Department for Education

Mental Health Services and Schools Link Pilots: Evaluation brief

Research brief

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Research brief

In summer 2015, NHS England and the Department for Education (DfE) jointly launched the **Mental Health Services and Schools Link Pilots**. The pilot programme was developed in response to the 2015 report of the Children and Young People's Mental Health Taskforce, *Future in Mind*, which outlined a number of recommendations to improve access to mental health support for children and young people.

Overview of the pilots

A total of 22 areas, incorporating 27 CCGs and 255 schools, were funded to establish named lead contacts within NHS CYPMHS and schools. They also participated in 2 joint planning workshops, involving other professionals from their local CYPMHS network. These included, but were not restricted to, school nurses, educational psychologists, counsellors and voluntary and community sector organisations (VCSOs). The local pilots were led by CCGs, often with active involvement from local authorities.

The joint planning workshops were facilitated by a consortium led by the Anna Freud National Centre for Children and Families (AFNCCF), using a framework developed specifically for the pilot programme (CASCADE) and involving a combination of reflection, action planning and review to benchmark local collaborative working.

In September 2015, Ecorys (UK) was commissioned by the DfE to undertake an independent evaluation of the pilot programme. A mixed methods design was deployed, incorporating survey research, research observations and qualitative case studies in a sample of 10 areas. The data collection took place between September 2015 and 2016.

Key findings

Overall, the evaluation found that the pilots had considerable success in strengthening communication and joint working arrangements between schools and NHS CYPMHS. This was often the case even where relationships were said to have been weak at the start of the pilot programme, although the extent of change varied between pilot areas.

At a programme level, the evaluation found quantifiable improvements to the following self-reported outcome measures, between a baseline and follow-up at +10 months:

- frequency of contact between pilot schools and NHS CYPMHS
- satisfaction with communication and working relationships between pilot schools and NHS CYPMHS
- understanding of the referral routes to specialist mental health support for children and young people in their local area among school lead contacts
- knowledge and awareness of mental health issues affecting children and young people, among school lead contacts

There was a smaller increase in the frequency of contact between school lead contacts for the pilots and other school-based mental health professionals. These varied between schools but included educational psychologists, counsellors and school nurses.

While harder to quantify, the interviews strongly suggest that the programme contributed towards improvements in the timeliness of referrals and helped to prevent inappropriate referrals within many areas. This was enabled by schools' improved understanding of pathways and ongoing contact with NHS CYPMHS. The qualitative interviews show that many of the pilots facilitated direct referrals to the NHS service and discouraged unnecessary indirect referrals via GPs, where this local flexibility was available. They sometimes helped to improve the flow of information beyond the initial referral. In this context of improved capability in schools, closer joint working and more timely direct referrals, it was noteworthy that, at programme level, there was not an overall increase in the level of referrals, although unmet need was identified within some pilot schools.

There was also quantifiable evidence of improvements for all knowledge and awareness-related measures among other school staff. There was a strong indication that many schools had cascaded the benefits of the programme beyond the lead contact and used their pilot to complement existing funding and support for mental health and well-being.

Aims and scope of the pilot programme

The overall aim was to test the extent to which joint professional working between schools and NHS CYPMHS can improve local knowledge and identification of mental health issues and improve the quality and timeliness referrals to specialist services.

The pilot programme centred on 2 joint planning workshops for local stakeholders from CYPMHS in each of the 22 areas. The workshops were designed and facilitated by a consortium led by the AFNCCF, using a bespoke framework (CASCADE).

The pilot programme was implemented in 3 phases:

- phase 1: forming partnerships – workshop 1 (September to December 2015)
- phase 2: embedding and building sustainability – workshop 2 (January to March 2016)
- phase 3: supporting ongoing learning through 2 national events (May 2016).

NHS England made funding of £50,000 available per CCG, to cover NHS capacity to release specialist staff to take part. CCGs were expected to match-fund this amount. Funding of £3,500 was made available per school to backfill staff time.

Design and set-up of the pilot programme

Strong CCG strategic leadership was a key factor in ensuring strategic buy-in across local CYPMHS, and schools and colleges, within challenging timescales. Pilot sites where CCGs had already developed this leadership role, often in close partnership with local authorities, were better placed to progress the pilot and to broker the sometimes-difficult initial conversations between schools and NHS CYPMHS at the start of the programme.

Most areas approached the pilot with a view to complementing activities identified in Children and Young People's Mental Health (CYPMH) and well-being local transformation plans. Strong synergies were also identified with emotional well-being and resilience work in schools. The opportunity was welcomed to add a stronger 'clinical' mental health dimension to this existing offer.

There is some evidence that the bidding timescales favoured schools that were already engaged with NHS CYPMHS to some extent and that the pilot schools were not necessarily representative of the wider population. Even so, here was a good mix of school types across the pilot programme. While further education (FE) colleges were not excluded from taking part in the pilot, they were not represented in this phase of piloting.

Lessons learned from implementation

Joint planning workshops

The majority of interviewees reported that the joint planning workshops met their expectations. Participants generally welcomed the combination of factual information, benchmarking and action planning using CASCADE. A few areas commissioned further workshops from the consortium led by the AFNCCF, to extend the opportunity to additional schools.

The main reported benefits from the workshops included new contacts established between professionals from schools, NHS CYPMHS and other CYPMHS, and the sharing of knowledge and good practices. The piloting underlined the need to match the workshops with the prior levels of joint working between schools and NHS CYPMHS. The format was less successful where this balance was not achieved. Again, this underlined the key leadership role of the CCG, often working with local authorities. Areas commonly used their pilot as an opportunity to review communication procedures between schools and NHS CYPMHS. They often developed new referral protocols, guidance documents for schools and 'maps' of CYPMH services. A few areas set in place new booking systems, helplines or triage arrangements.

Single point of contact arrangements

Local NHS CYPMHS recruited or seconded one or more primary mental health workers to perform the lead contact role. The approach was typically guided by decisions about the feasible offer of time per school. Most schools identified an operational lead contact with student welfare responsibilities, such as a SENCO or inclusion co-ordinator, reporting to the senior management team, although these roles were occasionally combined.

The specific responsibilities of the NHS CYPMHS lead point of contact varied between the pilots, but it was possible to group them according to 3 main types:

- NHS CYPMHS named lead with contact time in schools on a regular basis, delivering services and support directly to staff and young people
- NHS CYPMHS named lead offering dedicated training and support time to school-based professionals
- NHS CYPMHS named lead or duty team with designated responsibilities for the pilot, offering a single point of access

No single model emerged as being the most effective, as pilots developed their approach to suit local circumstances, priorities and aims. However, a shared commitment from schools and NHS CYPMHS was essential for embedding the joint working arrangements, alongside backing from senior management teams across both sets of agencies to also ensure that staff had sufficient time to participate.

A regular presence from NHS CYPMHS in schools enabled workers to support and consult to school staff, and to work with pupils directly. High levels of school-based support were costly, however, and some areas raised concerns about the sustainability of the external support, reflecting the need for a strategic, system-wide approach. The evaluation highlighted the potential value of potentially undertaking further work to model the return on investment and potential educational gains that schools and colleges might see in the event of establishing successful models of joint working.

The evaluation also showed that there were advantages to drawing upon the expertise available within the wider network of CYPMHS, including educational psychologists, school nurses and VCSOs. This resource was utilised to a varying extent by the areas within the pilot programme.

Sustainability

NHS CCG commissioners, NHS CYPMHS and schools were strongly supportive of sustaining effective channels of communication, but there were mixed views on how single points of contact (SPOC) might be funded beyond the programme. Many of the pilot areas were exploring options for working at scale, without diluting contact time with schools. This generally included a combination of the following:

- a traded offer, whereby a proportion of the costs were passed on to schools; this was sometimes based on a tariff system or menu of options
- cluster or locality-based support, whereby NHS CYPMHS lead contacts linked with a number of schools via established local multi-agency teams
- a single point of access for schools, generally based around a triage and duty system, with NHS CYPMHS workers responding on a rota basis; some areas had combined this with a telephone helpline and email address for professionals
- making full use of the wider network of NHS CYPMHS – rather than focusing on solely on specialist NHS CYPMHS and schools; some areas were reviewing the potential for educational psychologists, school nurses and VCSOs to an active contribution towards widening access to mental health support within schools
- training and capacity-building, often based around a foundation tier of training for potentially large numbers of schools, with the option of higher-level training

A smaller number of areas had already secured the funding and political commitment from the school community and NHS CCG with local authority support to scale up joint working when the evaluation fieldwork took place.

Conclusions and recommendations

At a national level, the pilot programme very much demonstrates the potential added value of providing schools and NHS CAMHS with opportunities to engage in joint planning and training activities, improving the clarity of local pathways to specialist mental health support, and establishing named points of contact in schools and NHS CAMHS. At the same time, the evaluation has underlined the lack of available resources to deliver this offer universally across all schools at this stage within many of the pilot areas. Given the pilots show that additional resources would need to be allocated locally to deliver the offer universally across all schools, further work is needed to understand how sustainable delivery models can be developed.

On this basis, the evaluators conclude that there is a good foundation for the Department of Health, NHS England and the DfE to consider how the learning from the pilot programme might be shared, disseminated and scaled up, beyond the 22 areas that participated in the pilot programme. This might include the potential collation and dissemination of good-practice resources and case studies. A number of critical success

factors emerged from the programme, which might inform the approach taken by other areas seeking to implement a similar approach (see boxed example below).

Critical success factors for establishing effective joint working arrangements between schools and NHS CYPMHS

a. a strategic role for the CCGs and LAs in providing leadership and mobilising different partners from across the local network of CYPMH services

b. a forum for collective planning and needs analysis at a local area level, linking into wider strategic commissioning processes and to the CYPMH and Wellbeing Local Transformation Plan

c. mapping of interventions and professional expertise, to ensure the best use of available resources within the local CYPMH network

d. clarity and common understanding of pathways and criteria for specialist support and accompanying tools and guidance to make this process as easy as possible; this includes agreement on common terminology and outcome measures

e. a single point of access in NHS CYPMHS for information and advice about mental health issues, supported by central telephone and email contact points

f. a thorough initial scoping review to determine schools' needs – including their relative needs – for specialist support, prior to determining the necessary staffing commitment by NHS CYPMHS

g. a minimum commitment from schools to identify a suitable lead point of contact, with support from the Senior Management Team to ensure that they have sufficient time to attend joint planning and training activities with NHS CYPMHS

h. a review within CYPMH Local Transformation Plans – including at least the CCG, schools and NHS CYPMHS; to determine and commission the appropriate CYPMHS support offer and how this is apportioned between schools

i. a commitment in the school development plan to sustain the SPOC arrangements and to develop a mental health and well-being policy

j. monitoring and self-evaluation of joint working arrangements, to review what works well/less well; to appraise the quality and appropriateness of referrals under the new working arrangements and to make adjustments as necessary

k. access to further training and bespoke guidance or support for schools, as identified through self-evaluation, via a menu of support from CYPMHS

l. quarterly or biannual mental health forums or network meetings, to ensure that all schools and other CYPMHS providers, including NHS CYPMHS, educational psychologists, school nurses, counselling services and VCSOs, have an opportunity to network and to regularly review and update working arrangements

Methodology

The evaluation was funded between September 2015 and December 2016 to provide an assessment of the effectiveness of the design and implementation of the pilot programme and the outcomes achieved within the first 12 months for data collection.

A mixed methods approach was used, comprising pre/post online surveys with SPOC in schools[1], other school staff[2] and NHS CYPMHS[3] (baseline prior to the initial workshops and follow-up at +10 months); a snapshot 'exit' survey of other local key stakeholders[4]; in-depth qualitative telephone interviews with NHS CYPMHS lead contacts; workshop observations; and 10 local area case studies[5]. Further details on sampling, data collection, analysis and reporting are provided within the main report.

The evaluation design and achieved sample sizes were sufficiently robust to allow for a good level of confidence in the results. The comparison of survey outcomes relates to the cohort of schools participating in the pilot programme. Limitations to the comparability and availability of administrative data held on statutory NHS CYPMHS entailed that it was not possible to undertake a quasi-experimental impact evaluation as part of the study.

[1] School lead contact survey, baseline *n* = 166 schools, follow-up *n* = 49 schools.
[2] Administered within a sub-set of 48 pilot schools, baseline *n* = 552 individuals, follow-up *n* = 95 individuals.
[3] NHS CYPMHS lead contact survey, baseline *n* = 18 respondents, follow-up *n* = 2 respondents.
[4] Administered at a single point in autumn 2016, achieved sample = 68 respondents.
[5] The qualitative research covered 15 of the 22 pilot areas, with a total of *n* = 124 respondents through the combined telephone interviews and case-study interviews. The 10 case studies were sampled purposively on the basis of socio-demographic characteristics, types of schools, baseline position for joint professional working (high/mixed/low) and areas of potential good practice. Each case study comprised interviews with the CCG strategic lead, NHS CYPMHS strategic and operational staff, school lead contacts and teaching staff, and partner organisations from CYPMHS.

Appendix One: A note on report terminology

Mental health provision for children and young people in England is provided under the umbrella of Children and Young People's Mental Health Services (CYPMHS). The CYPMHS framework incorporates all professionals working with children and young people, from universal provision through to specialist inpatient and outpatient services.

CYPMHS in England have historically been planned and funded under the banner of Child and Adolescent Mental Health Services (CAMHS) and organised around four 'tiers', corresponding with different levels of need or complexity[6]. These arrangements are acknowledged to be complex, and the 2015 report from the Government's Children and Young People's Mental Health Taskforce, *Future in Mind*, identified a priority to urgently review the existing framework, aspiring towards a "*system without tiers*[7]". Many areas are now moving away from this method of organising services, developing models such as 0–25 integrated pathways or adopting the THRIVE service framework[8].

The pilot programme was funded to strengthen joint working arrangements between schools and specialist CYPMHS. For the purpose of consistency in the report, we have made a distinction between the following:

- **NHS Children and Young People's Mental Health Services (NHS CYPMHS** – statutory children and young people's specialist mental health services funded by the NHS and commissioned locally via Clinical Commissioning Groups (CCGs), who were the recipients of the pilot funding from NHS England and who provided the primary mental health workers to link with pilot schools
- **Other Children and Young People's Mental Health Services (Other CYPMHS** – all other professionals within the wider network of organisations working with children and young people at different levels of need, including but not restricted to: school nurses, educational psychologists, counsellors and provision funded and provided via the voluntary and community sector (VCS)

The decision to replace the term CAMHS with CYPMHS throughout the report was taken by the Evaluation Steering Group in January 2017, to better reflect the feedback from children and young people that was incorporated in the Future in Mind priorities, and to avoid the risk of misunderstanding surrounding the CAMHS Tiers. As the term 'NHS

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[6] The four tiers include: Tier 1: universal services, Tier 2: targeted services, Tier 3: specialist services and Tier 4: specialised CAMHS. Further explanation of the framework can be found in the following report: CAMHS Tier 4 Report Steering Group. CAMHS Tier 4 Report. 2014. London: NHS England (p. 11). (Accessed 3 January 2017)

[7] Department of Health. Future in mind: Promoting, protecting and improving our children and young people's mental health and wellbeing. 2015. London: NHS England (p. 41). (Accessed 3 January 2017)

[8] The THRIVE Framework is a conceptual model for ensuring needs-led service planning and review for children and young people's mental health services. It is supported by training, resources and a community of practice. (Accessed 24 January 2017)

CAMHS' is still in widespread use, and was included within the original primary research tools for the evaluation, this terminology has been retained where the authors are reporting upon verbatim quotes or survey questions within the report.

A more detailed description of the designated roles and responsibilities of the different key stakeholders on the pilot programme can be found in Chapter 1 (Introduction). The local variations in the staffing model for the individual pilots are explained in Chapter 2 (Design and set-up of the pilot programme).

Appendix Two: Local pilot Implementation models

Table 1. Pilot implementation – three different types of delivery model

Local pilot Implementation models – Three models of delivery		
a) NHS CYPMHS lead with contact time in schools on a regular basis, delivering services and support directly to staff and young people		
Key characteristics • named lead point of contact in NHS CYPMHS offering a regular presence in schools (for example, weekly/fortnightly advisory sessions) • delivery of advice, training and one-to-one support to lead points of contact within schools • direct young person-facing work, potentially including classroom observations, workshops and sometimes individual appointments • may include some assessment and case-holding responsibilities • often performed by a single NHS CYPMHS primary mental health worker, linking with specific schools with back-office support • school single point of contact working within wider pastoral team	**Potential advantages** • regular direct face-to-face contact conducive to building trusting and supportive relationships • scope to support and consult to school staff in relation to their role and individual students • support to build schools' capacity to deliver light-touch interventions, joint pieces of work involving individual young people • NHS CYPMHS staff able to observe young people directly and identify any concerns • enhances and supports the interventions delivered by specialist NHS CYPMHS • in some schools with greater need, the investment may release equivalent internal resources	**Potential drawbacks** • time- and resource-intensive model for schools and NHS CYPMHS to sustain, over a longer period • challenges arising from varying levels of need between individual schools • not necessarily the most cost-effective model where schools gave lower levels of need • risk of setting unrealistic expectations with the school, parents and young people, if the provision is time-limited only and will not be sustained
b) NHS CYPMHS named lead offering dedicated training and support time to school-based professionals		
Key characteristics • named lead point of contact in NHS CYPMHS offering advice and consultative time to their counterparts within designated schools • scoping of individual schools' needs, support and advice on updating policies and protocols, communicating pathways	**Potential advantages** • regular ongoing contact conducive to building trusting and supportive relationships • scope to gain a detailed understanding of the needs of individual schools • sustainable approach, based on school-by-school quality. assurance and capacity-building	**Potential drawbacks** • tensions can arise where schools expect/require higher levels of in-school support • more limited opportunities to observe school staff and pupils, and to embed practices directly

Local pilot Implementation models – Three models of delivery		
• often involves the delivery of mental health awareness training • flexible menu of support; may include some school-based work, but on a more ad hoc basis • may occasionally involve limited, one-off direct contact with pupils - often jointly with school staff	• develops and supports school capability to support CYPMH, improving outcomes for students and reducing pressure to refer to specialist service • may be most efficient response for schools with lower level mental health needs (for example, smaller/primary schools)	• fewer co-productive opportunities • commitment to having a single named point of contact requires minimum time commitment • risk of setting unrealistic expectations with the school parents and young people, if the provision is time-limited only and will not be sustained
c) NHS CYPMHS named lead or duty team with designated responsibilities for the pilot, offering single point of access		
Key characteristics • systems-oriented model – focus on improving transparency and clarity of communication channels and referral pathways; commitment to better ongoing dialogue and feedback to schools • single point of access to specialist NHS CYPMHS, via telephone helpline/email or online contact • duty team and triage model – service is available when needed for advice, consultations or information; often using a rota system • schools may also have a named contact person in NHS CYPMHS but largely on an advisory basis • often supported with forums, and regular mental health awareness training for (groups of) schools	**Potential advantages** • ability to operationalise more quickly, and potentially less time and resource intensive to manage and implement • guaranteed single point of access to specialist NHS CYPMHS brings clarity and reassurance • supports information-sharing • more open communication and feedback between schools and NHS CYPMHS means less risk of miscommunication • increased scope for scalability	**Potential drawbacks** • tensions can arise where schools expect/require higher levels of in-school support • fewer opportunities to observe school staff and pupils, and to embed practices directly • fewer co-productive opportunities • onus is on schools to maintain a proactive approach in the event that the lead contact leaves or changes role • risk of unnecessary referrals to NHS as more CYP are identified

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The views expressed in this report are the authors' and do not necessarily reflect those of the Department for Education.

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