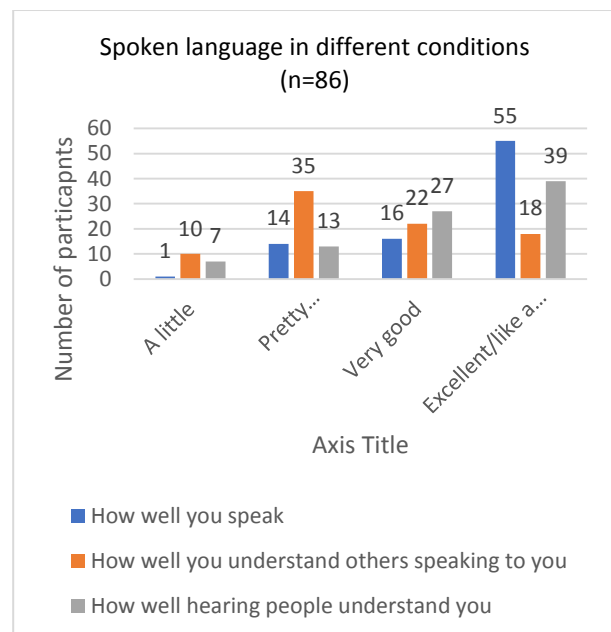
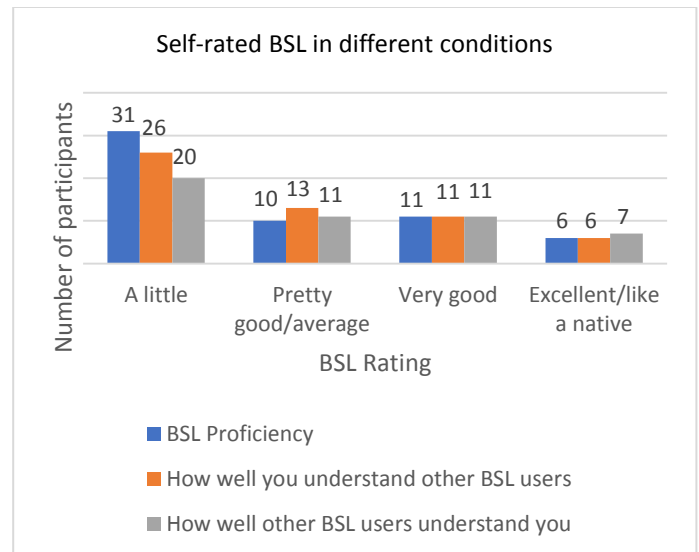
Nearly 90% of the sample were born deaf or became deaf under the age of 5 years and just under 10% had one or more parents who were deaf, with 4 of them having a deaf parent who was a BSL user.

¹ The study does not include Northern Ireland

Language use in the cohort

The age of this cohort means that the majority will have been born after the implementation of universal newborn hearing screening, early identification and intervention. They are also born in the era following the official recognition of BSL by the UK government as an indigenous language (which has raised its public visibility in everyday life) and great advances in cochlear implant and digital hearing aid technologies. More broadly, they have grown up in an increasingly multi-lingual, multi-cultural British society. The cohort's language profiles and preferences reflect this and it is an area of focus we will be following closely as the young people grow up and enter new social and learning environments.

Of the 86 who answered questions about their language use, all but one reported using some spoken language and 60 that they knew and used some BSL. Around 80% rated their spoken language as very good or excellent and of those who said they knew BSL around 30% rated their proficiency as good or excellent. In addition to rating their own proficiency, we asked the young people to rate how well they understood others and how well they thought they were understood, both in spoken language and BSL (for those who said they knew some). With respect to BSL, it was interesting to note that young people's ratings were very similar in all three conditions. However, with respect to spoken language, self-ratings were not so uniform.



Perhaps the visual component of BSL made it easier for individuals to rate their expressive/receptive communication more equally? Perhaps amongst spoken language conversational partners there was less awareness and ability to be flexible about register, articulation or environment than is more commonly the case amongst signers who are more used to having to make adaptations in order to be understood? We will be

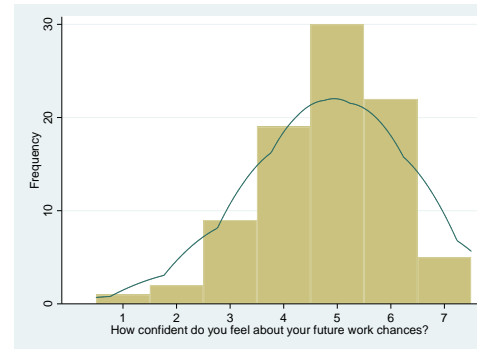
following this up in the interviews we will be doing with a sub-sample of the cohort.²

Education, Work and Training

A quarter of the cohort had not yet achieved any qualifications, mainly due to their age (data were collected before the GCSE examination period). Those who gave us the highest level of qualification achieved so far had achieved well with most at or above GCSE grade C, a benchmark for progression to further study. Fifteen of this group of high achievers already had qualifications at A level or equivalent.

Of the six who told us they were working, four were also in education. These young people were all well qualified at GCSE grade C or above while working, mostly part time. Over time we will be tracking the progress of all this cohort and those who supplement it³, following their educational and career pathways for the next 4 to 5 years.

The cohort were very confident about their future employment chances (n=88) with the average rating of confidence being 5, on a scale of 1 to 7 and two thirds answering in the highest 3 levels of confidence.



These levels of confidence in future employment were not affected by gender, age, ethnicity, degree of deafness or with/without additional needs. They were however affected by wellbeing. Those with higher scores for anxiety/depression had lower scores for confidence in employment. Additionally, 'feeling optimistic' had the strongest positive association with confidence in future employment chances followed by the 'feeling of being useful' and 'the feeling of being close to other people'.⁴

Wellbeing

Assessing wellbeing is important because it is strongly related to educational attainment, it is known to undergo change in adolescence/early adulthood and can be predictive of ability to cope with change and achieve personal goals.

No deaf young person in the READY study scored in the 'high' wellbeing category of the SWEMWBS.

² We will be interviewing up to 50 deaf young people annually.

³ Wave 1b is recruiting from June 2020 to June 2021 – together they make up the baseline cohort.

⁴ These are domains within the SWEMWBS.



Wellbeing is lower in the READY Wave 1a sample as a whole in comparison with an age-similar general population group. However, this difference only reaches statistical significance with respect to women. The lower wellbeing scores in the READY sample in comparison with the general population cannot be explained by the presence of additional needs in the READY group as there was no statistically significant difference in wellbeing between those with or without additional needs in the READY sample. We found no relationship between wellbeing scores in the READY Wave 1a sample and degree of deafness, ethnicity or socio-economic status. In future years we will be able to look closely at the relationship between wellbeing and educational attainment over time.

Participants were asked about their feelings of loneliness. A quarter of the group answered in the two most lonely categories. They also scored in the lowest wellbeing categories. Asked who they would turn to for help if they felt a bit down, 4 out of 86 said nobody and a

further 10 that they did not know. The majority said parents or best friends.

Health

We used a questionnaire to investigate domains of health (the EQ-5D-5L) that is adjusted for different populations; in this case the UK as a whole. Self-assessment scores are transformed using an algorithm that is based on variations in the general population which makes comparisons between groups more reliable. Responses from the READY study cohort indicate they have much poorer overall health than others of the same age when adjusted for norms in the UK. Differences were particularly strong in relation to anxiety/depression. Co-incidence of additional needs with deafness goes some way towards explaining the lower scores but does not adequately explain the result. Gender and degree of deafness have no influence on the result. Deaf young people overall assessed their health at a much lower level than hearing young people of the same age in other UK-wide studies. On a scale of 0 (worst possible health you can imagine) to 99 (best possible health you can imagine), the READY study cohort average was 72. This compares with the Health Survey of England average for 16 – 19 year olds of 81.

Self-Determination

Self-determination refers to the ability to act to achieve goals you have set and want. Research with populations of children with disabilities has shown that there is an established relationship

between enhanced self-determination and in-school academic and post-school employment and education outcomes. Self-determination scores for the READY Wave 1a sample are slightly lower than comparable general population scores. There were no statistically significant differences by age, ethnicity or with/without additional needs. Higher scores in all three domains of self-determination (volitional action, action-control beliefs and agentic action) and in the overall score were strongly related to higher confidence in future employment chances. Links between self-determination scores and educational attainment will be investigated with the larger group and when all of the sample have taken some examinations.

Social networks, friendships and relationships

During transition to adulthood, social networks usually undergo considerable change in terms of their composition but also their function. Social networks play enabling and protective functions. They act as new knowledge providers, as sources of support, they play a part in the formation of individual/social identity and are a means of acquiring information and support to assist with reaching one's goals. We asked the READY cohort a series of questions about their friendships in person and online and about their social networks.

We found a statistically significant association between the type of contact and the frequency: deaf people are

more likely to be talking with hearing people whether online or in person. However, for the group who report less than once a week contact, their contact is more likely to be other deaf people than with hearing people (online and in person). In relation to contact with people participants did not know, results indicate marginally greater comfort with deaf people than with hearing people. We found no significant difference in feelings of belonging between deaf and hearing communities.

Those with additional needs had a larger overall network size than those without. When asked about contact with 'close others' (which did not include family but could include mentors, teachers, etc.) this difference in network size was statistically significant. Also those who lived in less deprived areas tended to have larger overall network sizes and in particular larger 'close family' and 'close others' network sizes. It is likely that these confer advantages in terms of resources, information and active support to achieve goals. We know that network size increases through young adulthood and size of networks is positively associated with wellbeing. We will be following closely the changes in size, composition and benefits of social networks over time.

Those with higher levels of anxiety or depression gave lower scores for their satisfaction with close relationships and with friends' support. The less lonely a participant felt overall in life, the more

satisfied they were with their close relationships and support from friends.

Some implications of early findings

The READY study was commissioned by NDCS to understand the risk and protective factors in deaf young people successfully transitioning to autonomous adulthood, happiness, and making a meaningful contribution to society that is satisfying to them. Such evidence is required for the provision of effective support and intervention for deaf young people and their families.

At this very early stage in the READY study a picture is starting to emerge of the central significance of health, wellbeing and well developed social networks. Those with positive wellbeing, higher self-determination and good health are achieving well, have good social networks, feel less lonely, and are confident about future employment. Nonetheless overall this group of young deaf people are not reaching comparable levels of these components as those in the general population. Lower health index levels and self-assessment of general health is puzzling as there has been little focus on this in the past separate from mental health. Degree of deafness is not a major explanatory factor in this complex picture but higher socio-economic status is conferring some advantages with regard to wellbeing and richer social networks. The relationship with educational attainment, work and training will become clearer with the next wave of data collection.

Language profiles of this new generation of deaf young people are complex and binary categorisations of deaf young people as spoken language users or sign language users are not reflective of their life experience. How their language preferences and proficiencies change over time will be a fascinating element to explore as we follow up the group longitudinally and in real time as they transition to adulthood.

Future steps in the study include some peer to peer interviews with a group of 50 young people in the cohort by young deaf co-inquirers who have been trained and are working alongside the research team. This will enable deeper exploration of some of the early patterns we are observing.

Further annual updates will follow and there is also a technical research summary available of this Wave 1a cohort at this stage.

The Research Team

Professor Alys Young (lead), Rachel O'Neill, Garry Squires, Katherine Rogers, Helen Chilton, Claire Dodds, Francisco Espinoza, John Ravenscroft. Former members: Rita Giacoppo, Christine Mackintosh.



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