Department for Education

Mental Health Services and Schools Link Pilots: Evaluation report

Final report

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Laurie Day, Rachel Blades, Caitlin Spence and James Ronicle – Ecorys UK

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Glossary

Abbreviation	Definition
ADHD	attention deficit hyperactivity disorder
AFNCCF	Anna Freud National Centre for Children and Families
ASD	autistic spectrum disorder
CAMHS	Child and Adolescent Mental Health Services
CAPA	Choice and Partnership Approach
CBT	cognitive behavioural therapy
CCG	Clinical Commissioning Group
CYP	children and young people's
CYPMH	Children and Young People's Mental Health
CYPMHS	Children and Young People's Mental Health Services
DBT	dialectical behaviour therapy
DfE	Department for Education
EBD	emotional and behavioural difficulties
FE	further education
FSW	family support worker
FTE	full-time equivalent
GP	general practitioner
IAPT	Improving Access to Psychological Therapies
MARAC	Multi-Agency Risk Assessment Conference
MHSDS	Mental Health Services Data Set
NHS	National Health Service
PEVP	permanently excluded and vulnerable pupils
PMHW	primary mental health worker
SEN	special educational needs
SENCO	special educational needs co-ordinator
SFT	solutions-focused therapy
SLT	senior leadership team
SPOC	single points of contact
TaMHS	Targeted Mental Health in Schools
VCS	voluntary and community sector
VCSO	voluntary and community sector organisation

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[1]. 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*[2]". 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[3].

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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[1] 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)

[2] 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)

[3] 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).

Executive summary

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 areas.

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[4], other school staff[5] and NHS CYPMHS[6] (baseline prior to the initial workshops and follow-up at +10 months); a snapshot 'exit' survey of other local key stakeholders[7]; in-depth qualitative telephone interviews with NHS CYPMHS lead contacts; workshop observations; and 10 local area case studies[8]. 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.

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[4] School lead contact survey, baseline n = 166 schools, follow-up n = 49 schools.
[5] Administered within a sub-set of 48 pilot schools, baseline n = 552 individuals, follow-up n = 95 individuals.
[6] NHS CYPMHS lead contact survey, baseline n = 18 respondents, follow-up n = 2 respondents.
[7] Administered at a single point in autumn 2016, achieved sample = 68 respondents.
[8] 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.

1.0 Introduction

In September 2015, Ecorys (UK) was commissioned by the Department for Education (DfE) to undertake an independent evaluation of the **Mental Health Services and Schools Link Pilots**. This final report presents the summative findings from the evaluation, which was carried out between September 2015 and November 2016, covering all 22 pilot areas. A mixed methods approach was deployed, using a combination of desk research, surveys of representatives from schools, NHS Children and Young People's Mental Health Services (CYPMHS[9] and other local stakeholders and qualitative case-study research.

In this introductory chapter, we give an overview of the background to the pilot programme, its aims and objectives, and how it was structured. We then go on to explain the aims and research methods that were deployed for the evaluation, and we outline the data caveats and limitations framing the analysis within the report.

Background to the pilot programme

In September 2014, the Government established the *Children and Young People's Mental Health Taskforce*[10], bringing together experts on children and young people's mental health including children and young people, with leaders from key national and local organisations across health, social care, youth justice and education sectors. The remit of the Taskforce was to identify what needs to be done to improve children's and young people's mental health and well-being, with a particular focus on making it easier to access help and support, and to improve how CYPMHS are organised, commissioned and provided.

Published in March 2015, the Taskforce report, *Future in Mind*[11] outlined a number of recommendations to help improve access to effective support for children and young people. The recommendations included the establishment of a named point of contact within specialist NHS CYPMHS and a named lead within each school. The named lead in schools would be responsible for mental health, developing closer relationships with NHS CYPMHS in support of timely and appropriate referrals to specialist services. The report also recommended the development of a joint training programme for named school leads and NHS CYPMHS. The original proposal is outlined in the box below.

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[9] Refer to the 'Note on Terminology' at the start of this report for a full explanation of terms in use.
[10] Children and Young People's Mental Health and Wellbeing Taskforce: Terms of Reference. (Accessed 3 January 2017)
[11] Department of Health. Future in mind: Promoting, protecting and improving our children and young people's mental health and wellbeing. 2015. London: NHS England. (Accessed 3 January 2017)

> **Taskforce proposals for the single points of contact (SPOC)**
>
> We propose the following to improve communication and access:
>
> i.   Create an expectation that there is a dedicated named contact point in targeted or specialist mental health services for every school and primary care provider, including GP practices … Their role would be to discuss and provide timely advice on the management and/or referral of cases, including consultation, co-working or liaison. This may include targeted or specialist mental health staff who work directly in schools/GP practices/voluntary sector providers with children, young people and families/carers.
>
> ii. Create an expectation that there should be a specific individual responsible for mental health in schools, to provide a link to expertise and support to discuss concerns about individual children and young people, identify issues and make effective referrals … This individual would make an important contribution to leading and developing whole school approaches.
>
> iii. Develop a joint training programme for named individuals in schools and mental health services to ensure shared understanding and support effective communications and referrals.
>
> Source: Department of Health (ibid., 2015, p. 42)

In early summer 2015, NHS England and DfE asked for expressions of interest from CCGs to join with local specialist NHS CYPMHS and schools to pilot the named lead approach and a joint training programme. Over 80 expressions of interest were received. A total of 22 areas (27 CCGs) and 255 schools were selected.

The Taskforce report builds on a longstanding recognition of the challenges faced by CYPMHS in England. An independent review of CYPMHS commissioned by NHS England[12] and evidence presented at the 2014 House of Commons Health Committee's inquiry[13] each indicated an urgent need for improvements to the timeliness, quality and accessibility of specialist support for mental health issues and a whole-system response, including a more active role for schools and other CYPMHS. These findings are supported by previous research into school-based interventions, which identified a need

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[12] CAMHS Tier 4 Report Steering Group. CAMHS Tier 4 Report. 2014. London: NHS England. (Accessed 3 January 2017)

[13] House of Commons Health Committee. Children's and adolescents' mental health and CAMHS: Government Response to the Committee's Third Report of Session 2014–15. 2015. (Accessed 3 January 2017)

"… to prioritise improved relationships and referral routes between schools and specialist CAMHS" (p. 3).[14]

Aims and objectives of the pilots

The overall aim of the pilot programme was to test how or whether training and subsequent joint professional working between schools and NHS CYPMHS can improve local knowledge and identification of mental health issues, and improve the quality and appropriateness of referrals to specialist services. Specifically, the programme aimed to:

- improve joint working between school settings and specialist NHS CYPMHS
- develop and maintain effective local referral routes
- test the concept of a lead contact in schools and specialist NHS CYPMHS

The pilot programme centred on 2 joint professional planning and development workshops for local stakeholders from CYPMHS in each of the 22 participating areas, including CCGs, local authorities, NHS CYPMHS, pilot schools and other key partner organisations such as Educational Psychology, School Nursing Services and VCSOs.

The workshops aimed to contribute towards the following outcomes:

- develop a shared view of the strengths and limitations and capabilities and capacities of education and mental health professionals
- develop knowledge of resources to support the mental health of children and young people
- make more effective use of existing resources
- improve joint working between education and mental health professionals

The workshops were facilitated by a consortium led by the 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 using a number of key criteria. A summary of the CASCADE framework can be found at Annex 2.

The pilot programme was implemented in 3 phases, as follows:

- Phase 1: forming schools and children and young people's mental health partnerships – workshop 1 (September to December 2015)
- Phase 2: embedding partnerships and building sustainability – workshop 2 (January to March 2016)

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[14] Wolpert M and others. Me and My School: Briefing Note from the National Evaluation of Targeted Mental Health in Schools. 2011. London: Department for Education. (Accessed 3 January 2017)

- Phase 3: supporting ongoing learning and the development of best practice and ensuring ongoing sustainability through 2 national events (May 2016)

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

Roles and responsibilities

The roles and responsibilities of key stakeholders were set out in a joint briefing note from NHSE and DfE and are summarised in the highlight box overleaf.

Roles and responsibilities of key stakeholders for the pilots

CCGs

CCGs were responsible for identifying an overall lead; typically the CCG commissioning lead for CYPMHS, to co-ordinate and act as the overall point of contact for the pilot. Specifically, their role was to:

- commission NHS CYPMHS to participate in the pilot and link with schools
- organise and attend both workshop days, ensuring that representatives from the CYPMHS network were invited, and building in local elements to help support relationships and reflect local circumstances
- develop and deliver a presentation at the first workshop that outlines how services are currently working together in their area, what their transformation plans involve and what their vision is for the pilot, and developing joint working practices.
- report pilot progress – at the midpoint and at the end of pilot

NHS specialist CYPMHS

NHS CYPMHS were tasked with identifying a named lead(s) to work with each school and oversee operational and organisational issues. Specifically, their role was to:

- participate in the pre and post requirements for the workshops and attend the national events in phase 3 of the pilots to share learning
- work with schools and health colleagues to develop closer links and protocols
- participate in the process and impact evaluations of the pilot, for example by completing baseline and follow-up surveys, interviews and providing other data including after the end of the pilot. Schools and CCGs may be asked to take part in follow-up surveys and questionnaires up to 1 year after the pilots are completed

Schools

Each school was required to nominate a lead person with an overview of mental health issues within their school, to fully participate in the training and the development of the joint working models. This could be a member of the leadership team or someone who has a mental health or well-being role, special educational needs co-ordinators (SENCOs), education welfare officers, staff with a pastoral lead or educational psychologist where they are employed by the school. Specifically, their role was to:

- attend both workshop sessions, bringing a member of the senior leadership team
- commit to working with NHS CYPMHS professionals to agree joint working and develop shared protocols
- participate in the pre and post requirements for the workshops and attend the national events in phase 3 of the pilots to share learning
- engage with colleagues working in schools who also have a remit to support the emotional and psychological well-being of pupils such as school counsellors, educational psychologists and school nurses to take part

Overview of the evaluation

The evaluation aimed to provide an independent assessment of the following:

- The **effectiveness** of the design and implementation of the *Mental Health Services and Schools Links* pilot programme, and of the 22 individual local pilots, including:

    o challenges and lessons learned from setting up the pilots
    o success factors for engaging schools and other key stakeholders
    o staffing models developed by schools and NHS CYPMHS and their effectiveness
    o lessons learned from planning and implementing the workshops
    o sustainability and potential for wider roll-out

- The **outcomes** achieved within the 12-month time frame for data collection, including the extent to which the pilots resulted in improvements, were as follows:

    o knowledge and awareness of mental health issues
    o changes to joint working between schools and NHS CYPMHS
    o timeliness and appropriateness of referrals from schools to NHS CYPMHS
    o wider changes to the culture around mental health in schools
    o service and systems improvements in NHS CYPMHS and specialist services

The evaluation covered the SPOC in schools and NHS CYPMHS, and the joint workshops (phases 1 to 3). It also aimed to assess the extent to which the pilots facilitated joint professional working across all CYPMHS within the participating areas, including non-NHS funded services.

Methodology

A mixed methods approach was used for the evaluation, including quantitative and qualitative data collection and analysis within a framework mapped to the evaluation aims and objectives, and a final synthesis of the evidence. The main elements included:

- **Quantitative survey research** – four sets of online surveys were designed, piloted and implemented within the 22 pilot areas:

    o **Pre and post surveys of the SPOC in schools and NHS CYPMHS for the pilot programme,** to measure changes over time in levels of knowledge and awareness and joint professional working, using Likert-scale classifications and data on numbers of consultations and referrals. The baseline survey took place in autumn 2015 (n = 166 schools, and n = 18 NHS CYPMHS), with follow-up at +10 months (n = 49 schools, and n = 2 NHS CYPMHS).

    o **Pre and post online survey with a sub-sample of pilot schools**, to establish the extent to which 'whole school effects' were measurable. Lead contacts assisted with sampling staff across different grades within each school, from

senior managers, to teachers and support staff. The baseline survey was conducted within 1 month of the first workshop (n = 552 individuals, from n = 48 schools), with follow-up at +10 months (n = 95 individuals, from n = 8 schools).

- o **Snapshot survey of other local stakeholders within the pilot sites**, to test levels of awareness of the pilot programme, levels and scope of involvement, and views on the effectiveness and outcomes from the local pilots. The survey took place in autumn 2016 (n = 68) alongside the follow-up surveys with schools and NHS CYPMHS lead contacts. The sample was sourced from updated contact details provided to NHS England by CCGs in May 2016.

- **Qualitative telephone interviews with NHS CYPMHS lead contacts** – in-depth interviews were conducted with NHS CYPMHS lead contacts (n = 15) in autumn 2015, exploring early lessons learned from setting up the pilot; historical arrangements for working with schools and other organisations within local CYPMHS networks, and expectations for the pilot. The interviews were also used to scope the availability of relevant administrative data held on consultations, referrals and other key metrics.

- **Structured research observations** – a sample of (n = 8) workshops were observed in autumn 2015 and spring 2016 to gain a deeper understanding of the context for joint professional working in those areas and to explore the challenges and successes from planning and delivering the workshops. The AFNCCF also provided data from assessments made using the CASCADE framework for all 22 pilot areas.

- **Case-study visits to 10 x pilot sites** – conducted in summer and autumn 2016, to explore lessons learned from implementation, successes, challenges and how these were overcome, and plans for wider roll-out. Each case-study visit comprised qualitative interviews and focus groups with key strategic and operational stakeholders from the selected pilot sites, including CCGs, NHS CYPMHS, schools and partner organisations, and the collection of documentary evidence and data. The case studies were sampled according to four main criteria: socio-demographic characteristics, pilot schools mix (type), baseline position for joint professional working (high/mixed/low) and areas of potential good practice.

Analysis of evaluation data

The quantitative survey data was extracted and cleaned before matching the baseline and follow-up responses to measure change across different outcome measures. The results were then compared by respondent type and area. Paired t-tests[15] were used to test for statistical significance and to establish the confidence levels in the results.

The evaluation included a feasibility study for undertaking a comparison of outcomes[16] between pilot schools and a matched comparison group of non-pilot schools, using a quasi-experimental design. The feasibility study concluded that this strand was not feasible, owing to the fact that referral data cannot be disaggregated by individual school within most local NHS CYPMHS. The new national Mental Health Services Data Set (MHSDS[17]) was considered but was found to be at an early stage of implementation.

The notes from the qualitative interviews were entered into a structured grid, based on the agreed topic framework, and supplemented with verbatim quotes and examples from the transcribed interviews. A thematic analysis was undertaken, to manually compare and contrast the views of the different respondents under common topic headings from the qualitative interviews. Attention was given to key similarities and differences in perspectives, according to pilot area, stakeholder type and professional roles. The findings from the interviews and case-study research were then triangulated with the survey data, to establish the degree to which the different data sources support or refute each other. Emerging themes were discussed with the steering group at the interim reporting stage, with feedback and adjustment prior to final reporting.

Further details on the qualitative sample can be found in Annex 1 (A1.2).

Interpreting the results

The qualitative strand of the research was based on interviews with NHS CYPMHS representatives from 15 of the 22 pilot areas in autumn 2015 who opted to take part, and with a wider range of key stakeholders within the 10 case-study pilot areas in autumn 2016, including representatives from CCGs, pilot schools and partner organisations such as educational psychologists, school nurses and VCSO mental health specialists (*n* = 124 individual respondents). The ability to sample the case-study areas and schools using the surveys and workshop data allows for a good level of confidence in the results. As with all case-study research, the findings do not claim to be exhaustive, and the case studies do not fully document more recent developments in the remaining pilot areas.

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[15] T-tests were used to compare the quantitative variables in the data, thereby enabling us to go beyond comparison of sample means to make inferences generalisable to the populations of interest

[16] The outcome measures of interest included referral rates, acceptance rates and conversion rates (from schools to specialist NHS CAMHS).

[17] Available online (Accessed 5th January 2017)

The quantitative baseline survey of school lead contacts was completed by almost two-thirds of all pilot schools (65%, or 166 out of 255 pilot schools), thereby giving a good level of statistical confidence in the results. The response was lower at follow-up stage (49 respondents) but nonetheless proved sufficient to measure statistically significant changes for a wide range of outcome variables. A comparison of the school sample at baseline and follow-up stage shows that there were no systematic differences in composition (see also note in Annex 1, A1.3). However, we did not adjust for multiple comparisons in our analysis, and the results in some cases may therefore be specific to our particular sample and not generalisable to the wider population[18].

There were far fewer NHS CYPMHS lead contacts compared with schools, and while the baseline survey covered the majority of pilot areas (18 out of 22), just 2 of the original NHS CYPMHS leads took part at the follow-up stage. The reasons are not fully known, although it seems likely that the staffing changes in between the sharing of provisional contact lists in August 2015 and pilot implementation in spring and summer 2016 were a factor. The low survey numbers mean that it is necessary to draw upon the qualitative evidence to a greater extent for NHS CYPMHS perspectives on the pilot programme.

The pilot areas and schools have been anonymised within this report, in the interests of confidentiality. However, Annex 1 (A1.1) includes further summary information on the socio-demographic profile and geographical distribution of the pilot areas across Government regions in England.

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[18] A drawback of using t-tests is the risk of type 1 error – the probability of rejecting the null hypothesis when it is actually true. This is known as the multiple comparison problem, in that the more attributes are compared between the baseline and control groups; the more likely it is that the test will reject the null hypothesis because the 2 groups will appear different on at least one feature by random chance alone.

Structure of the report

The remainder of this report is structured as follows:

- **Chapter 2** examines how the pilot programme was designed and set up. It gives an overview of the context for joint working within the pilot areas before the start of the programme, and how this shaped the development of the local models.

- **Chapter 3** considers the lessons learned from planning and implementing the workshops and CASCADE framework. The chapter goes on to examine the staffing arrangements for the lead points of contact in schools and NHS CYPMHS; the challenges and barriers to implementation and how these were overcome.

- **Chapter 4** reviews the evidence for the impact and outcomes from the pilot programme, considering in turn the knowledge and understanding of individual practitioners in NHS CYPMHS and schools, joint professional working and communication arrangements, and services and systems transformation.

- **Chapter 5** considers the extent of the longer-term support for the models developed during the pilot programme, and how or whether these were anticipated to result in lasting change. The chapter also looks at a number of case-study examples where the pilot sites were successful in securing funding to scale up.

- **Chapter 6** concludes upon the findings from the evaluation, and offers a series of recommendations for policy and practice based on the findings in this report.

2.0 Design and set-up of the pilot programme

Key findings

Local context prior to the pilot programme

- The 22 pilot areas varied in their levels of capacity and prior experience of joint working between schools and NHS CYPMHS. Their aims for the pilot differed accordingly, from taking first steps to build joint working relationships, to scaling up provision. This had a direct bearing on how the pilots were designed and delivered.

- The concept of SPOC was not without precedent, and a good number of the areas had tested similar models previously, with mixed success. The main constraints related to time-limited funding, service restructuring and variable demand for traded services. This had often resulted in patchy coverage.

- Schools cited barriers to joint working that they perceived as related to the complexity of NHS CYPMHS pathways and thresholds, inconsistencies in how referrals were handled and too much indirect communication. NHS CYPMHS commonly reported challenges relating to the lack of visibility of mental health provision within some schools and a propensity to refer indirectly via GP surgeries where in many localities it was not necessary to do so.

- Schools and NHS CYPMHS often had a shared concern about the frequent hand-offs between services, with young people passed backwards and forwards, resulting in delays to receiving a specialist assessment and treatment where this was needed.

- The baseline surveys showed that school lead contacts generally held more positive views about the priority afforded to mental health by senior management. However, they were often less confident in managing risk around the identification and referral of young people with mental health issues, and discussing these issues with parents and carers. Awareness of schools' procedures and protocols was also mixed.

Pilot set-up arrangements

- There was a good level of endorsement for the aims of the pilot programme at a local level. The CCG bids showed a widespread recognition of the need to strengthen the links between NHS CYPMHS and schools, to improve channels of communication and to develop clearer pathways to specialist mental health support.

- Most areas approached the pilot with a view to complementing activities identified in CYPMH and Wellbeing 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.

- The CCG lead for the bids was generally considered to have been effective in ensuring strategic buy-in across local CYPMH services and to mobilise the network within challenging timescales. This leadership was also important in brokering the sometimes difficult initial conversations between schools and NHS CYPMHS.

- The tight timescales for bidding often favoured those areas with established networks and schools that were already engaged with NHS CYPMHS. Even so, there was a good mix of school types across the programme. FE colleges were not excluded from taking part but were not represented in this phase.

Early pilot development

- Post selection, most areas required a further development phase to scope their schools' individual needs and to determine the optimum level of NHS CYPMHS staffing resource. The final 'offer' for schools was determined in varying ways, typically involving school-by-school consultation or a menu of support.

- The pilot programme development phase showed that other areas looking to develop a similar approach would benefit from having a longer lead-in, to embed the pilot within local service frameworks and to recruit or backfill within NHS CYPMHS.

In this chapter, we set the background context for the implementation of the pilots by first giving an overview of the situation within the 22 pilot areas regarding joint working between NHS CYPMHS and schools, prior to the start of the programme. We draw on the qualitative interviews and survey research to compare and contrast the views of schools and NHS CYPMHS in relation to the quality and appropriateness of mental health support in the pilot schools and the barriers to accessing specialist NHS CYPMHS.

We then go on to consider how the aims of the programme were communicated and how the areas responded in developing their local bids, with attention to local priorities and approaches for identifying and recruiting schools to take part. Finally, we review the lessons learned from early pilot development, including the steps taken following approval to get the pilots off the ground and to establish schools' needs and expectations for involvement.

Local context prior to the pilot programme

NHS England and the DfE had set out to include a mix of local areas with different levels of capacity and experience of joint working between NHS CYPMHS and with schools, and this was evident within the 22 successful pilots. The early interviews showed that a wide spectrum of needs were represented within the pilot programme, from areas where communication channels were already well established, and the focus was on achieving

excellence, to those where relationships were historically more challenging, and the pilot was seen as an opportunity to take first steps.

The interviews highlighted the changing landscape for specialist mental health support, with access to specialist NHS CYPMHS quite strongly influenced by a legacy of previous initiatives and funding. A good number of the areas within the pilot had been involved in the Targeted Mental Health in Schools (TaMHS) pilot programme, which had invariably supported the development of mental health and well-being pathways, and formed the basis of ongoing links with schools. Other areas had invested in CYPMHS quality improvement frameworks such as the Children and Young People's Improving Access to Psychological Therapies (CYP IAPT) change programme[19] and/or were involved with existing pilot programmes involving schools, such as the Emotionally Healthy Schools initiative and the *HeadStart* pilot programme.

In addition to this, many of the areas were in the process of undergoing structural change, having recently recommissioned or consolidated their NHS CYPMHS services. This influenced the proximity of NHS CYPMHS provision to school-based support. One area (**Area A**) had recently moved to a joint commissioning model between the CCG and LA, with the result that NHS CYPMHS expertise was embedded within multi-agency teams, with some primary mental health workers line-managed by social workers. Several others had developed bespoke commissioned services in conjunction with VCS partners, which included an element of school-based liaison and support. Furthermore, the timing of the pilot programme meant that all CCGs had recently submitted their CYPMH and Wellbeing Local Transformation Plans, with wider changes planned across 'whole system' commissioning. This timing generally added to a sense of momentum, with local stakeholders being more receptive to change.

Significantly for the pilot programme, many of the areas had already tested SPOC within NHS CYPMHS, and came with an awareness of the challenges of offering this type of model. A number of areas had trialled SPOC in schools historically, but the model had ceased following the expiry of time-limited funding or following the restructuring of primary mental health workers into locality teams. In several instances, a lack of demand among schools was cited as a factor in discontinuing this service by the NHS CYPMHS leads who were interviewed. Other areas offered SPOC as part of a traded offer, which involved providing this service 'at cost' on a commissioned basis and was therefore taken up by a more limited number of schools. **Area B** had developed a traded service based on mental health aspects of behaviour support, in response to demand from primary schools.

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[19] The Children and Young People's Improving Access to Psychological Therapies (CYP IAPT) programme is a service transformation programme delivered by NHS England that aims to improve collaboration, integrated working and user participation within community-based mental health services:

On balance, the main difficulty with previous SPOC arrangements was the patchiness in coverage, with gaps arising from specialist NHS CYPMHS capacity to offer comprehensive coverage and mixed levels of take-up. **Area C** was unusual in having reached a situation immediately prior to the pilot programme where NHS specialist CYPMHS link workers were available in secondary and special schools, and some primaries, with a triage service to meet any shortfall. In **Area D**, budgets were ring-fenced to fund 3 Tier 2 posts to work with clusters of schools. The workers all had a background in Special Educational Needs (SEN) or Emotional and Behavioural Difficulties (EBD) and teaching experience, to ensure that they "*spoke the language of schools*". This role included advisory work and some interventions for young people with moderate needs. Similarly, **Area E** had commissioned an emotional well-being service for schools, which was available alongside a traded counselling service. Stronger operational links between schools and NHS CYPMHS were sometimes further assisted by regular opportunities for shared learning and development across all CYPMHS, including forums, joint training and networks.

As we go on to discuss further in Chapters 3 and 5, these different starting points shaped the ways in which NHS CYPMHS developed their pilot offer and would also seem to have had a bearing on their plans for roll-out following the pilot programme.

Challenges and barriers to accessing specialist support

A number of challenges were identified among the pilot areas, when reflecting on the situation before the programme. While not common to all areas, the qualitative interviews suggest that the recurring issues raised by NHS CYPMHS included:

- highly variable working relationships with individual schools, resulting in inconsistencies in staff and young people's access to specialist advice and support
- a propensity for schools to refer via general practitioner (GP) surgeries, in areas where it was not necessary to do so, for example, in the belief that this would increase the chances of success
- difficulties posed by parental consent for sharing information on referral outcomes with schools
- lack of visibility of mental health provision within schools, as a result of perceived inconsistencies in the management, staffing and funding of mental health support

From the perspective of schools, the principal challenges included:

- a perception of too much indirect or impersonal contact via letter-writing or email communication, resulting in misunderstanding, with insufficient post-referral feedback
- complex and fragmented commissioning, resulting in inconsistencies and poor links between providers and provision that formed part of the NHS CYPMHS offer
- perceived inconsistencies in the response to schools from NHS CYPMHS services, resulting in variations in the service offered within the same authority

Furthermore, both schools and NHS CYPMHS respondents cited a common barrier relating to the frequent hand-offs between services. This was sometimes reported to have led to situations in which young people were passed backwards and forwards between schools, GPs and NHS CYPMHS, resulting in delays to the time taken to receive treatment.

The baseline surveys for the evaluation provide further insights to the views and experiences of schools and NHS CYPMHS, prior to taking part in the pilot programme. Online surveys were conducted with lead contacts for pilot schools, and NHS CYPMHS, prior to the initial workshops. The survey data is particularly useful in understanding schools' perspectives on access to mental health services, and overall levels of self-reported knowledge and confidence. In total, 166 school lead contacts were surveyed, representing almost two-thirds (65%) of all pilot schools and therefore providing a robust sample for the purpose of understanding the range of views within the cohort.

When asked about mental health support within their school (Figure 1), the lead contacts reported largely positive views on leadership and management arrangements, with a considerable majority of respondents (97%) agreeing or strongly agreeing that children and young people's mental health is afforded a high priority by the school leadership team (base = 166). Views were less strong, but still very positive, regarding satisfaction with support available from specialist colleagues within the school (73% agree or strongly agree) and the adequacy of resources allocated for specialist colleagues (64% agree or strongly agree). The overall picture, therefore, is one of a fairly high baseline level of confidence in school-level arrangements. As we go on to discuss further in the next section, this is perhaps indicative of an "*above average*" profile of the pilot schools regarding expertise and capacity for mental health support.

Figure 1 To what extent do you agree with the following statements about mental health support within your school? (school lead contacts)
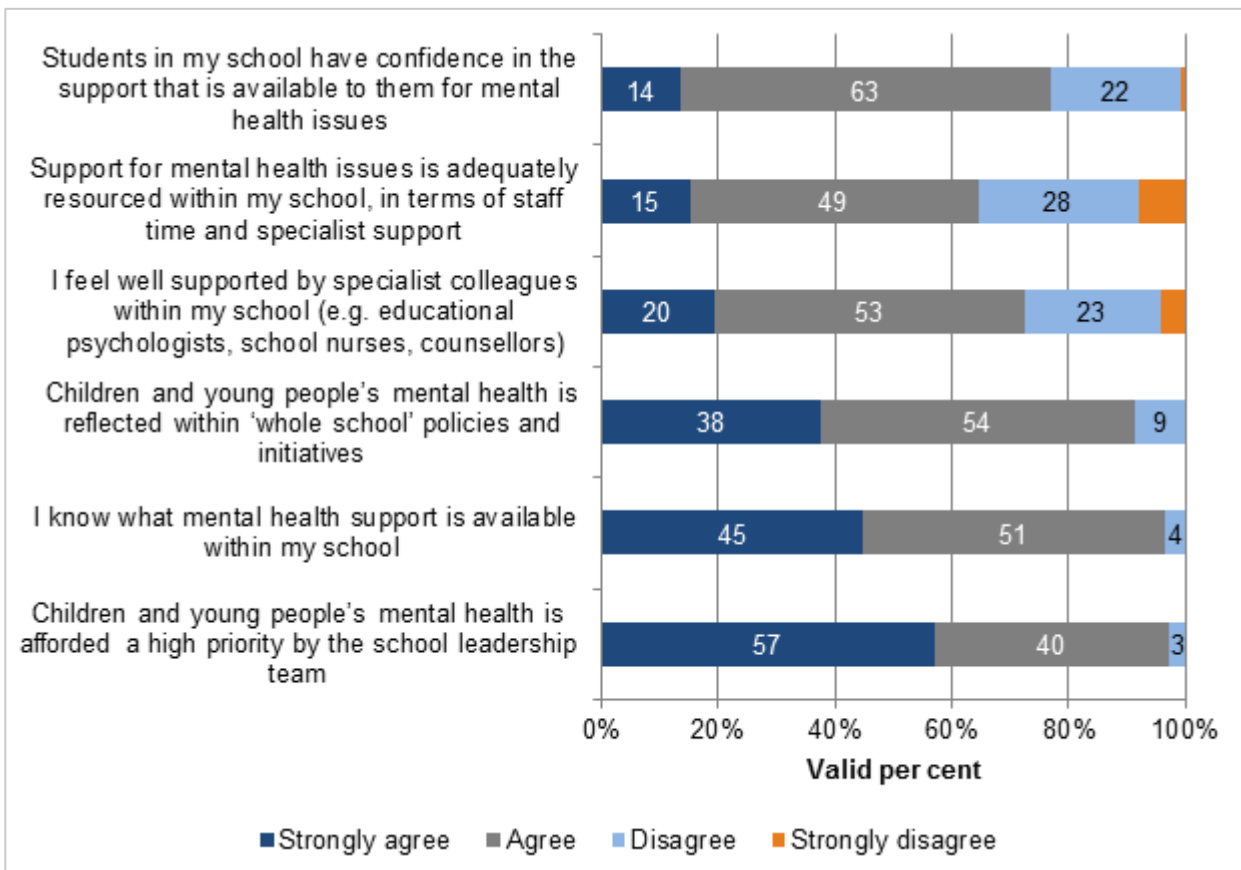
Base: 166 respondents.

Turning to measures of individual professional knowledge and confidence (base = 166[20]), school lead contacts similarly expressed high overall levels of confidence in their abilities to identify risk factors and behaviours[21] (76% agree or strongly agree) and in signposting students to appropriate support[22] (70% agree or strongly agree). However, they were less confident in their knowledge of different types of mental health issues[23] (54% agree or strongly agree) and of supporting children with different mental health needs in the classroom[24] (16% agree or strongly strong agree/agree). The survey results reflect a theme that emerged during the qualitative interviews at the subsequent case-study stage of the evaluation that school staff were considerably less confident when talking about what were perceived to be "clinical" mental health issues, despite often being much more comfortable in their knowledge and awareness of working with students with complex needs or challenging behaviours.

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[20] To what extent would you agree/disagree with the following statements about your knowledge of children and young people's mental health?
[21] I am aware of a range of risk factors and causes of mental health issues in children and young people
[22] I know how to help pupils with mental health issues access appropriate support
[23] I am knowledgeable about a wide range of mental health issues
[24] I know all I need to support children with different mental health needs in my classroom

Figure 2 Overall, how satisfied are you with the way that referrals were handled during the past school year?[25] (school lead contacts)
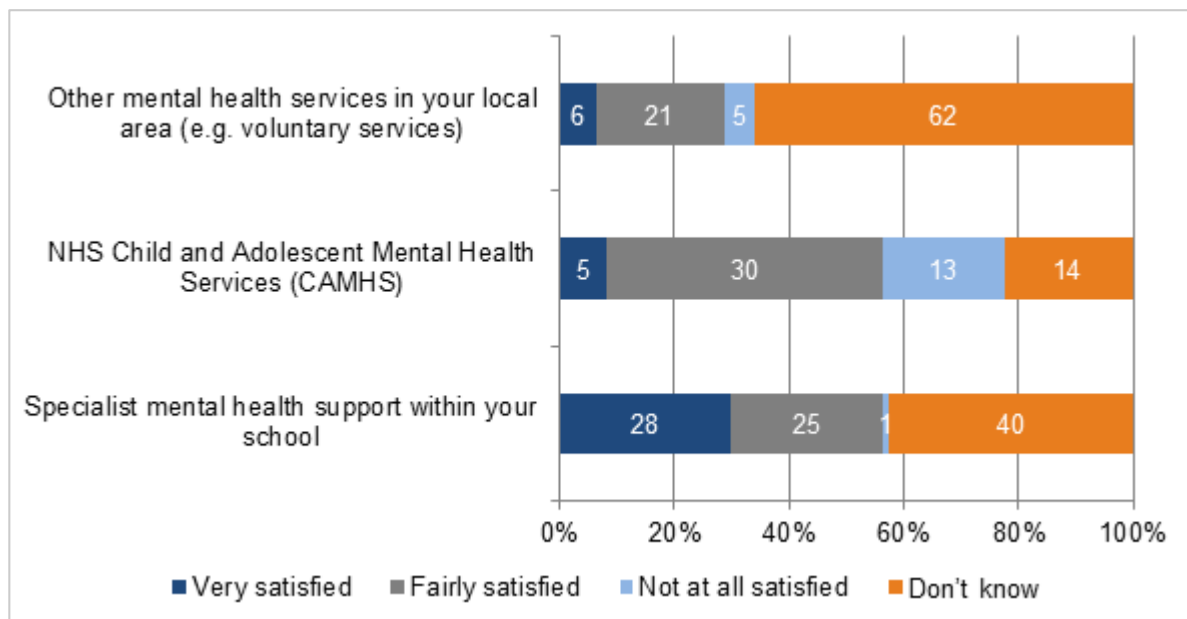
Base: 166 respondents.

The baseline survey also allowed for a consideration of schools' perceptions of referrals to specialist mental health support (base = 166). Overall, school lead contacts reported the highest overall satisfaction with referrals to specialist mental health support available within their school, such as counsellors or educational psychologists, with over half of respondents (53%) either 'fairly' or 'very' satisfied (Figure 2). In contrast, they reported the lowest level of satisfaction with NHS CYPMHS referrals, with just over one-third of respondents (35%) either 'fairly' or 'very' satisfied. They reported the lowest level of *awareness* of referrals to other mental health services, with nearly two-thirds of respondents (62%) unable to comment. This response is likely to include a proportion of respondents who did not make any such referrals within the past year.

The main reasons given by school lead contacts who were 'not very' or 'not at all' satisfied with referral arrangements included: perceived high levels of unsuccessful referrals, long waiting lists/times, inability to refer directly to NHS CYPMHS and lack of communication. These views largely concur with the issues reported by NHS CYPMHS, as described previously.

The same question was asked in the surveys of school and NHS CYPMHS lead contacts, regarding the main barriers to providing effective mental health support. This allows for a comparison between the perspectives of these 2 stakeholder groups (Figure 3).

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[25] The baseline figure refers to the 2015/2016 school (academic) year, covering the 12-month period from September 2015 to September 2016.

Figure 3 Significance of potential barriers to providing effective mental health support (combined – school and NHS CAMHS/CYPMHS lead contacts)
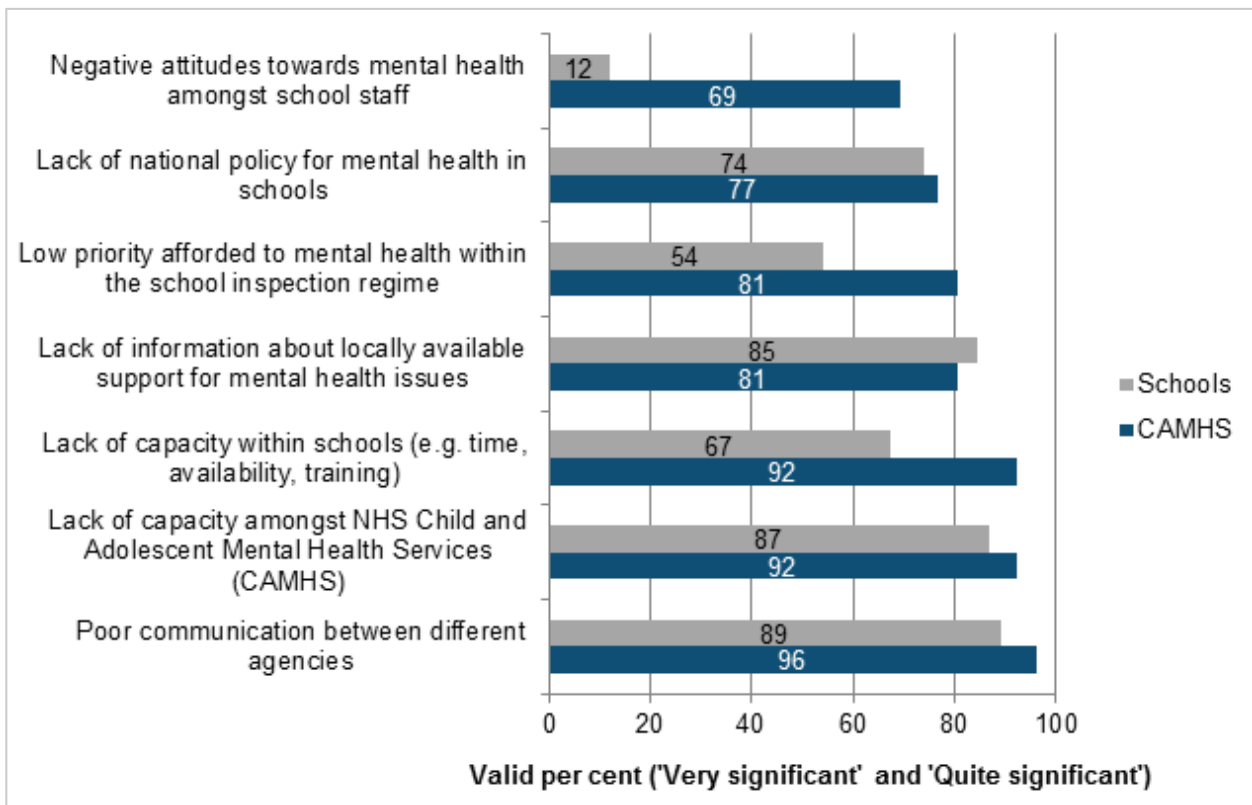
Base: 166 respondents (school lead contacts), 18 respondents (CAMHS/CYPMHS lead contacts).

While it is necessary to exercise caution, owing to the differences in numbers of professionals providing the lead contact role in schools and NHS CYPMHS (and therefore also in the survey respondents, at 166 and 18 respectively), the results show some interesting areas of similarity and difference. NHS CYPMHS held a slightly more pessimistic view overall, across most types of barriers. While these differences tended to be fairly small, there were 2 notable exceptions. NHS CYPMHS lead contacts assigned considerably greater importance to school-related barriers, including negative attitudes among school staff and the influence of the school inspection regime.

A baseline survey was also undertaken with a cross-section of school staff at different grades and levels of seniority, within a sub-set of 48 pilot schools (*n* = 552 respondents). This 'whole school' survey provides an insight to the views and experiences of school staff beyond the immediate lead points of contact. The top-line findings are as follows:

- As might be expected, less than half of respondents reported having attended training in issues related to children and young people's mental health (43%). Of those who participated in training, over half had done so within the past year, and well over three-quarters within the past 2 years. Training was sourced from a diverse range of sources, including local NHS CYPMHS, and local or national independent or third sector providers. Almost one-quarter of respondents (24%) had completed training online, purchased externally to their school.

- School staff were aware of referral procedures for mental health issues affecting students from a variety of different sources, including written protocols (52%), inductions for new staff (41%) and special briefings (41%). However, 2 in 10 respondents were unaware of how procedures regarding children and young people's mental health were communicated in their school.

The survey also casts some light on how school staff engage with students and parents and carers on the subject of mental health and well-being. The results show quite frequent discussion with students. Nearly two-thirds of respondents (63%) reported talking to students about their mental health and well-being at least monthly, and over three-quarters of staff felt confident in doing so (76%). Just over one-third of respondents (35%) reported talking to parents and carers with the same frequency, while one-quarter (25%) never talked to parents and carers about these issues. On average, school staff were less confident in talking to parents and carers about mental health issues than they were with students.

Figure 4 How confident do you feel about talking to students about their mental health and well-being? (whole school survey)
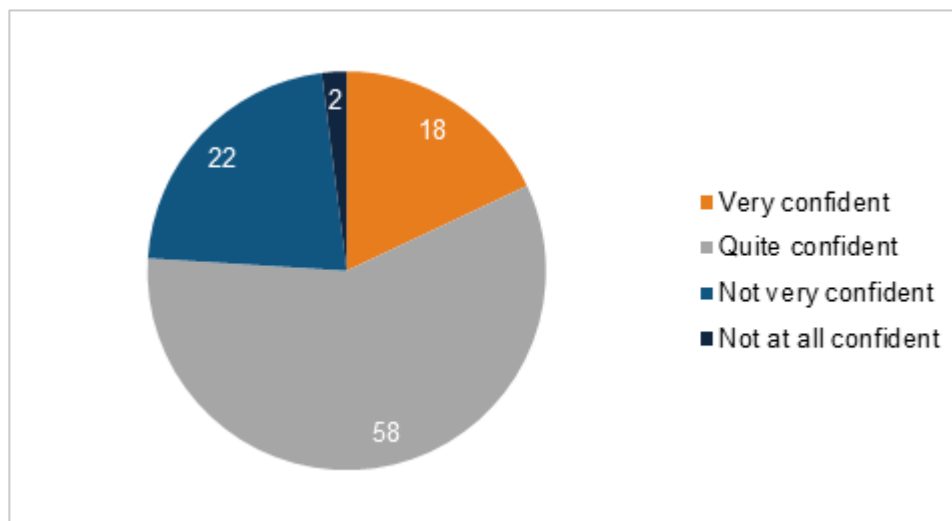
Base: 470 respondents.

Figure 5 How confident do you feel about talking to parents and carers about the mental health and well-being of students in your school? (whole school survey)
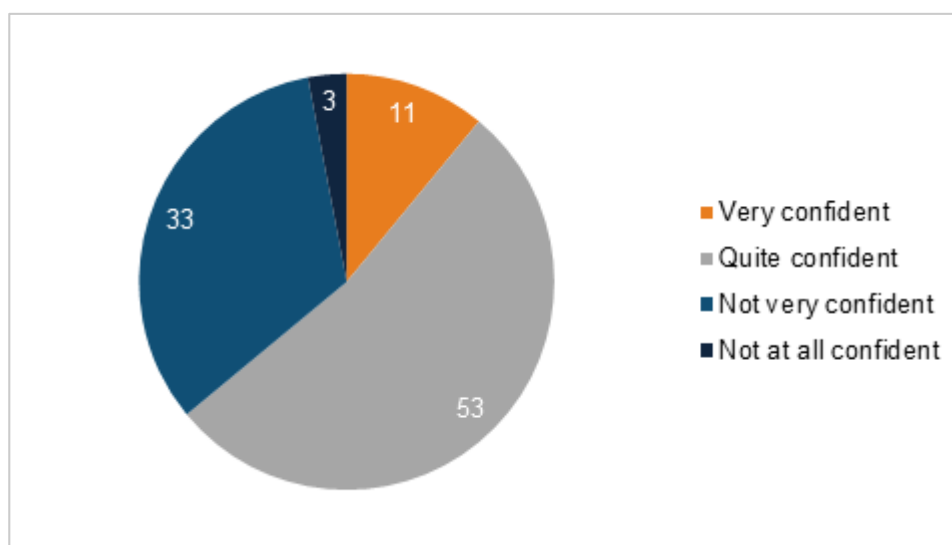
Base: 391 respondents.

In summary, therefore, the baseline survey shows that institutional barriers to joint working within schools were a particular concern to NHS CYPMHS in the period immediately prior to taking part in the pilots. The school surveys raised some questions about the confidence of school-based staff in managing 'risk' around identification and referral of young people with mental health issues. They also showed some gaps in confidence at discussing mental health issues with parents and carers, and varying levels of awareness of referral procedures and protocols. Later, in Chapter 4, we review the extent to which positive changes were reported at the follow-up survey stage, post implementation.

Pilot set-up arrangements

The DfE and NHS England invited Expressions of Interest for the pilot programme in June 2016. There was a high level of response, with over 90 applications from CCGs. This response was mirrored locally in many areas, where the demand from local schools often outstripped the number of available places. The evaluation evidence showed that there was a good deal of consensus among all respondent groups, of the need to strengthen links between NHS CYPMHS and schools, and to improve the quality and consistency of communication with schools.

The local aims and objectives very much echoed those of the DfE and NHS England. CCGs cited the importance of improving relationships between schools and NHS CYPMHS. The local bids also included a strong *workforce* dimension – developing a common understanding of the 'language' of schools and NHS CYPMHS, and shared approaches. From an NHS CYPMHS perspective, the pilot was also seen as a potential mechanism to empower schools to confidently support young people with lower-level

mental health needs below the threshold for specialist CYPMHS, and to boost the capacity for schools to undertake preventative mental health support:

> *"For me the overall ambition of the pilot was quite clear ... improving those working relationships and links between specialist mental health services and schools … recognising what the specialist mental health service might be able to provide ... but also recognising what schools need to do and provide themselves to make it all work and fit together."*
>
> (NHS CYPMHS manager)

While the concept of a single point of contact was not entirely new, most areas welcomed the opportunity to test these arrangements more systematically than was possible before, often with a view to informing wider service transformation work that had been earmarked within local CYPMH and Wellbeing Local Transformation Plans. One of the pilot areas had already committed funds for an NHS CYPMHS Development Worker to provide a stronger link with schools, and their time was matched to the pilot programme. Similarly, in another pilot area, the CCG delivered the pilot in conjunction with emotional well-being training, to make the resource go further.

Although the high-level aims of the programme were welcomed, some difficulties arose as a result of miscommunication of the programme structure and content at a local level. Specifically, there was a fairly widespread perception among schools that they were releasing staff to attend training on supporting young people with mental health issues, rather than to participate in joint planning and development activities. This led to a mismatch in expectations, which CCGs and NHS CYPMHS teams needed to address, although it was confirmed in the workshops that all schools were able to access *MindEd*[26] online training free of charge. There was also some frustration among CCGs that more detailed information on the programme requirements was issued retrospectively in the form of a fact sheet. Some of the areas had to make adjustments to roles and responsibilities as a result of having misinterpreted the original requirements.

Having a CCG lead for the pilots was generally considered to have been effective in ensuring that there was strategic-level buy-in, and mobilising the CYPMHS network within a short timescale. This local leadership was also welcomed at the workshop planning stage, to lead what were sometimes difficult initial exchanges between schools and NHS CYPMHS. The bidding process was felt to have been too 'top down' in a few areas, however, and there were several examples where NHS CYPMHS providers felt that they should have been involved to a greater extent in bid preparation. The

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[26] MindEd is funded by the Department of Health and Department for Education, as a free educational resource on children and young people's mental health for all adults working with, or caring for, infants, children or teenagers. Available online (Accessed: 5 January 2017)

implication in some areas was that NHS CYPMHS felt that opportunities were overlooked to engage with schools where improvements to joint working would have been the most beneficial.

Identifying and engaging schools

The pilots used a range of criteria to inform the selection of schools to participate while also exercising a degree of pragmatism. Most areas had sought to recruit a mix of school types, enabling them to test how a single point of contact model might differ between primary and secondary schools, for example, or to ensure that the model was piloted with special schools or alternative education providers. A few took a more specific approach:

- **Area E** aimed to include a mix of schools that were known to have well-developed arrangements for mental health support through a previous initiative and those that did not. The rationale was to develop a peer-support network within the pilot.

- **Area B** targeted secondary schools, and academies in particular, on the basis that the take-up for traded services was historically much lower than for primary schools, and the pilot was viewed as an opportunity to establish a working relationship. Similarly, **Area K** focused on a specific district where there had been greater difficulties in engagement, and waiting lists were comparatively high, with a view to using the pilot to address these issues head on.

- **Area F** aimed to develop a locality model, based on a (geographical) cluster of schools within a specific district where there were challenges relating to co-ordinating CYPMH services across a rural area. The rationale was to test the potential for replicating a link model in other districts within the county.

In practice, however, the timing of the pilot meant that areas had just 2 weeks to identify schools before the end of the school term. This tended to favour those areas with established networks or forums, and schools that were known to NHS CYPMHS. The result was that the pilots were thought to include a fairly high proportion of schools that were already engaged and that were not necessarily typical of the wider school population. Nevertheless, the final schools mix covered a good spread of school types (Table 1) and geographies. One of the areas (**Area R**) had even managed to engage schools in the development of the bid, which helped strengthen the partnership.

Table 1 Pilot schools according to type of school

School type	Total
Primary	131
Secondary	78
Secondary with sixth form	20
Special school	12
Pupil referral unit	7
Other alternative/specialist	4
'All through' school	3
Grand total	**255**

Key learning points from the school recruitment included the importance of securing headteacher/deputy endorsement for the pilot, and relating the offer clearly to the work that schools were already doing around social and emotional well-being. This was achieved in various ways, ranging from a '*school-by-school*' approach to identify a senior lead and to ensure commitment to the pilot (**Area O**) to engaging with local head teacher's forums (**Area B**) to disseminate the opportunity.

Early pilot development

After having been selected to take part in the pilot programme, most areas reported a need for a further development and scoping phase to agree protocols for working with their schools, and in determining the optimum configuration of NHS CYPMHS expertise.

Typically, **further consultation was required to establish schools' needs**. In **Area G**, a light touch 'audit' of schools was completed as part of the pilot a first step to help tailor the offer of support. Other areas ran 'consultation phases' to inform planning. In one example, they held an initial scoping workshop to identify needs and co-produce a '*business proposal*', within which the necessary level of resource was identified. This led to delays in backfilling the NHS CYPMHS posts required for the pilot and reduced capacity to support schools in the early stages until the posts were filled. NHS CYPMHS also visited all participating schools to further develop the local plan using the IAPT Train the Trainer model. Elsewhere, the timing of the initial consultation coincided with the consultation on the CYPMH and Wellbeing Local Transformation Plan needs assessment, which provided NHS CYPMHS with the opportunity to talk to different people to inform the pilot at the same time.

A different approach was taken in **Area H**, where NHS CYPMHS presented schools with a proposed package of options that they would like to take forward and asked schools to report back at the next meeting. The package included: development of a life skills book for young people; creation of a social skills group to tackle social anxiety; introduction of anxiety-based cognitive behavioural therapy (CBT) programmes; and guidance around systems and assessment. **Area I** and **Area E** adopted similar approaches. In other areas,

schools were offered support from NHS CYPMHS on a more ad hoc basis, and the offer was shaped more gradually through the process of testing demand.

It was also necessary to **scope the specialist NHS CYPMHS capacity to meet the resource requirements** and consider how to organise their offer of support in the context of different needs (for example, by area or type of school). This inevitably resulted in delays with assigning link worker(s) to schools, while suitable arrangements were agreed to **backfill or put in place interim posts**. This was estimated to take anything up to 6 months in some instances, which was some way beyond the original date when NHS CYPMHS expected to be offering the school liaison. Other areas had struggled to find an individual worker who was suitable for the role, because they considered it important to find an individual who had experience of working in a school setting, although this was not a specific requirement of the pilot programme.

While the initial bids were usually firmly CCG-led, some areas were mindful of the sensitivities that existed around additional money (the £50,000) being made available at a time when many services were facing cuts. Methods were therefore sought to ensure **collective responsibility** for pilot resourcing and expenditure. In **Area J**, NHS CYPMHS set up a steering group with the school leads to plan how to use any expenditure that was not absorbed by the primary mental health worker role and took their action plan to the local authority and CCG leads. Schools were effectively offered the choice of having either a dedicated NHS CYPMHS lead offering a day each week in each of the schools plus training or regular CYPMHS drop-in sessions and encouraging school staff to visit CYPMHS to understand how they operate and provide support.

Many sites also wanted to **align their work programme for the pilot with wider CYPMH and Wellbeing Local Transformation Plan objectives**. Although plans had already been submitted shortly before the pilot programme was launched, there was often scope to find ways for these developments to be complementary. For example, the Transformation Plan in **Area A** included themes relating to developing a more child-focused service, including linking in with wider support services, and the pilot was seen as a part of this model. Another area (**Area I**) was in the process of redesigning CYPMHS as an integrated 0–25 service, with high levels of consultation with young people, and the pilot came at a good time to help determine what the 'schools' element of this commissioning model might look like.

In some areas, there was a need **to clarify the pilot purpose** and ensure schools were on board. The NHS CYPMHS lead in **Area K** explained that some schools were initially apprehensive about what the pilot would entail and the level of time and resource they were committing, which meant that the original enthusiasm at bidding stage had dissipated. The CCG and NHS CYPMHS were able to sell the benefits of the single point of contact model and show that there was a real commitment from health to invest time and resources. The importance of **managing expectations** was further highlighted, to ensure that schools were aware of the capacity-building purpose of the pilot, and that

they were not expecting to receive high levels of open-ended support from NHS CYPMHS. **Area E** had developed a specification for their link worker for the benefit of schools, setting out the amount and range of support that could be expected. This was felt to have got the pilot off on a strong footing, with schools fully briefed on what to expect.

Consultation with schools was not the only step to ensuring that the pilots were demand-led, and a few of the areas had also undertaken **consultation with children and young people**, to secure their input. **Area G** had already commissioned a service review to ask young people about their needs and priorities for mental health services, and were able to consult on their plans for the school link pilot. In **Area E**, NHS CYPMHS worked with several VCSOs to plan young people's involvement in the development of the content for the training programme, to ensure that this was fit for purpose.

The experience of early pilot development showed that other areas looking to develop a similar approach would benefit from having a longer lead-in time to embed the pilot within local service frameworks, and to consult with schools to fully understand their needs. There was also a clear message about the need to allow time to backfill capacity within specialist NHS CYPMHS, to ensure service continuity when individual staff take on the additional time and responsibility needed to perform the link role with local schools.

3.0 Lessons learned from implementation

Key findings

Joint planning workshops

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

- The main reported benefits included new contacts established between professionals from schools, NHS CYPMHS and other CYPMH services, and sharing of knowledge and good practices. The workshops often fostered a mutual understanding of the strengths and challenges of mental health provision in schools and NHS CYPMHS.

- Clear communication of the aims and format were important. The piloting underlined the need to consider prior levels of joint working between schools and NHS CYPMHS. The format was less successful where this balance was not achieved.

- The national events were almost unanimously thought to have been useful in allowing schools, NHS CYPMHS and CCGs to share experiences with their counterparts from other areas. Some areas expressed a demand for ongoing networking opportunities and access to a repository of case studies and materials.

Implementing the 'single point of contact' role

- Most schools identified an operational single point of contact for the pilot, reporting to a senior manager, but these roles were occasionally combined. The lead contact was most commonly either an individual with student welfare responsibilities, such as a SENCO or inclusion coordinator, or a deputy/assistant headteacher.

- NHS CYPMHS typically recruited or seconded one or more primary mental health workers (PMHW) to perform the lead role. The number of FTE workers ranged from 1 to 7 across the pilots, with an average (mode) of 2. This resource was usually guided by decisions about the feasible offer of time per pilot school.

- The roles and responsibilities of the NHS CYPMHS lead worker were specific to each pilot, but it was possible to group them according to 3 main types:

  a) NHS CYPMHS lead with contact time in schools on a regular basis, delivering services and support directly to both staff and young people.
  b) NHS CYPMHS named lead offering dedicated training and support time to school-based professionals.
  c) 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, and the pilots developed their approach to suit local circumstances. However, a commitment from both schools and NHS CYPMHS was essential to embed the joint working arrangements.

- The demand for face-to-face contact time from NHS CYPMHS lead contacts varied between individual schools. Secondary schools often perceived a need for higher levels of contact time than primaries, although this was not always the case. It was important to monitor and review contact time per school to avoid wasting resources.

- A regular presence for NHS CYPMHS in schools enabled workers to support and consult school staff, and to work with pupils. This occasionally involved co-working with individual pupils. High levels of school-based support were costly, however, and some areas raised concerns about dependency on external specialist support.

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

Communication and reporting arrangements

- 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.

- Alongside bilateral communication between individual schools and NHS CYPMHS, many of the areas made use of multi-agency panels or forums to share information between local partners for the pilots. This ranged from pilot-specific working groups, to representation on existing CYP multi-agency panels such as Early Help hubs.

Barriers and enablers to effective delivery

- The commonly reported challenges included staffing capacity, with NHS CYPMHS often requiring lead-in time to release staff to participate in the pilots and to backfill. Within schools, the lead contact role was sometimes less effective where staff had too many other responsibilities or were not being supported by senior management.

- The joint working arrangements were often more successful where the lead contacts were flexible, proactive and willing to take time to understand the cultural differences between working in school and health settings. They were often less successful where a 'one size fits all' approach was implemented with pilot schools.

We have so far considered the initial development of the pilots. In this chapter, we go on to consider the lessons learned from implementation, before addressing the question of the impact and outcomes from the pilot programme in the following chapter. First, we examine the role of the workshops, which were developed by the consortium led by the AFNCCF and delivered in co-ordination with the CCG leads within each of the pilot areas. We then go on to compare and contrast the staffing and governance arrangements for the pilot programme, including how the SPOC were identified, what this role entailed and the main challenges and success factors from the piloting phase.

Joint planning workshops

The joint planning workshops were delivered in 3 phases:

- an initial workshop taking place in each of the pilot areas on a rolling basis between November and December 2015 to initiate joint working

- a second workshop for each area taking place between January and March 2016 to agree upon actions to take forward

- two national learning events – one each in the north and south of England, held during April and May 2016 for the pilot participants to share their experiences

The workshops were co-ordinated and facilitated by experts who were contracted to, or engaged by, AFNCCF, with inputs by the CCG lead contact to provide a contextual overview and to embed within the local context.

The workshops followed a common structure but with opportunities for some local variation. The format included a mix of self-assessment and benchmarking, using the CASCADE framework – a tool developed by the AFNCCF and used in the pilot workshops to help Children and Young People's Services to identify priority areas for action. There was also an informational element, including an overview of common tools and outcome measures, and how schools can foster resilience in children and young people. There was an element of online training with all workshop delegates being given access to a bespoke learning path via *Mind Ed*, which consisted of 10 modules developed specifically for the pilot for Mental Health Leads.

Overall, the majority of representatives interviewed during the case-study visits reported that the workshops met their expectations, including representatives from CCGs, NHS CYPMHS, schools and partner agencies. They generally felt the workshops were delivered to a high standard and with good-quality content, with some notable exceptions where the first of the 2 workshops was less well received, as will be explained later in this section. Many case-study interviewees regarded the initial workshop as an effective way to commence the pilot, primarily because it brought everyone involved together in the same room.

A small number of areas commissioned additional workshops, showing the value that was placed on them by local stakeholders. This expanded format was usually implemented where the pilot areas chose to use alternative sources of funding to roll the model out to an additional cohort of schools (for example, **Area L** and **Area D**). One area intended to adopt the workshop format to engage local stakeholders in reviewing progress with their CYPMH and Wellbeing Local Transformation Plan.

In general, case-study interviewees reported that the workshops had the following benefits, in broadly this order of significance:

- building relationships
- sharing information, knowledge and good practices
- supporting action planning

The qualitative interviews showed that **networking** was often considered to be a primary benefit from attending. Many participants had valued the opportunity to meet with representatives from other services, within a supportive environment. Although the workshops sometimes started on a tense footing, they were generally thought to have provided an effective forum for discussing issues openly and honestly, and many interviewees reported that their relationships with other services improved as a result. Indeed, the workshops quite often provided the springboard for ongoing contact:

> *"It was a much-needed opportunity to get everyone in the same room and start building those relationships."*
>
> (senior manager, pilot school)

> *"It was a good opportunity to come together ... to chat these things through and share ideas. Meeting CAMHS in that environment was useful because you get to meet the clinician. And that's important, because it helped us to build a relationship with people you are going to work with."*
>
> (lead contact, pilot school)

The workshops were also an important source of **information-sharing**. Schools often valued the information they received about support that was available within the locality of which they were unaware, while NHS CYPMHS were able to gather direct feedback from schools on their current mental health provision. This invariably helped to identify where local resources were being underutilised, resulting in some quick wins.

Joint planning workshops – making effective use of existing resources

In **Area G**, the NHS CYPMHS team was shocked to hear that schools were accessing mental health interventions ad hoc through online searches and that they were unaware of the commissioned services available through the network. The ensuing discussions resulted in 2 action points, which were taken forward: the development of a resource directory and updating referral pathways helped to signpost schools back.

In **Area F**, the first pilot workshop revealed that many of the designated school lead contacts were unaware of the NHS CYPMHS professional helpline, which had been funded for more than 5 years, providing access to consultation and advice across the county. This helped to address the perception among some schools that there was no obvious point of contact with specialist NHS CYPMHS and showed the NHS CYPMHS team that further work was needed to publicise the helpline.

Schools were also able to ask questions and to gain a better understanding of how NHS CYPMHS is structured. This helped to dispel some misconceptions. Schools had often previously overestimated the size of the service, but seeing the CCG presentation and hearing from the NHS CYPMHS manager highlighted the difficult staffing ratios. This helped to develop empathy and understanding around difficulties in meeting demand, while NHS CYPMHS experienced first hand how emotive the subject of mental health issues was within schools, and the stress and anxiety among school staff.

Additionally, it became apparent in a number of workshops that schools were not fully aware of the range of services available from CYPMHS. Some areas incorporated presentations from VCSOs or schools with well-established policies or initiatives. In **Area C**, the workshop included inputs from the CCG, education psychology services, public health and the voluntary sector.

This element was covered to a varying extent, however, with a feeling that the wider CYPMHS network was poorly represented at some of the initial workshops, where the attendees were mainly from schools or NHS CYPMHS. One CCG lead contact rued the missed opportunity to deliver a "*multi-agency marketplace*" format, with network partners showcasing what they could offer. It was often more down to the opportunism of individuals to use the workshops as a platform to raise awareness. The head of the Educational Psychology Service stood up in one workshop and made an offer to work with all pilot schools to set up nurture groups, which was well received.

The **planning** aspect of the workshops was a further important function, and the CASCADE framework provided a supporting framework within which these discussions took place. There was a mixed response to the usefulness of the CASCADE approach. This was viewed as a useful tool to support strategic planning by some, and the small group discussions around the 7 criteria highlighted some important issues that were

carried forward into the resulting action plan. The framework was sometimes felt to have been mismatched with the workshop audience, however, with participants not always feeling sufficiently well informed to contribute, and some commented that the scoring exercise was too time-consuming and detracted from opportunities for stakeholder engagement. One CCG lead commented that CASCADE would be more effective if linked to processes that were under way "behind the scenes", linked to service transformation:

> *"[CASCADE] needs to be owned by strategic leaders, who are already involved in service transformation … it needed decision-makers, there"*.

(CCG lead contact)

There was a real shift in opinion between the first and second workshops, with tangible action points emerging by the follow-up stage. The box below illustrates two examples where the workshops were integral to the pilots and helped to move discussions forward.

Joint planning workshops – ensuring collective action

At the end of the second workshop in **Area M**, the CCG lead contact chaired a session on plans for implementation. The group agreed collectively what the aims for the pilot should be. They broke into small groups, with key stakeholders moving between each group, to discuss what actions they should deliver to achieve the aims. The CCG lead contact used these to devise the action plan. Some of the actions delivered as part of the pilot stemmed directly from ideas raised at the workshop, such as a 'networking event' for different mental health organisations to showcase their offer for schools.

Prior to the first workshop in **Area E**, local stakeholders decided that they would use the first workshop to test and develop a menu of services that the NHS CYPMHS link workers would provide to schools. This proved to be a highly interactive session, with schools able to input and reach a consensus on how the offer should look.

The workshop specifically resulted in agreement on four key elements:

1) support schools to develop an emotional well-being policy
2) provide individual one-to-one sessions for children and young people
3) provide training for parents and/or children
4) help schools prepare for Ofsted inspections and to articulate the work of the school in supporting children's emotional well-being

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Learning points and areas for development

While there was no 'magic formula' for workshop delivery, there was some evidence that the initial workshops were better received in some sets of circumstances than others:

- There quite often seemed to be a better response in those pilot areas where dialogue between NHS CYPMHS and schools was at an earlier stage in development, but without significant underlying tensions. In this context, it proved helpful to provide a "*safe environment*" to de-mystify roles and remits, and having external facilitators added value, in moderating the discussions but also in being able to bring their expert knowledge of evidence-based tools and interventions.

- In contrast, the workshops seemed to have been less well received in pilot areas where the delegates were already well informed and were looking to build on very well-established local projects or initiatives. The format was sometimes perceived to be too generic where this was the case and lacked engagement with more tangible joint work that was under way. One CCG representative described the premise of "*broaching difficult conversations*" between schools and NHS CYPMHS as "*patronising*". At the other end of the scale, the workshops also seemed less well suited to areas with more significant underlying tensions where the atmosphere might be too adversarial, with NHS CYPMHS put in the firing line:

  "It was very, very heavily from the school perspective. That's my only downside with doing an exercise like that; there were only a few CAMHS workers. Afterwards they said to me, 'Are you all right?' The schools felt 'it's our opportunity, bosh'. it was very much about them voicing they're not happy with the system."

  (NHS CYPMHS lead contact)

  "To throw us in the deep end, to take the hits, was difficult at times … It was straight into, 'You're not doing, you're not doing' … We had to make friends first, and we didn't."

  (NHS CYPMHS manager)

The above illustrates the importance of tailoring the workshops and development work to the evolutionary stage of the local area and the key leadership role of the CCG and other system leaders including NHS provider managers and local authority leaders.

A further challenge was that the early publicity surrounding the pilot programme had fuelled schools' expectations for 'training' rather than networking. This sometimes created a difficult atmosphere, with some schools feeling short-changed, which put additional pressure on the facilitator to win back the group. These tensions were largely reported to have been addressed by the time the second workshops took place, however, with overall more positive feedback from respondents on the value of attending.

  "The second training tranche was much, much better, much more respectful … we were asked for our opinion about how it should be done."

  (NHS CYPMHS lead contact)

It was generally felt that steps had been taken to rectify gaps in representation, with stronger representation from NHS CYPMHS and a more multi-agency feel within some areas, while single-point-of-contact roles were more developed, and there was a more stable set of key individuals assigned to the pilot. In Chapter 4, we go on to examine the actions that arose from the second workshops in further detail, and the evidence from the CASCADE benchmarking exercise, between the 2 phases.

Staffing and governance arrangements

When applying to be part of the pilot programme, CCGs had to ensure that specialist NHS CYPMHS identified named leads to work with each school. The qualitative interviews showed that these staffing arrangements were influenced by local contexts and relationships between schools and mental health services. Frequently, the case-study interviews highlighted that areas had positioned the pilot as an integral part of CYPMH and Wellbeing Local Transformation Plans, which ran in parallel with wider developments in health and education. Other areas approached the pilot as a distinct piece of work in the early stages but linked in with Transformation Planning over time.

Across the different areas, the pilot was:

- informed by the School Health Improvement Plan
- part of the Healthy Minds Framework covering bronze (awareness of mental health), silver (targeted joint working) and gold (specialist support)
- positioned as part of an Early Help offer and efforts to address gaps locally in primary mental health provision
- linked to emotional well-being policy development
- described as a "smaller step" along the process of the CYPMH and Wellbeing Local Transformation Plan
- one method of triaging referrals, addressing any stoppages in the system via the lead contact while supporting wider systematic change through the already well-embedded Transformation Plan

Reflecting on the pilot design, the NHS CYPMHS lead in **Area L** highlighted how staffing and governance arrangements were developed with sustainability in mind from the outset – a consideration that was at the forefront of many of the local areas that took part.

"We didn't want to have something that was fit for purpose now, but then wouldn't work as we go through transformation … I think we're just on a 2-year post, aren't we, so we're just going to go for 2 years from when we arrived."

<div align="right">(NHS CYPMHS, lead contact)</div>

The **governance arrangements** also needed to be worked through. Although the pilots were all CCG-led, many areas sought to ensure that they were grounded within a wider governance framework for education, health and well-being. In **Area N**, the pilot was closely aligned with the Emotional Healthy Schools Pilot and steering group, and the same clinical lead was responsible for both pilots. As the pilots progressed, sites set up or began to report to some form of steering group. These included: an NHS CYPMHS working group (**Area C**); a steering group comprising headteachers, the children's commissioner, multi-agency Tier 2 support team and NHS CYPMHS (**Area G**); and area-based cluster meetings that fed into the NHS CYPMHS Partnership Board (**Area D**), and subsequently up to the Health and Well-being Board.

Defining the 'single-point-of-contact' role

The evaluation found a **wide variation regarding 'single-point-of-contact' role**. While the DfE and NHS England jointly issued a fact sheet to all areas clarifying expectations of NHS CYPMHS for the role, this was open to varying implementation. Local areas needed to balance capacity constraints, and especially the feasibility of releasing PMHW from existing duties, with the amount of time that was considered necessary to deliver the offer to pilot schools.

We go on to examine these approaches in more detail later in the chapter. Looking across the different pilot areas, however, some of the main differences related to:

- the number of FTE staff performing the role, and the ratios of PMHW to pilot schools
- the grade and experience of the individuals selected, and their professional background and service linkages
- the scope of managerial responsibilities, including whether the role was purely operational, reporting back to the management in NHS CYPMHS, or whether the lead points of contact also had managerial responsibilities
- what the role(s) entailed, including whether there was an element of direct delivery in schools, training and/or provision of information, advice and guidance
- how responsibilities were organised, often either geographically determined (for example, NHS CYPMHS lead contacts operating out-of-locality team arrangements, where covering schools across a wider geographical area) or by expertise (for example, in a few instances, the link worker for special schools was assigned on the basis of prior experience and specialism for special educational needs and

disabilities (SEND), and supported 2 or 3 special schools within the pilot, irrespective of geography)

NHS CYPMHS – pilot staffing arrangements

The qualitative research found that the number of FTE PMHW ranged from 1 to 7. This usually reflected the numbers of schools to be covered, as some pilots subsequently recruited additional schools and were working with 20 or more. It often also reflected the level of staffing that was needed to offer a 'guarantee' of a fixed number of hours of contact time per week with individual schools, where a drop-in arrangement was in place. Typically, NHS CYPMHS teams adopting this approach offered weekly or fortnightly allocated slots within individual schools of between 0.5 and 1 day, although the time inputs quite often changed as the pilots rolled out, and workers developed a better understanding of need. The demands for contact time varied between individual schools, and some – although not all – areas found that primaries rarely required the same level of physical presence for NHS CYPMHS at the school.

Most areas opted for a staffing model based on the secondment of an existing specialist primary mental health worker and backfilled from elsewhere within the service. This decision reflected the short timescale to manage a recruitment exercise and the recognition that the school liaison role required a particular qualities and experience, as it often entailed handling sensitive relationships with schools. A number of areas undertook new recruitment, however, or dovetailed the pilot with the appointment of new NHS CYPMHS posts that were already earmarked within the CYPMH and Wellbeing Local Transformation Plan. One area had already foreseen the need for a Development Worker post, and the timing of the pilot was ideal to draw upon this resource for the local pilot.

With regard to management arrangements, the majority of sites assigned one or more NHS CYPMHS PMHW as the operational lead for the pilot, supported by a senior manager in NHS CYPMHS. In rarer instances, the lead role was performed by a more senior NHS CYPMHS practitioner-manager. This was usually a temporary measure, however, to ensure that the pilot could get off the ground while posts were backfilled. In several areas, the NHS CYPMHS manager undertook the initial liaison and attended the workshops, before posts were filled for the SPOC. This was described as a "*school-by-school*" approach by one NHS CYPMHS representative, who had visited each of the 10 schools individually to build a firm base for the pilot before resource allocations from within NHS CYPMHS were agreed.

Schools – pilot staffing arrangements

There was also variation in the staffing model adopted by schools. Typically, either schools had an operational lead contact, who was supported by a senior manager, or this role was combined where the person undertaking the direct liaison with NHS CYPMHS held a senior management post. Some schools based their lead contact within larger student welfare or pastoral teams, to embed the model and draw upon a wider pool of expertise and capacity more flexibly.

The baseline survey of school lead contacts provides a more detailed breakdown. While not offering complete coverage, it gives a snapshot for almost two-thirds (65%) of all schools within the pilot programme, excluding those that were recruited at a later stage. As Figure 6 shows, the SPOC responsibilities in schools varied considerably but tended to be performed either by an individual with welfare responsibilities or by senior management. While SENCOs and inclusion co-ordinators were the single most commonly reported posts undertaking the lead role, it should be noted that headteachers, deputy headteachers and assistant headteachers made up almost one-third (29%) of the lead contacts within the schools represented in the survey.

Figure 6 In addition to being a lead contact for the mental health pilot, what other role(s) do you have within your school? (school lead contacts)
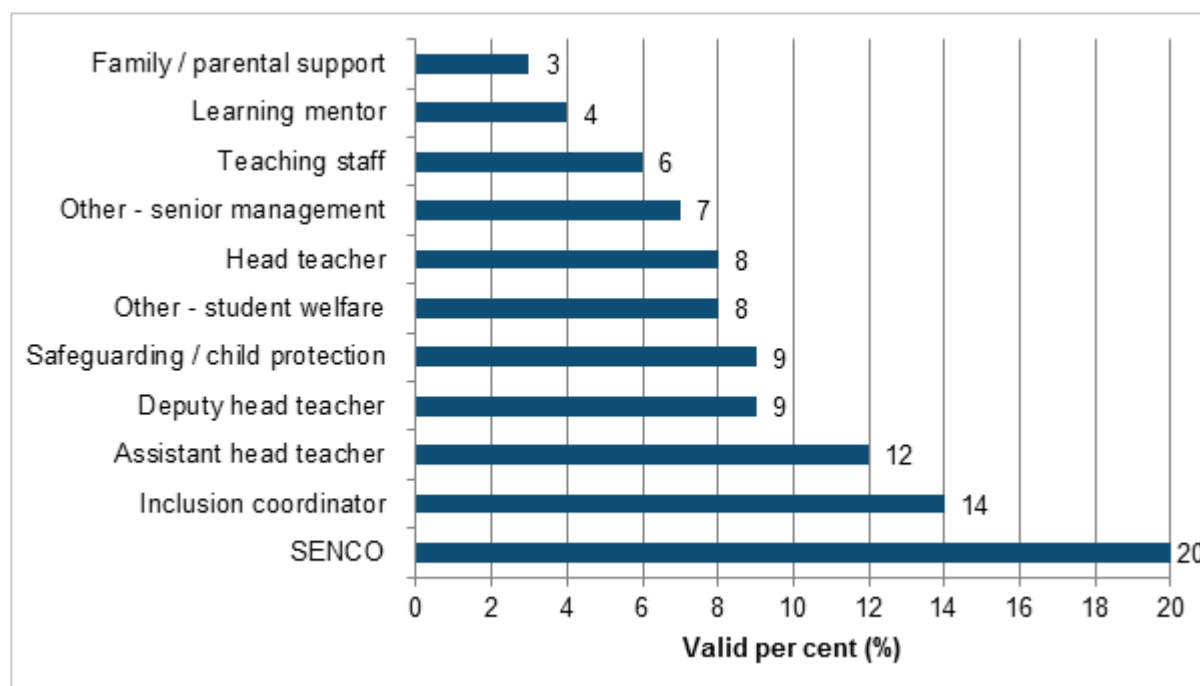
Base: 166 respondents.

Schools varied in the number of individuals who held responsibilities for the pilot, and this had implications for how the pilot was embedded at strategic and operational levels. In **Area O**, the pilot was designed so that each school would have one named lead, as in **Area M**, where the lead was a SENCO. Similarly, in **Area G**, the model was based on one named lead per school (a SENCO, safeguarding officer or assistant head), supported by one or more school staff. Among schools with a single lead, there was a

perception that there needed to be senior support in place if the lead was not a senior member of staff. In contrast, and to support the pilot to become embedded, partners in **Area H** developed a model that assumed that up to 3 people from each school would take on aspects of the link role to help cascade their knowledge and share the load. Across the pilot sites, responsibility for the pilot was given to experienced staff who were already providing welfare support; therefore this proved to be a natural fit, and these individuals were therefore well placed to cascade knowledge to their colleagues.

The school lead contact role was shaped by individual schools, but the role typically included a combination of the following tasks:

- setting aside regular time for face-to-face and/or telephone and email-based contact with the specialist NHS CYPMHS single point of contact

- raising awareness of the pilot within the school; cascading information and ensuring that responsibilities and referral pathways are widely understood

- consulting with colleagues to identify further training needs

- liaising with senior management within the school, to review policies, protocols and resources for mental health support

- planning for drop-in or clinic sessions for staff, parents or pupils, if appropriate

Overall, there was more limited evidence of **mental health professionals from the wider network** playing a more active role in direct liaison with schools through the pilot, although they were engaged to a varying extent through the joint planning workshops and the activities to remodel mental health pathways. One exception to this was found in **Area C**, where 2 educational psychologists were assigned a role to complement the work of the NHS CYPMHS PMHW, and to support schools in developing internal capacity. Several of the areas that were implementing the vulnerable children pilot[27] seemed to have a stronger involvement from VCSOs. Haringey had commissioned 3 local VCSOs to deliver their vulnerable children offer and were keen from the outset to ensure that these arrangements complemented the pilot. In **Area P**, a large children's charity was subcontracted to help boost capacity and deliver the support to primary schools. However, these arrangements were by no means the norm within other pilot areas.

Roles and responsibilities in practice

Although the pilots implemented diverse working arrangements, it is possible to identify a number of broad groupings or types that help distinguish them according to their

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[27] The Department for Education provided additional funding for a smaller number of areas to test models of delivering mental health support to vulnerable groups of children and young people.

structure and purpose. This offers a potentially useful way of comparing and contrasting and considering the relative advantages and drawbacks of different approaches:

a) NHS CYPMHS lead with contact time in schools on a regular basis, delivering services and support directly to staff and young people

b) NHS CYPMHS named lead offering dedicated training and support time to school-based professionals

c) NHS CYPMHS named lead or duty team with designated responsibilities for the pilot, offering single point of access

In the first approach, support from NHS CYPMHS was offered directly to school staff and young people, including an element of school-based contact time (for example, weekly drop-ins). It comprised advice, guidance and training for staff, and some direct work with young people – individually or in groups. It sometimes also included case-holding responsibilities. The second approach was similar in many respects, but with little or no direct work with young people. Here, the role was mainly focused on inter-professional training and support. The third approach did not include significant amounts of time for NHS CYPMHS workers in individual schools. Advice and guidance were more frequently delivered by telephone or email, and there was a greater relative emphasis on improving the clarity of protocols, pathways and lines of communication.

Table 2 provides a more detailed overview of these 3 main types of model.

Table 2 Pilot implementation – 3 different types of delivery model

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	**Potential advantages**	**Potential drawbacks**
• 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	• 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	• 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	**Potential advantages**	**Potential drawbacks**
• 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	• 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	• 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 • fewer co-productive opportunities

- 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)	- 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	**Potential advantages**	**Potential drawbacks**
- 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	- 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	- 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

To help illustrate what these differences looked like in practice, the following case studies showcase an example of a delivery model with a heavy school-based element (type a) and an example of a single point of contact approach (type c).

> ## Case-study example 1 – roles and responsibilities in practice
>
> **Area R –** *NHS CYPMHS lead with contact time in schools on a regular basis, delivering services and support directly to staff and young people*
>
> Prior to the pilot, the CCG and NHS CYPMHS were "*doing a lot of firefighting*" in relation to mental health and wanted to upskill school staff to support children and young people to improve their resilience. By opening up a conversation about roles, responsibilities and a common language, the pilot aimed to increase awareness around mental health being "*everybody's business*". While links were already established between some wider mental health services and secondary schools, the service was patchy and relationships between NHS CYPMHS and schools stretched.
>
> To deliver the pilot, an operational lead was supported by existing link workers, and an additional 0.8 Full Time Equivalent (FTE) NHS CYPMHS primary mental health worker was recruited for the pilot. On the schools' side, there was substantial priority given to recruiting a member of the senior leadership team (SLT) in each school, who was paired with an operational contact – usually the SENCO – to provide a SPOC.
>
> The core offer to participating schools was "*an enhanced link worker model*", which comprised advice, consultation, signposting and close working through training and delivering and workshops in schools. The development and introduction of common outcome measures and awareness raising were supported by notice boards in schools for parents, students and staff. This multi-faceted approach was intended to embed the pilot arrangements within schools at all levels. Having a regular presence for the primary mental health worker was thought to have been essential.

Testing and implementing the single-point-of-contact role

The process for determining the **levels of contact time offered to schools** differed between the pilots. Some used a more consultative approach. In **Area Q**, for example, the NHS CYPMHS lead contact visited all participating schools to develop a local plan using the IAPT Train the Trainer model. In **Area E**, schools were presented with a menu of options that were developed jointly at the workshops and asked to choose which elements they required, **Area I** adopted a similar approach. Other sites developed a more standard offer that was rolled out across all pilot schools. Schools that sought advice from NHS CYPMHS as and when required effectively steered the type of support they received. This was because the service responded to their specific requests.

Case-study example 2 – roles and responsibilities in practice

Area L – *NHS CYPMHS named lead or duty team with designated responsibilities for the pilot, offering single point of access*

Prior to the pilot, local links between schools and NHS CYPMHS were variable but with some areas of good practice. Leading up to the Expression of Interest for the pilot, there was an area-wide review of mental health services. The review identified a number of themes specifically around schools, and the pilot bid was based on the findings. Schools felt that they were not getting the support they needed, specifically for young people with enduring mental health needs, and generally found it difficult to access NHS CYPMHS. Their feelings were compounded by the size of the county and the scale of need, and the service was in crisis from NHS CYPMHS's perspective.

Instead of testing a single point of contact, which was thought to be untenable, the pilot sought to improve access to NHS CYPMHS training and support for schools by making the optimum use of the 2 workshops facilitated by the AFNCCF. As part of ongoing developments associated with Transformation Planning, 2 new staff were recruited and came into post in spring 2016. A school's implementation group was also established. These arrangements were thought to have worked well, and schools reported greater visibility of NHS CYPMHS and improved flows of information. There was also an awareness, however, that the onus was on schools to initiate contact when they had concerns, and further monitoring was planned to test whether the initial momentum could be sustained without a more regular presence in schools.

The qualitative interviews showed that there were varying degrees of satisfaction with the amount of time offered. Many schools valued having consistent and regular contact with NHS CYPMHS. In **Area I**, for example, schools were in regular contact with their primary mental health worker, both in school and outside these times. One respondent commented that "… *she [NHS CAMHS worker] was always at the end of the phone … never gave the impression they were running off*". This was an apparent benefit of strong professional relationships established through a consistent presence in school. In contrast, there were examples where schools had less direct contact time and felt dissatisfied with both the amount and quality of support they received. One secondary school reported having only received 6 out of 10 contact hours promised for assemblies and training, which were poorly received and described as "*dry and not tailored*". This illustrates the importance of service commitment and communication, and also perhaps the importance for the NHS staff in understanding the context and needs of schools.

Other areas had found it less problematic to offer lower amounts of contact time to individual schools. In **Area D**, the 3 NHS CYPMHS leads each provided 2-hour clinic sessions on a weekly basis to groups of 10 schools within the cluster they were supporting. They found this arrangement manageable with largely positive feedback from

schools on the format while observing that there had been relatively few requests for more intensive work within individual schools outside this forum.

The interviews also highlighted where schools already felt that they were operating at a high level of competence and confidence with regard to mental health support and found the pilot arrangements to be of more limited value. In **Area M**, the NHS CYPMHS lead found the time commitments easier to manage than expected because many of the schools were already "*mental health aware*". A SENCO lead contact for a participating school agreed with this, noting that the pilot was "… *nothing I wouldn't do normally*". The only real difference was that she now referred directly to NHS CYPMHS rather than via the school nurse. While the initial referral proved more time-consuming for her personally, subsequent communications required less chasing, so additional resources were not required.

There were also examples of schools that were making limited use of the available resource, where the issue seemed to be more one of disengagement with the pilot. One school interviewed had not yet made contact during the dedicated time slot for the NHS worker and consequently had not had any interaction outside cluster meetings.

Looking across the pilot case-study sites, the purpose of the contacts generally fell into one of the following broad categories: training (sometimes accompanied by direct case work with children and young people); information, advice and guidance; and systems/policy development. In practice, these were often interrelated.

Delivery of training in schools

All sites incorporated some form of **training** for schools. In **Area Q**, bespoke training sessions were split in two. The NHS CYPMHS lead spent half the time delivering training to staff and the remainder answering questions about specific children and young people. Often, the sessions would overrun, but teaching and support staff found the built-in opportunity for dialogue very helpful, providing evidence of flexibility to meet schools' needs. In **Area I**, the aim was to train up the school leads first as school champions; experts who would then be able to cascade their knowledge. The training was run in two hour slots. Frequently, NHS CYPMHS leads delivered mental health awareness training alongside already pre-scheduled training activities for schools, which helped to avoid placing high levels of additional time expectations on school staff and worked well around inset days. **Area M** offered bespoke training to staff as and when required, as did **Area E**, delivering training to teaching assistants at one school on autism-spectrum disorders when a need was identified.

Where schools received training, it was often considered to be just the start. A school in **Area I** said that while staff had become experienced in one area, they were not yet confident to train others and would need more training. Partners in **Area B** developed an NHS CYPMHS training pathway for schools to consider. Mental health leads worked together to provide further training and support through quarterly clustered locality

meetings. There were other examples of pilot schools coming together to **develop discussion forums and share learning**, in addition to the area-based cluster structure operating in some CCG areas. Some training was delivered to school and professional groups, for example group training for SENCOs in **Area I**.

Examples of joint working between schools and NHS CYPMHS

One of the features of the pilot that schools and NHS CYPMHS reported as being noticeably different in some areas was the opportunity for **joint working** throughout the duration of the support or treatment for the young person. These lead contacts described a shift in mind-set between seeing the referral process as a hand-off between 'education' and 'health' (or vice versa) under the previous arrangements, to a more integrated model based on joint planning, observation and review under new arrangements. Key enabling factors included having a designated point of contact with whom there was a trusting relationship, and where there was a genuine mutual recognition of professional expertise. As one school lead worker commented: *"There is value in having someone from outside. You need someone else to see it … that's why the trusting relationship is so good."*

Where this model worked well, the NHS CYPMHS worker was able to capitalise on the regular contact between the young person and the school to help prevent disengagement. The school lead contact could remind parents and young people about upcoming appointments, where a potential risk of non-attendance had been flagged. There was also a reduced risk of professionals being blindsided by changes in circumstances for individual families that they were not in a position to observe. So, for example, in one case the NHS CYPMHS worker expressed concerns that a family had become non-responsive, but the school was quickly able to establish that there had been a change of address. In another example, a school lead contact described feeling much better able to support a child who had experienced a significant traumatic event at a younger age, where there was a dialogue with the health worker. They described how, prior to the pilot, there had been very little feedback from NHS CYPMHS.

In the best examples where NHS CYPMHS staff were seeking to transfer skills and expertise to schools, this included elements of coaching, advice and joint work, with the aim of building capacity and reducing dependency on the health worker.

In **Area Q**, an NHS CYPMHS lead reported that by delivering support directly in schools and helping staff to better recognise the early presenting signs of mental health issues, school staff were better equipped to identify an inappropriate referral. A combination of training and direct work with young people in **Area I** helped staff to develop the confidence to move forwards with new skills.

> *"With a young person where they (the school) have started to work and got stuck, we've actually started to work jointly and see the resources, methods and strategies to use ... kind of like training on the job, they can take notes and observe what's happening. We have used a combination of things. They can come*

*and discuss a case and then brief them of what might be the next helpful step …
giving advice and guidance rather than seeing them more myself.”*

(NHS CYPMHS, lead contact)

As a result of the pilot, one school began working with a school nurse to deliver focused support to children on anxiety. A number of case-study examples are provided in the following boxed example.

Case-study examples: joint working between schools and NHS CYPMHS

Example 1 (**Area R**) – the school lead contact was alerted to concerns about a pupil who had been self-harming, and whose attendance had worsened. The NHS CYPMHS worker attended a panel meeting at the school to discuss the case and agreed that a clinical assessment was needed. The assessment took place within 2 weeks and was also attended by the Family Support Worker (FSW) from the school, who had a positive relationship with the young person. The assessment concluded that the young person was feeling low, but their needs could be met without an outbound referral. Weekly meetings were scheduled with the FSW, with guidance from the NHS CYPMHS lead contact. The young person showed a significant improvement at the 6-week review point, and the intervention was concluded.

Example 2 (**Area R**) – a young person was referred to the school lead contact, following a period of rapid weight loss, changes in behaviour and falling asleep in class. The school immediately contacted the NHS CYPMHS lead contact, who was able to oversee a referral to specialist NHS CYPMHS. An assessment took place within 7 days. With consent, a copy of the report was shared with the school, confirming that the young person had an eating disorder. The NHS CYPMHS lead contact followed up with their counterpart within the school to discuss the treatment plan, which included the need for a reduced timetable. Regular reviews have been held since, including the young person, parent, school and NHS CYPMHS clinician. The inclusion of the school in the treatment plan was an unusual step, which highlighted the flexibility within the working arrangements for the pilot.

In a small number of sites, joint working was extended further. In **Area I**, NHS CYPMHS also completed some home visits to engage parents. Where the pilot offer was less intensive in **Area E**, parents who were experiencing mental health issues and would not engage with school were reached through parents' surgeries. In **Area R**, there was an example of joint working where young people were engaged to help deliver resilience training to children. In **Area C**, the pilot ran alongside a re-launch of the telephone duty response line, which was made available to pilot schools.

Several sites operating both more and less intensive pilot models did some work around developing outcome measures (**Area G**, **Area R**). While not all areas provided training to schools on using **common outcome measures**, there were a number of examples where this was managed successfully, resulting in improvements to data quality. Key learning points included the importance of NHS CYPMHS providing a clear explanation of what was being collected and why, and the importance of taking time to equip schools to administer the tools and to understand the results.

> **Case-study example: effective use of common outcome measures**
>
> In **Area I**, the PMHWs provided training to their counterparts from the pilot schools in the use of validated outcome measures. The aim was to help school staff make better informed decisions about referral pathways for individual children and to provide the PMHWs with "… *a little bit of extra evidence*".
>
> The model was discussed at the evaluation case-study visit and was generally agreed to have worked well. School staff liked the fact that the tools helped to "… *raise more questions*" during the initial conversation with the child, which might not have been covered intuitively. They also took reassurance from the clinical significance of the results, which had allowed them to refer with greater confidence when necessary.

Communication and reporting arrangements

All pilot sites involved some degree of **direct communication with specialist NHS CYPMHS**, whether that was part of regular dedicated contact time on school sites, as part of initial introductions to NHS CYPMHS leads or through meetings. In **Area I**, PMHW shared email addresses and telephone contact details to support communication between the weekly sessions and beyond the end of the pilot. This also enabled greater flexibility in how and when schools used the weekly sessions. Here, they also shared presentation slides if people missed sessions to help raise awareness and increase knowledge and skills around mental health.

Where NHS CYPMHS were not regularly present in schools, having an individual named lead contact could be particularly significant. Often, having the name and contact details for a named worker brought reassurance and clarity when trying to distinguish between presenting behaviours relating to a mental health issue and those relating to conduct disorder or behavioural difficulties. However, in **Area E**, a school lead contact did report bypassing their NHS CYPMHS lead because they already knew the relevant clinician for a specific case. Furthermore, a school in **Area C** continued with business as usual, querying the benefit of a named lead if this did not increase capacity by helping to deliver interventions in schools. This particular example related to miscommunication at the start of the pilot, as the school was expecting to receive additional in-school specialist time from NHS CYPMHS, but this was not part of the offer developed for the pilot.

In several areas, the school lead contacts had **additional access routes** to support lines of communication. **Area Q** used a bespoke booking system for the lead contact pilot, which covered communications around consultations, assessments and IAPT Train the Trainer training. In a number of other areas, the school lead contacts were also able to access the duty lines via the established triage system.

In several areas, new triage systems offered a single point of entry for these lines of communication to feed into. Introduced within the CYPMH and Wellbeing Local Transformation Plan, the pilot offered opportunities to test these new arrangements as well as the extent to which the 'single point of contact' had an impact on the effectiveness of existing systems. In **Area Q**, NHS CYPMHS leads undertook daily screening and weekly case allocation, working through the referrals with their teams. A large part of the pilot locally involved triaging cases that would not have otherwise been picked up:

> *"If we know the school of a referred child or young person, we now always allocated it automatically to the relevant link worker. I would say that we can deal with 3 cases at a time per school site. We have quite quickly worked through schools' waiting lists that way."*
>
> (NHS CYPMHS lead)

In some areas, the pilots used existing referral forms and processes, while other sites saw this as an opportunity to introduce new and improved protocols and accompanying guidance. **Area C** developed a written tool for schools to help staff who are not mental health professionals gather the necessary information to give NHS CYPMHS staff what they need to identify the appropriate next steps for the child. This covered guidance on the child's presenting behaviour; acknowledging any gaps and limitations in the reliability of evidence; identifying any aggravating factors; proactive and resilience factors; and sharing information about previous interventions.

While the individual contact between NHS CYPMHS and schools was a key feature of the pilot, a number of sites also made use of **multi-agency panels or forums** to share information multi-laterally. This generally happened in one of 2 main ways:

- through a dedicated mental health forum of some kind
- by linking into multi-agency panels, such as Early Help or locality hubs

In **Area F**, the pilot working group provided an opportunity to maintain ongoing involvement in decision-making, alongside health partners and other CYPMHS, to share experiences and to troubleshoot. The school-to-school format was particularly valued, although some schools felt the strain of attending additional meetings, and this was understood to be time-limited. Other sites already had an established mental health forum and were able to link into this**.**

In a number of the sites, the NHS CYPMHS lead contact was also represented on local multi-agency panels. This arrangement was generally intended to help maintain the

profile and visibility of the pilot, to gather intelligence and to input to more complex cases involving the pilot schools. In **Area G**, a steering group worked well to help clarify the purpose of the pilot, manage messaging, secure buy-in and essentially make the pilot happen. This led them to conclude that this governance model would be replicated in future. In **Area B**, the NHS CYPMHS lead contact was represented on the Early Help panel, which provided an overview of cases referred by schools:

> "*There was a perception from schools and other partners that things went into the CAMHS system and were lost … Now with [lead contact] sitting on the panel, when they bring a case, a child, a family, when there's a blockage, and they say 'Well, we referred to CAMHS and they haven't done anything', [lead contact] is able to say, 'well actually, we did offer this', 'the reasons why we closed is this' or 'we are still involved, and this is our plan of action' … So it's been really useful*"

<div align="right">(NHS CYPMHS manager)</div>

In a further local pilot (**Area R**), the pilot provided leverage to secure NHS CYPMHS representation on the multi-agency Permanently Excluded and Vulnerable Pupils (PEVP) panel, which covers 6 secondary schools and 43 primaries. This proved to be hugely beneficial as a forum for making decisions about NHS CYPMHS inputs to individual cases and keeping an open line of communication with key partner organisations. A significant proportion of referrals to the panel were found to include young people with mental health needs, and the panel discussions allowed NHS CYPMHS to input to the transitional arrangements for these young people, at a critical time during their education.

Elsewhere, there were mixed views on the extent to which the pilots had meaningfully engaged partners within the wider network of CYPMHS. Concerns were voiced in several areas about the exclusivity of the SPOC model, which was perceived to have focused on bilateral communication between NHS CYPMHS and schools but with more limited value for School Nurses, Educational Psychology and other partner organisations. It was questioned how far it would be possible to achieve the objective of making better use of existing resources, where the pilot model was too narrowly defined. The fact sheet issued jointly by the DfE and NHS England sought to provide further clarification, by emphasising the importance of engaging a wide range of specialist staff beyond NHS CYPMHS. This engagement with a wider tier of partner organisations was certainly much more apparent within the second of the workshops within many of the pilot areas.

Barriers and enablers to effective delivery

One of the major barriers encountered by the pilot was the finite capacity of professionals within schools and NHS CYPMHS. Within and across the pilots, tailoring the NHS CYPMHS offer and being flexible proved critical to meeting schools' needs and ensuring effective engagement. In **Area I**, there was initially variable take-up for the offer, with feedback showing that some schools found the weekly slots too much to manage.

Combining the training offered through the pilot with pastoral training proved an effective way of streamlining the offer and minimising the time burden on school staff:

> *"Time is always something that you need, and this can become strained … [so] we looked for a slot where we were coming together anyway. The training took place during a pastoral meeting, and that ensured that we were on board with it."*

<p style="text-align: right;">(school lead contact)</p>

NHS CYPMHS commonly found that teachers' inset days were already booked up by the time the pilot was approved. This often posed a challenge with scheduling training dates, as most school staff had very limited availability. A range of approaches were taken to deliver training as flexibly as possible, including as part of twilight inset sessions, whole school training and during SENCO development days. Teleconferencing was sometimes said to be enough for schools who were clearest about what they wanted to do.

In some areas, it was thought that capacity issues were greater where the school lead contact for the pilot had too many separate responsibilities. One area found that the combination of safeguarding lead and lead contact for the pilot had been too much in some schools, while the NHS CYPMHS lead contact in another area commented that one of their counterparts in a local secondary school was "*wearing too many hats*" and had struggled to commit the time that was needed to set the joint working arrangements in place. The key learning point was to make the tasks and time commitments transparent from the outset and to ensure that the individual taking on the lead contact role was fully aware.

Managing changes to staffing capacity also proved challenging, particularly within the short timescale for the pilot. Recruiting and backfilling roles proved to be time-intensive. Several of the pilots discovered a great need for administrative support, which is an important consideration for any future roll-out. In **Area Q**, NHS CYPMHS found that they were spending double the amount of time they had originally dedicated to each school when they accounted for the planning and administration needed to make this happen. Administrative resourcing requirements were also emphasised by a special school that found the 2 different referral forms they were asked to complete very time-consuming. They had to bring in additional support from the wider pilot team to cover this task.

A further challenge related to getting the best out of regular time slots within schools, where these were offered. Some areas had encountered difficulties where the NHS CYPMHS lead contact attended a regular slot only to find that nothing had been planned, and there had been no awareness-raising internally to the school, resulting in wasted time. Conversely, some schools were reported to have unrealistic expectations of what was possible to achieve in the weekly or fortnightly slots and tried to schedule too much. In one area, these sessions were intended for staff consultation and training, but the schools had increasingly used the slots to book consultations with young people, which was not the intended purpose. The key lesson learned from these experiences was to

ensure that the purpose of drop-in sessions was clearly outlined at the outset; that schools were encouraged to prioritise the finite time available, and to review and reduce or cease drop-in sessions where it was clear that they are not being supported.

Enabling factors

A number of common factors were found to have been critical to successful implementation of the pilots.

The **personal attributes of the lead contacts** and the relationships they were able to develop were reported to have been important to support joint working. Lead contacts needed to be flexible, proactive and willing to adapt to a school setting and the *"language of schools"* rather than perceiving the role as being a purely instructional one, which sometimes risked patronising schools. One school lead contact reported that:

> *"The whole process has been really easy because of the type of person [NHS CAMHS lead contact] is. She's very approachable; she has made every member of staff and every person on that training feel very valued. She said 'You guys have got so much knowledge'. She started in a very positive way, as opposed to 'the problems CAMHS have with schools'."*
>
> (school lead contact)

Areas that were working with multiple schools could sometimes see first hand how the differences in the effectiveness of engagement came down to personal attributes and commitment: *"It really does come down to individual working relationships."*

Relatedly and importantly, across the sites the need for **support from the SLT** was highlighted to help overcome barriers to engagement. Schools needed the SLT to release staff to attend training or workshop activities associated with the pilot. It was important to ensure that both schools and mental health workers could fulfil their responsibilities within the dedicated time.

> *"You have to be really clear about what is needed. As a head, you have 5 or 6 projects working at the same time; we are very project heavy at the moment, as all good things are coming out at the same time, and you don't want to miss out ... if you are very clear at the beginning, this only happens if school does this and this, then will make sure it happens ... if it's a bit wiffly [sic.], then it may not happen."*
>
> (headteacher, pilot school)

Interviewees in **Area R** also highlighted how important strategic support was for successful implementation.

> *"If you have a single point of contact, that person has to believe in the importance of mental health. And they have to be part of the Senior Leadership Team. They need to be able to make choices and decisions in collaboration with our service. It*

feels more important that they are in the Senior Leadership Team than that they are the SENCO."

<div align="right">(CCG lead contact)</div>

Finally, the experience of the pilot programme has underlined the **importance of local context**. There really was no single 'one size fits all' model, and any generalisations about what works best for particular types or profiles of schools quickly fall down when the pilot areas are compared. This was apparent from the contrast between one area (Birmingham), where the perception of one NHS CYPMHS primary mental health worker was that "*primary schools hardly need anything and secondary could fill a whole day a week or more*", and another (**Area C**) where large inner city primary schools were presenting with high levels of need and where the single point of contact arrangement was often thought to have been the most impactful. These examples illustrate how a bottom-up and needs-led approach was essential for planning and delivering the pilots.

4.0 Impacts and outcomes

Key findings

Professional knowledge, awareness and understanding

- The survey evidence demonstrates that the intended knowledge and awareness-related outcomes were largely achieved. Eight in 10 of all respondents (80%) either agreed or strongly agreed that the pilots had improved their knowledge and awareness of mental health issues affecting children and young people.

- All of the school lead contacts who were surveyed reported being aware of a range of risk factors and causes of mental health issues at follow-up stage, and all but one felt equipped to identify behaviour that may be linked to a mental health issue. The improvements from baseline to follow-up (+10 months) were statistically significant.

- There was also a statistically significant improvement for all knowledge and awareness-related measures reported through the 'whole school' version of the survey. This provides a strong indication that the schools were successful in cascading the benefits of the programme beyond the SPOC.

- The qualitative interviews show that the reassurance and additional support provided by the NHS CYPMHS worker often helped to alleviate anxiety that had built up, where school staff had been operating beyond the margins of their expertise.

- The qualitative evidence demonstrates that the programme helped to improve the confidence of health professionals of working in a school environment within many areas. Spending time with staff around the school day helped to gain a better sense of routines and time pressures, and enabled support to be tailored accordingly.

- While no simple causal relationship was found, outcomes were generally less pronounced where links were already well established prior to the programme. They were also less apparent in those pilots where there were significant delays and where activities were not delivered at the intended scale or level of intensity.

Joint professional working and communication

- The evaluation found strong and direct evidence of increases in the frequency of contact between schools and NHS CYPMHS. Well over one-third of school lead contacts reported being in 'continuous' contact by the follow-up survey. There was a smaller increase in contact with other school-based mental health professionals.

- The qualitative interviews further demonstrate the improvements to the quality of communication and working relationships between schools and NHS CYPMHS. School lead contacts generally reported having a better sense of NHS CYPMHS

capacity constraints and thresholds, and vice versa regarding issues facing schools.

- Overall, there was a sizeable increase in the proportion of school lead contacts who felt that it was either 'easy' or 'very easy' to arrange a consultation with specialist NHS CYPMHS when they needed one, rising from just under one-half of respondents at baseline, to just over three-quarters of respondents by the follow-up stage.

- Across all surveys, well over three-quarters of all respondents agreed or strongly agreed that the pilots had improved their understanding of the referral routes to specialist mental health support for children and young people in their local area.

- 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 the pathways and ongoing contact with NHS CYPMHS.

Service and systems outcomes

- The CASCADE framework showed an overall positive change to collaborative working within the pilot areas, based on self-assessment data from the 2 joint planning workshops. The mean score improved across all 7 indicators between each stage, although some areas continued to report significant challenges.

- The largest changes using CASCADE related to the clarity of professional roles within local CYPMH services. The changes were smaller regarding the use of common outcome measures and the take-up of evidence-based interventions

- The evaluation found some evidence of improvements in the availability and resourcing of mental health support within pilot schools, although much of this work was still under development at the stage when the research took place.

- The types of provision showing the greatest increase in availability in pilot schools included: therapeutic support/interventions, staff training and whole school strategies. By the end of the programme, the most widely offered provision included staff training, educational psychological support and learning in the curriculum.

- Nearly all NHS CYPMHS responding to the follow-up survey reported improved working methods and processes with pilot schools. Many had developed new school-specific resources, including new referral protocols and feedback forms. A few areas had developed new school mental health quality marks or accreditation schemes.

In the previous chapter, we examined how the pilot programme was implemented at a local level, including the perceived effectiveness of the different models of joint working between schools, NHS CYPMHS and other CYPMHS. In this chapter, we review the extent to which the pilot programme achieved the intended impact and outcomes. The chapter is structured into 3 main sections:

- first, we consider the outcomes relating to the knowledge, awareness and understanding of different professionals – both individuals and groups

- next, we examine the outcomes relating to joint professional working and communication, with a focus on the links between schools and NHS CYPMHS

- finally, we consider the impact of the pilot programme on systems and services transformation, at local area and organisational levels respectively

The chapter draws upon all strands of the data collection and analysis, and takes a programme-wide perspective. It should be noted, however, that there was considerable variation in the extent to which individual schools, NHS CYPMHS and CCGs attributed change to the pilot programme. While no simple causal relationship was found, there is some evidence to suggest that the outcomes were weaker for those schools, NHS CYPMHS or CCGs where practice was already considered to have been very well established prior to the pilot programme and for whom the net additional gains were smaller. Outcomes were also less apparent where significant delays were incurred in the recruitment or secondment of SPOC and where the local model was not therefore delivered at the intended scale or level of intensity.

The pilot programme was rolled out against a backdrop of heightened policy and practice interest in children and young people's mental health. All areas were at various stages in implementing the funded actions within their Transformation Plans, and in many cases the pilot programme was consciously aligned with other activities to boost local mental health provision. While clearly advantageous, this does entail that certain measures, including those relating to staff awareness and school-based funding for different types of mental health provision, are likely to include an element of deadweight, which we can only estimate, given that a quasi-experimental design was not feasible. A number of self-report questions were administered across all surveys at the +10 months stage to provide a broad measure of attribution for the primary evaluation outcome measures. Data and methodological considerations are further discussed in Section 1.2.

With these caveats and points of clarification in mind, we will now review the detailed evidence under the following 3 key headings:

- professional knowledge, awareness and understanding

- joint professional working and communication

- service and systems outcomes

Professional knowledge, awareness and understanding

Looking across the combined surveys at the follow-up stage, it is apparent that there was considerable success in achieving the intended knowledge and awareness-related outcomes for the pilot programme. The highest overall agreement within the combined surveys at +10 months related to respondents' **knowledge and awareness of mental health issues affecting children and young people** (*n* = 215). On aggregate, 8 in 10 of all types of respondents (80%) either 'agreed' (60%) or 'strongly agreed' (20%) that the pilot had brought about improvements, with the strongest agreement found among the school lead contacts.

The survey of school lead contacts allows for a further breakdown. The survey respondents were asked to rate 6 attitude statements/categories using a 4-point scale (from 1 = strongly disagree to 4 = strongly agree). These statements included:

A. I feel equipped to identify behaviour that may be linked to a mental health issue.
B. Appropriate support to identify mental health issues in pupils is available in my school for all classroom teachers.
C. I know how to help pupils with mental health issues access appropriate support.
D. I am knowledgeable about a wide range of mental health issues.
E. I am aware of a range of risk factors and causes of mental health issues in children and young people.
F. I know all I need to support children with different mental health needs in my classroom.

Figure 7 To what extent would you agree/disagree with the following statements about your knowledge of children and young people's mental health? (school lead contacts)

Base: 49 respondents.

73
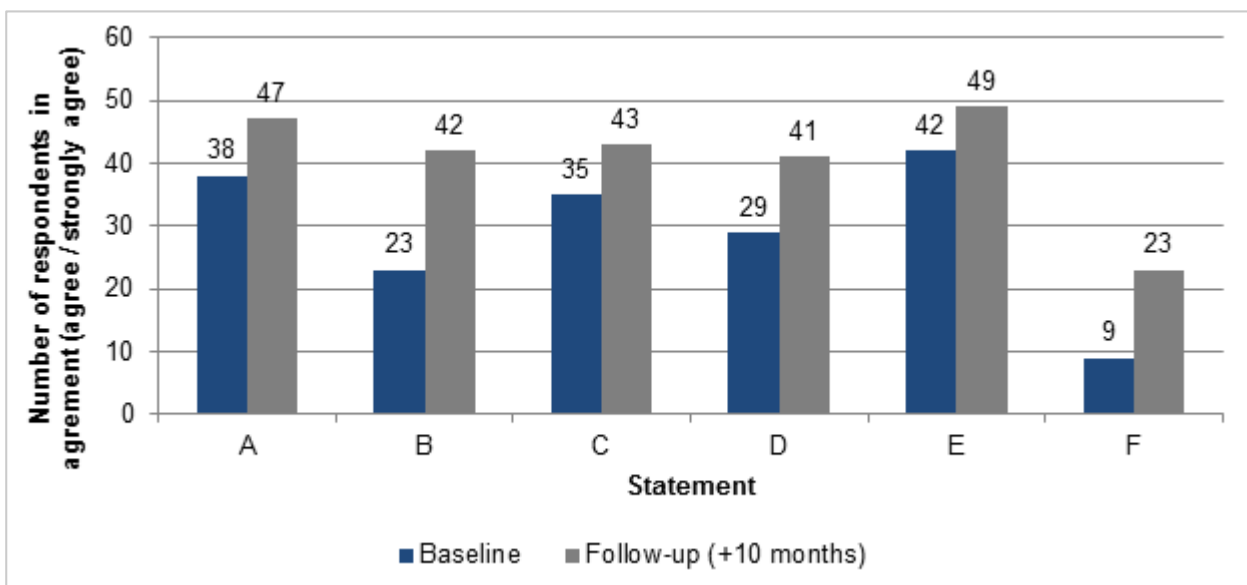
Figure 7 plots the numbers of respondents who agreed or strongly agreed with the scaled attitude statements at baseline and +10 months, respectively. The chart shows that there was a marked shift across all statements. By the end of the pilot, all 49 school lead contacts responding to the survey reported being aware of a range of risk factors and causes of mental health issues in children and young people (E), while all but one agreed that they felt equipped to identify behaviour that may be linked to a mental health issue (A). Statement F (support in the classroom) showed the greatest level of improvement between the 2 points in time but still ranked lowest overall, with just under half of respondents (47%) in agreement at the final survey point.

To further test the extent of these changes, the responses to each statement were ranked from 1 (strongly disagree) to 4 (strongly agree) to generate mean scores at each survey point. A paired t-test was then applied to test for statistical significance, with the null hypothesis that the mean at baseline is smaller than the mean at the follow-up stage. The results were found to be highly significant at the 1% level for 5 of the 6 statements (A, B, D, E, F) and significant at the 5% level for the statement relating to knowing how to help pupils with mental health issues access appropriate support (C).

Table 3 Average rating of knowledge and confidence: baseline and +10 (school lead contacts)

Statement	A	B	C	D	E	F
Mean baseline (standard error)	2.98 (0.09)	2.57 (0.12)	2.94 (0.10)	2.65 (0.09)	2.96 (0.08)	2.07 (0.09)
Mean endline (standard error)	3.20 (0.07)	3.12 (0.08)	3.19 (0.09)	2.98 (0.08)	3.25 (0.06)	2.54 (0.11)
Paired t-statistic	−3.02***	−3.76***	−2.38**	−3.65***	2.83***	−0.415***

*Significant at the 10% level; **significant at the 5% level; ***significant at the 1% level.

The same statements were asked of respondents to the 'whole school' version of the survey. While levels of knowledge and awareness were lower than for the school lead contacts across all categories at baseline and at the follow-up stage, the overall extent of improvement was greater for the whole school group than for the school lead contacts. The results were found to be highly significant at the 1% level for all 6 attitude statements (A, B, C, D, E and F[28]). This would seem to indicate that the pilot had a contributory role to play in raising awareness of mental health issues beyond the immediate points of contact for the pilot. Indeed, respondents to the whole school survey also showed a high level of agreement to the survey question where they were asked to rate the contribution of the pilot towards a number of outcome measures.

The qualitative interviews largely support the survey evidence. The frequent contact with the NHS CYPMHS link worker often proved invaluable in supporting school staff to

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[28] Sample sizes for the whole school version of the survey were $n = 552$ respondents at baseline stage and $n = 95$ respondents at the follow-up stage as a result of attrition.

distinguish between presenting behaviours relating to a mental health issue and those relating to conduct disorder or behavioural difficulties. School staff routinely valued this support as part of their everyday practice, as well as being able to access advice on more complex cases when they needed it (for example, involving ASD/ADHD).

The reassurance and additional support provided by the NHS CYPMHS worker sometimes helped to alleviate tensions that had built up, where school staff felt that they had been operating beyond the margins of their expertise in managing children with mental health issues within a classroom setting. Anxiety levels were reported to have been running high in some schools, and having access to the NHS CYPMHS worker made quite a significant difference to staff confidence and morale.

> *"If you've got teaching staff that are anxious about managing a child who is anxious, it cascades up to the parents, and everybody is anxious … everybody gets really worked up. So it's about containing the situation by helping staff to manage, and then it cascades down and calms down. It's managed in a much better way … I think schools feel much better reassured and informed."*

<div align="right">(NHS CYPMHS lead worker)</div>

The qualitative interviews underlined that the pilots also helped to improve the knowledge and awareness of health professionals of working in a school environment. At a strategic level, the pilot afforded local NHS CYPMHS teams with the opportunity to test models of effective engagement with schools and to identify how best to secure the backing of senior management. At an operational level, the direct contact time within schools often proved invaluable for NHS CYPMHS workers to gain insights into the parameters within with school staff operated, as well as being able to observe students within a peer-group setting and to benefit from the schools' insights into their family circumstances.

Spending time with staff around the school day helped to gain a better sense of routines and time pressures, and therefore to suggest tools or approaches that were realistic to implement within a classroom setting. In some instances, this centred on drawing attention to how noise levels were compounding issues of stress and anxiety among students in ways that were overlooked by school staff as a result of being immersed in this environment.

It was also apparent that improvements to the mental health knowledge and awareness of school staff had contributed towards **increased capacity and capability for preventative mental health and well-being support**. Although it was less common for schools to report delivering 'interventions' per se, it was certainly the case that many were willing to engage in preventative work with young people, where the default response would have been to make a referral. NHS CYPMHS lead contacts often adopted a scaffolded approach to build levels of competence among staff. This ranged from providing elements of direct intervention with individual children and young people alongside school staff to lighter-touch monitoring and advice when needed (described by

one primary mental health worker as "watchful waiting"). This approach often had mutual benefits in up-skilling school staff, while reducing their dependency on external support for lighter-touch work. One NHS CYPMHS manager (**Area M**) estimated that the improved confidence of school staff had saved the equivalent of 30 to 40 telephone calls to NHS CYPMHS across the pilot schools, under business as usual.

In a few cases, NHS CYPMHS observed a real shift in the willingness of schools to engage with issues affecting groups of children and young people. One such example related to a cluster of self-harming, which schools had found particularly challenging:

> *"In a school you may have a child who is self-harming, but there is a ripple effect on the peers and the school not dealing with that. Having [the NHS CAMHS lead contact] in a school means that you can advise and guide them. So, you can go in and do casework with the young person that needs direct support and input, but the peers may have a very different, more preventative issue, and schools are quite anxious about dealing with that … Those are the types of things that probably get prevented and we don't see coming through."*

<div align="right">(NHS CYPMHS, manager)</div>

At a strategic level, these improvements were sometimes evident in the confidence of senior management to benchmark their practice, as part of the school improvement cycle. The knowledge gained through the pilot was an important enabling factor:

> *"As with SEN policy, we are adopting a 'plan, do, review' approach with mental health. Now we are able to review and try alternatives, because we know what they might be [following the pilot]."*

<div align="right">(headteacher)</div>

The survey showed an overall moderate increase in confidence among school lead contacts in talking to students about mental health and well-being issues, and an overall increase in the frequency of doing so, between the survey points. School leads reported talking more frequently to students about mental health issues than whole school respondents, at baseline and +10 months. The proportion of school leads reporting at least 'weekly' contact with students rose from 18% at baseline to 43% by the end of the pilot. However, respondents to the whole school survey reported the greatest proportional increase in the frequency with which they talked to students.

Perhaps surprisingly, whole school survey respondents reported greater average levels of confidence in talking to both students and parents about mental health issues at baseline and +10 months, compared with school lead contacts. Moreover, the increase in confidence between the survey points was highly significant at the 1% level.

Joint professional working and communication

The evaluation found **strong and direct evidence of increases in the frequency of contact between schools and NHS CYPMHS** within the pilot programme, along with changes in the mode and purpose of communication in many areas. The pre/post survey of school lead contacts underlines these changes.

Figure 8 Approximately how often did you have contact with the following mental health professionals – NHS CYPMHS (school lead contacts)
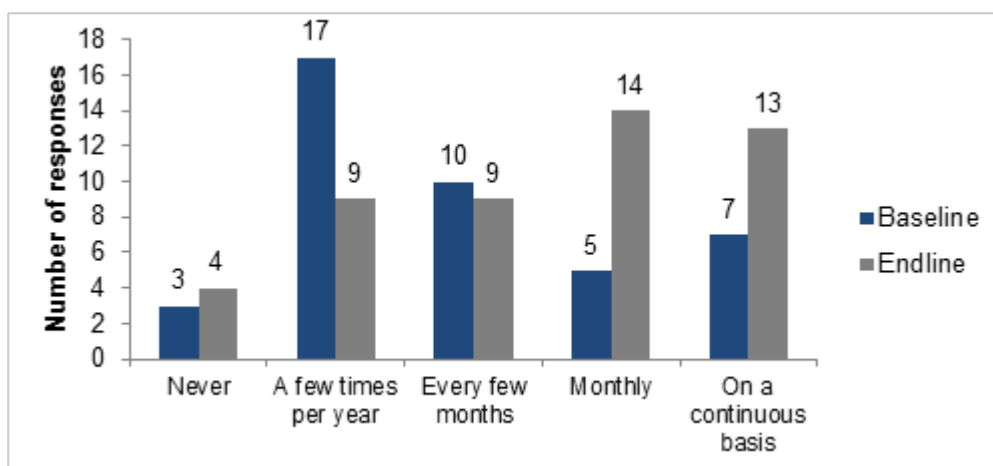
Base: 49 respondents.

As shown in Figure 8, there was a change in the modal category of school leads reporting contact with NHS CYPMHS "a few times a year" at baseline[29], to "monthly" at the follow-up stage. By the time the follow-up survey took place, well over one-third of school leads were in contact with NHS CYPMHS "on a continuous basis". These trends are much as would be anticipated, given the single-point-of-contact model and the expectations on pilot sites.

The school lead survey also found an overall increase in the frequency of contact with professionals providing mental health support within schools, although the extent of change was smaller than for NHS CYPMHS (Figure 9). Contact with other (external) mental health services showed less change during the programme, but there was an

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[29] The baseline figure refers to the 2015/2016 school (academic) year, covering the 12-month period from September 2015 to September 2016.

overall reduction in the proportion of respondents who reported zero contact at baseline, while a greater proportion of respondents had contact "a few times a year".

Again, the qualitative evidence largely supports these findings. The workshops often assisted with brokering contact between school lead contacts and professionals from other organisations within the wider CYPMHS network, although, as we discussed in Section 3.1, the multi-agency composition of these workshops varied considerably.

Figure 9 Approximately how often did you have contact with the following mental health professionals? (school lead contacts)
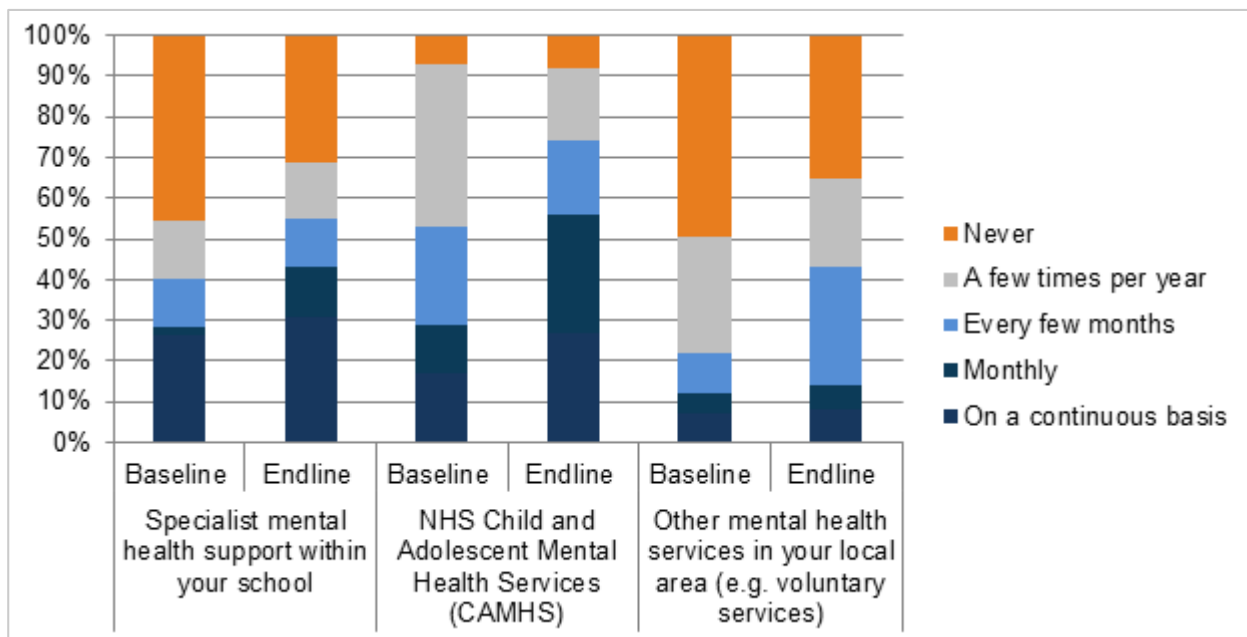
Base: 49 respondents.

Alongside these more objective measures, the qualitative interviews underline the role of the SPOC in driving up the **quality of communication and working relationships between schools and NHS CYPMHS**. Lines of communication varied considerably between areas (and individual schools/NHS CYPMHS teams) prior to the pilot programme, with some stakeholders reporting strained relationships arising from a mismatch between schools' expectations and NHS CYPMHS capacity. The pilot provided an opportunity to better understand challenges and strengths, and to build trust where this had been lost. This was achieved through small steps and a willingness to "start afresh". For example, school staff in one area described a real step change with the pilot, citing a low point in relationships in the previous year when NHS CYPMHS had written to schools to raise the issue of poor-quality referrals, which proved to be antagonistic. The workshop kick-started a new working relationship and laid a foundation for the pilot.

School lead contacts generally reported having a better sense of the capacity constraints within which NHS CYPMHS teams were operating, while their counterparts reported better understanding the daily pressures faced within the school environment. A prerequisite for this improved communication was to recognise the shared goals around

providing holistic support for children and families, and reducing the impact of academic pressures on their social and emotional well-being.

When **different types of contact with NHS CYPMHS** are examined, there was an overall shift away from engagement via panels or case reviews, towards training and making direct referrals (Figure 10). There was also a very modest increase in average numbers of consultations with NHS CYPMHS, from a mean of 6.4 at baseline to 7.5 at the follow-up stage. This change was not statistically significant, using a paired t-test. While this might appear somewhat surprising, given the focus of the pilot, the qualitative research showed that regular face-to-face contact between the SPOC often negated the requirement for a formal consultation, and it seems likely this was a contributory factor.

Figure 10 Which of the following types of contact did you have with these mental health professionals – NHS CAMHS? (school lead contacts)
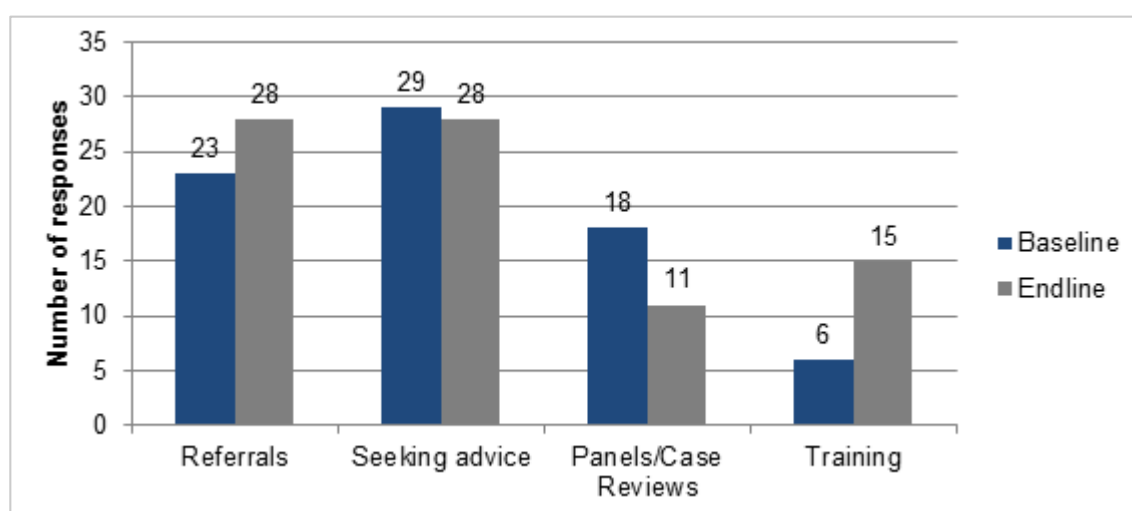
Base: 49 respondents.

Overall, there was a sizeable increase in the proportion of school lead contacts who felt that it was either 'easy' or 'very easy' to arrange a consultation when they needed one, rising from just under one-half of respondents (47%) at baseline, to just over three-quarters of respondents (77%) by the +10 months follow-up stage. When asked about the purpose of the most recent consultation, school leads were slightly more likely to report seeking help with an individual child by the end of the pilot programme (91%, compared with 82% at baseline) and less likely to report seeking help about a group of children (9%, compared with 16% at baseline).

Referrals for specialist support – pilot schools

There was a largely positive picture regarding the impact of the pilot programme on experiences of referrals from schools to CYPMHS. Across all 4 surveys, well over three-quarters of respondents (78%) agreed or strongly agreed that the pilots had **improved their understanding of the referral routes to specialist mental health support for children and young people in their local area**. These aggregated results cut across all of the key stakeholder groups for the pilot programme, including schools, NHS CYPMHS, CCGs and other organisations. As such, it is apparent that the pilots achieved – on average – a heightened level of awareness of pathways across local networks and that these benefits were not confined solely to the joint working between schools and NHS CYPMHS. This is consistent with the qualitative research, which showed that the areas participating in the pilot programme routinely used the opportunity to revisit and refresh how information on pathways and support was shared and disseminated.

As might be anticipated, improved levels of understanding of referral pathways also translated into increased overall levels of satisfaction with referral *processes*, although these changes were observed to a varying extent between different types of mental health support. Table 4 shows the average (mean) levels of satisfaction with how referrals were handled by different types of mental health services, as reported through the school lead contact survey. When the responses are ranked from 1 (not at all satisfied) to 4 (very satisfied), it is apparent that the scores increased across all 3 types of services. However, the increase was only statistically significant for NHS CYPMHS, using a paired t-test. This increase was highly significant, at the 1% level.

Table 4 Satisfaction with referral handling (school lead contacts)

	Specialist mental health support in school	NHS CAMHS	Other local mental health services
Mean baseline (standard error)	3.46 (0.10)	2.32(0.10)	2.78(0.40)
Mean endline (standard error)	3.58 (0.10)	2.93 (0.12)	3.11 (0.11)
Paired t-statistic	−1.14	−4.31***	−0.89

*Significant at the 10% level; **significant at the 5% level; ***significant at the 1% level.

Figure 11 further breaks down the responses on the satisfaction of referral handling by NHS CYPMHS. It shows that there was a marked shift from 'not very satisfied' and 'not at all satisfied' at baseline to 'fairly satisfied' and 'very satisfied' by the +10 months stage.

Figure 11 Overall, how satisfied are you with the way that referrals to NHS CAMHS were handled, during the past school year? (school lead contacts)
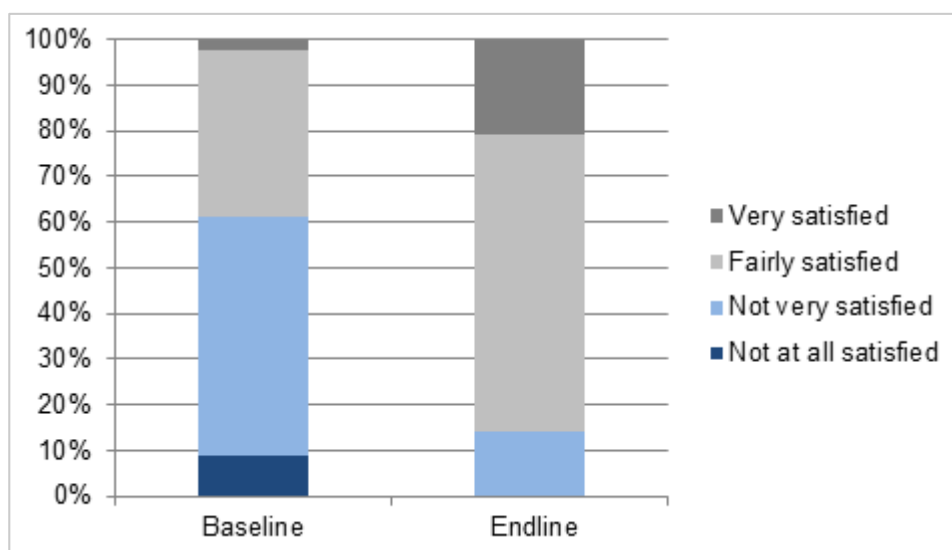
Base: 49 respondents.

By the end of the pilot programme, specialist mental health within the school remained the main 'go to' source of support among most schools and received the highest overall (mean) rating of 4.0 regarding the helpfulness of the services or support provided to schools, compared with 3.3 for NHS CYPMHS and 2.8 for other local mental health services[30]. Increases in mean scores between the baseline and +10 months stage were small across all 3 types of services, although the increase in mean score from 2.3 to 2.8 for NHS CYPMHS was statistically significant at the 5% level.

The qualitative interviews reinforce the overall pattern of survey findings. While there were substantial variations between pilot sites, the case-study schools frequently reported having better access to information and feedback from NHS CYPMHS, compared with the arrangements prior to the pilot. Having a single point of contact served to address some of the main areas of dissatisfaction with these processes, pre-pilot, within schools where this was an issue. The pilot was commonly used as an opportunity to challenge the practice of routing referrals via GPs, where it was not a requirement to do so, to ensure the ongoing involvement of schools beyond the initial point of referral, with parental consent and to agree better ways to share information on outcomes.

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[30] The question was worded as follows: "*In your experience, how helpful have you found the following sources of mental health support, for students that have accessed them?*" Respondents were asked to score their response on a 5-point scale: 1. Almost always helped, 2. Often helped, 3. Usually neither helped nor made things worse, 4. Often made things worse, 5. Almost always made things worse, D/K.

With regard to the quality of referrals, there is quite clear evidence from the evaluation that the pilot programme contributed towards improvements in the **timeliness and appropriateness of referrals** and that it helped to **prevent inappropriate or unnecessary referrals** within many of the participating areas. While these outcomes are more difficult to quantify, it is notable that well over half of respondents to the 4 combined surveys (59%) agreed or strongly agreed that the pilot programme had brought about improvements to the effectiveness of referral routes that are available to specialist mental health support for children and young people within the local area.

The qualitative evidence provides a more nuanced picture of what these changes looked like in practice. Often, the closer communication and trust between the school and NHS CYPMHS lead contact meant that school staff would ask for advice about a young person that was giving them cause for concern, rather than automatically making a referral. A better understanding of referral pathways, combined with ongoing contact with the NHS CYPMHS worker, helped to calibrate schools' judgements about when to refer.

> ## Case studies: reducing inappropriate referrals
>
> - In **Area E**, the NHS CYPMHS team established a direct telephone line for the pilot schools and ran briefings for schools highlighting the differences in the typical characteristics of cases best managed within school, by NHS CYPMHS and by children's social care teams. These measures were thought to have helped embed a shared understanding of the criteria, with fewer inappropriate referrals as a result.
>
> - In **Area I**, where the Choice and Partnership Approach (CAPA)[31] is used, the NHS CYPMHS service received 160 consultations during the pilot, of which 50 resulted in Choice appointments. Only 3 of these appointments required specialist NHS CYPMHS referral, while 28 went on to be supported by their school.
>
>   The NHS CYPMHS manager reflected that, in the absence of the pilot, all 50 Choice appointments would almost certainly have been referred to NHS CYPMHS by schools, along with a proportion of the cases that reached consultation stage. The pilot underlined the extent of external pressure on the specialist team, along with the potential time- and cost-savings from addressing the issue of inappropriate referrals.

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[31] The Choice and Partnership Approach (CAPA) is a participatory management model within NHS CAMHS, which is informed by demand and capacity theory, and places an emphasis on user involvement and reinforcement of staff morale and team working.

Having a named point of contact in NHS CYPMHS often meant that referrals could take place more quickly, where an acute need was identified. Numerous examples were provided where the NHS CYPMHS worker identified presenting behaviours that gave cause for concern and were able to advise school staff or to support them with making a referral for specialist support where this was appropriate.

It was not uncommon for the NHS CYPMHS worker to play a role in securing appropriate engagement with partner agencies – especially so where cases had become 'stuck'. Examples included where information had been overlooked, appointments had been missed without any follow-up or the young person had been passed backwards and forwards between school and GP. The following provides one such example:

> *"It was around anxiety with this particular boy, and Mum had barriers around going to the GP … they kept telling the school to refer him, and we kept telling them 'We can't refer. It needs to be the GP.' It was back and forth, back and forth, and [NHS CAMHS lead contact] – it took her half an hour's observation to say, 'He needs a referral into CAMHS', which is what she did. That wouldn't have happened without her, because it still would have been back and forth …"*
>
> (school lead contact)

In a further example, the school lead contact had requested advice on supporting a young person who had been excluded from a previous school and was calling out in class and using sexualised language. The NHS CYPMHS lead worker met with the school lead contact (SENCO), the child and their family, and was quickly able to identify that there was a history of neurodevelopmental problems but no paediatric involvement. A referral to a paediatrician was arranged to assess for suspected Tourette's syndrome.

The pilot quite often underlined the extent to which referrals could become lost in the system, as a result of complexity, misunderstanding and – sometimes – administrative error, with a significant impact on the time that young people needed to wait before receiving support. This was not always solely attributable to NHS CYPMHS waiting lists, as commonly perceived by other stakeholders, but quite often also involved mishandling of referrals at different stages in the chain. The pilot helped to shine a spotlight on these issues, to raise awareness of roles and responsibilities, and to streamline referral processes. The impact on the waiting times for young people was often very stark, as the following comparison of cases (from **Area M**) serves to illustrate.

Table 5 Case study: 'before and after' – two referrals by the same school

Referral example, pre-pilot Total duration: 17 months	Referral example, during pilot Total duration: 4 months
• **Nov 2013** – school refers to school nurse • **Dec 2013** – initial appointment with first community paediatrician • **June 2014** – appointment with second community paediatrician, following caseload re-allocation • **Sept 2014** – pupil reallocated to first community paediatrician, who refers pupil to NHS CYPMHS • **Dec 2014** – meeting with school, parents and community paediatrician – no news on outcome from NHS CYPMHS referral • **Feb 2015** – pupil's mother phones NHS CYPMHS to chase up appointment and learns that NHS CYPMHS referral was not made until Jan 2015 (disputed) • **April 2015** – pupil attends NHS CYPMHS appointment – diagnosis given	• **July 2016** – school makes referral directly to NHS CYPMHS, using online pro-forma • **Sept 2016** – school liaises with NHS CYPMHS link worker (pilot) for a status update on the NHS CYPMHS appointment, following inquiry by parents • NHS CYPMHS link worker informs school that appointment is to be arranged for October, with letter to follow • School informs parents • **Oct 2016** – pupil attends NHS CYPMHS appointment – diagnosis given

Although there were reported improvements in the appropriateness and quality of referrals, **there was no evidence that the pilot programme had a measurable impact on overall numbers of referrals from schools to NHS CYPMHS**. A negative outcome should not be inferred from this result for the pilot programme overall, as it was never the intention to increase volumes of referrals. And indeed the contribution of the pilot programme towards improving engagement between schools and NHS CYPMHS without resulting in an influx of referrals is largely positive, viewed from a policy perspective.

A number of possible factors might help to explain this result. The interviews with NHS CYPMHS and CCG managers showed that the pilot was not scaled at a level where these changes would have been anticipated, given the much greater numbers of non-pilot schools falling within administrative boundaries. Data was rarely disaggregated on an individual school basis, and indeed where referrals were made indirectly via GP surgeries, this information was not always traceable to the referring school without a manual search. Moreover, the pilot corresponded with the roll-out of actions from local Transformation Plans, and much larger infrastructure and staffing developments were under way, making any kind of causal attribution of referral numbers to the pilot highly problematic. **Area B** recorded a 52% increase in referrals to specialist NHS CYPMHS during the final quarter of 2015, for example, but this corresponded with a service-wide push to clear a backlog of cases and an awareness-raising campaign by the school health advisory service.

The low response to the NHS CYPMHS survey at the follow-up stage means that the school lead contact survey provides the main source of data on referral numbers, and these figures must be approached with caution, given that they were typically based on estimates rather than recorded statistics (69% at baseline and 76% at endline). Overall, the pilot schools reported a small decrease in the average number of referrals from schools to NHS CYPMHS via GP surgeries within the past 6 months (from 6.7 to 3.4). This result was found to be significant at the 10% level when a paired t-test was applied. Although there was also a small increase in the average number of direct referrals to school-based specialist mental health support (from 19.0 to 21.7) and a very small increase in the average number of direct referrals from schools to NHS CYPMHS (from 4.6 to 4.9), these results were not found to be statistically significant.

The case-study research also shows a very mixed picture with regard to the impact of the pilot programme on referral numbers. There was a good deal of consensus that referral quality was a better indicator than numbers of referrals per se, although some NHS CYPMHS services noted that historic referral numbers were unsustainable and could not continue at the same level. In certain scenarios, an increase in referrals was a positive sign – where schools had historically disengaged, for example, and where the pilot programme uncovered pockets of unmet need. In **Area Q**, the presence of an NHS CYPMHS lead contact in local schools helped to identify and engage with a group of Bangladeshi children who were previously not on the radar of NHS CYPMHS.

Service and systems outcomes

A third key group of outcomes that were explored through the evaluation related to service and 'system' changes – at an **organisational level** (that is, individual school or NHS CAMHS service) and at a **local area level** (that is, across the CAMHS 'network').

Area-level capacity-building

The CASCADE framework provides a key point of reference for understanding stakeholders' perceptions of changes to CYPMHS at a local area level, following the early implementation of the pilot programme. The scoring framework was administered with local stakeholders at 2 points in time – during the initial workshop in the autumn of 2015 (phase 1) and again during the second workshop in the spring of 2016 (phase 2). The scores were obtained via a group voting and feedback exercise, whereby participants arrived at consensus on a score for each of 7 key indicators, on a 4-point scale (Major challenge = 0, Good elements of practice = 1, Widespread good practice = 2 and Gold standard = 3).

The 7 key indicators include:

1) clarity on roles, remit and responsibilities of all partners involved in supporting CYP mental health

2) agreed point of contact and role in schools and CYP mental health services
3) structures to support shared planning and collaborative working
4) common approach to outcome measures for young people
5) ability to continue to learn and draw on best practice
6) development of integrated working to promote rapid and better access to support
7) evidence-based approach to intervention

Although the scores are based on self-assessment and are therefore subjective in nature, they add an important dimension to the data collection for the programme, as they represent a *collective* perspective for each of the local pilot partnerships.

The overall picture to emerge from a comparison of the phase 1 and 2 data is a positive one. Across the 25 areas for which valid data was obtained at both phases, there was an overall average (mean) change of 4.5 in CASCADE scores across the 7 indicators combined. The margin of change between phases 1 and 2 varied considerably between individual areas, from high change scores of +10 points (**Area T**) and +9 points (**Area I**) where areas were moving from a lower baseline, to marginal gains of just +1 point (**Area N**) and +2 points (**Area R**, **Area S** and **Area M**). There were also differences in the overall level of confidence expressed by the individual areas at the follow-up stage, ranging from 10 points to 3 points. This scoring pattern does suggest that some areas continued to face quite significant challenges, as might be anticipated given the narrow window period within which the scoring took place.

The CASCADE scores can be further broken down by individual indicator (Table 6). While there were improvements across all indicators, the overall impression is one of quite direct and tangible self-reported improvements in the clarity of professional roles within the CAMHS network – particularly regarding SPOC within schools and NHS CAMHS but also for other partners involved in CYPMHS. The changes were smaller regarding the use of common outcome measures and the take-up of evidence-based interventions – a trend that largely concurs with the findings from the survey research and qualitative interviews.

Table 6 CASCADE data – scoring by indicator (phases 1, 2 and change)

Phases		Indicators						
		1	**2**	**3**	**4**	**5**	**6**	**7**
P1	Phase 1 totals	15	17	3	4	8	10	8
	Phase 1 mean	0.6	0.7	0.1	0.2	0.3	0.4	0.3
	Phase 1 rank	2	1	7	6	4	3	4
P2	Phase 2 totals	31	37	23	17	23	24	22
	Phase 2 mean	1.2	1.4	0.8	0.7	0.9	0.9	0.8
	Phase 2 rank	2	1	4	7	4	3	6
	Change	+16	+20	+20	+13	+15	+14	+14
	Change rank	3	1	1	7	4	5	5

Finally, it is possible to review changes in distribution of CASCADE scores across the 4-point rating scale (0 to 3), between phases 1 and 2. Whereas 8 areas reported having a 'major challenge' at phase 1, no areas reported ongoing challenges by phase 2. Moreover, 12 areas were reporting 'widespread good practice' by this stage. The extent of change was equally impressive for the indicator relating to structures to support shared planning and collaborative working. At phase 1, the considerable majority of areas (22) reported having a 'major challenge'. By phase 2, this figure had decreased to just 5 areas, with most showing progress to 'good elements of practice' and 3 areas reporting 'widespread good practice'.

Among respondents to the 4 combined surveys at the +10 months stage (*n* =215), 47% agreed and 13% strongly agreed that the pilot programme had brought about improvements to the sharing of mental health resources and information between different organisations within their local area.

School-level capacity-building

The evaluation found **some evidence of improvements in the availability and resourcing of mental health support within pilot schools**, although much of this work was still under development at the stage when the research took place. Almost two-thirds of respondents to the 4 combined surveys (63%) either agreed or strongly agreed that the pilot had brought about improvements in availability (base = 215). There was lower overall agreement that the pilot programme had improved access to evidence-based interventions, at just under half of survey respondents (47%).

The survey of school lead contacts further explored views on the sufficiency of mental health support within pilot schools. Respondents were asked to rate 6 statements, using a 4-point scale (from 1 = strongly disagree to 4 = strongly agree). These included:

A. Children and young people's mental health is afforded a high priority by the school leadership team.
B. Children and young people's mental health is reflected within 'whole school' policies and initiatives.
C. Support for mental health issues is adequately resourced within schools, in terms of staff time and specialist support.
D. Students in schools have confidence in the support that is available to them for mental health issues.
E. The respondents know what mental health support is available in the school.
F. The respondent feels well supported by specialist colleagues in the school (for example, educational psychologists, school nurses, counsellors).

As shown in Table 7, the mean score increased between baseline and the follow-up stage for each of the 6 statements. This increase was highly significant at the 1% level for statements C, D, E and F, when using a paired t-test with the null hypothesis that the mean at baseline is smaller than the mean at +10 months. However, this increase was not significant for statements A and B. The results would therefore seem to indicate greater confidence in the improvements to resourcing and internal signposting to mental health support over the course of the pilot programme but lower confidence in improvements to the profile of mental health issues at a policy level within schools and with school leadership teams. These findings must be approached with some caution, however, as we have seen that many of the pilot schools appeared to be starting from a fairly high baseline level of awareness and engagement with mental health issues.

Table 7 Average rating of mental health support in the pilot schools (school lead contacts)

Statement	A	B	C	D	E	F
Mean baseline	3.57	3.36	2.69	2.86	3.43	2.88
Mean endline	3.71	3.47	3.06	3.20	3.67	3.22
Paired t-statistic	−1.22	−1.22	−3.1***	−3.15***	−2.5***	−2.75***

*Significant at the 10% level; **significant at the 5% level; ***significant at the 1% level.

The whole school survey respondents were generally more optimistic. Their average score was higher for each of the statements at both baseline and follow-up, and their increase in mean scores was highly significant at the 1% level for all statements.

There was some evidence that schools increased their range of mental health provision for children and young people over the course of the pilot programme. The pilot schools offered an average (mean) of 7.29 categories of support at baseline and 8.36 categories at +10 months. This increase is significant at the 5% level, using a paired t-test. While these changes cannot be directly attributed to the pilot, the workshops and the increased engagement with NHS CYPMHS put a greater spotlight on mental health issues within schools across the pilot programme.

As shown in Table 8, the types of provision showing the greatest increase in availability included: therapeutic support/interventions (19%), staff training (19%) and whole school strategies (17%). By the end of the pilot programme, the provision most widely offered by

pilot schools included staff training, educational psychological support and learning in the curriculum.

Table 8 Types of mental health support offered within pilot schools (school lead contacts)

	Type of provision	Percentage of schools at baseline	Percentage of schools at endline	Percentage change
a)	Staff training	69	88	+19
b)	Therapeutic support/interventions	57	76	+19
c)	Whole school strategies	61	78	+17
d)	Mindfulness	31	45	+14
e)	Peer-led support	35	49	+14
f)	Learning in the curriculum	69	80	+11
g)	Themed support group (for example, eating disorders, anxiety)	20	31	+11
h)	Parenting programmes	41	49	+8
i)	Family intervention	47	43	+4
j)	Clinical psychological support	16	20	+4
k)	Educational psychological support	80	84	+4
l)	Counselling	53	53	-
m)	Nurture groups	55	55	-
n)	Anger management group	43	43	-
o)	External agency 1:1 (for example, drug service)	51	45	–6

Base: 49 respondents.

There were also signs that a greater number of schools were planning to take action to shore up their capacity in the near future. While these changes had sometimes arisen from ongoing work, the surveys indicate that the CASCADE workshops helped to provide additional focus for many of the schools that attended. As illustrated in Figure 12, almost 9 in 10 (85%) of school leads who attended the workshops reported having committed to one or more individual action points, which most commonly related to investment in additional training for staff (57%) or conducting a mental health training needs analysis/audit for staff (51%). Eight in 10 of respondents to the stakeholder survey who attended the workshops also committed to one or more action points. The main actions included pledging additional specialist time or resources for schools-based mental health support and/or releasing staff to train.

Figure 12 Actions taken by schools since participating in the pilot (school lead contacts)
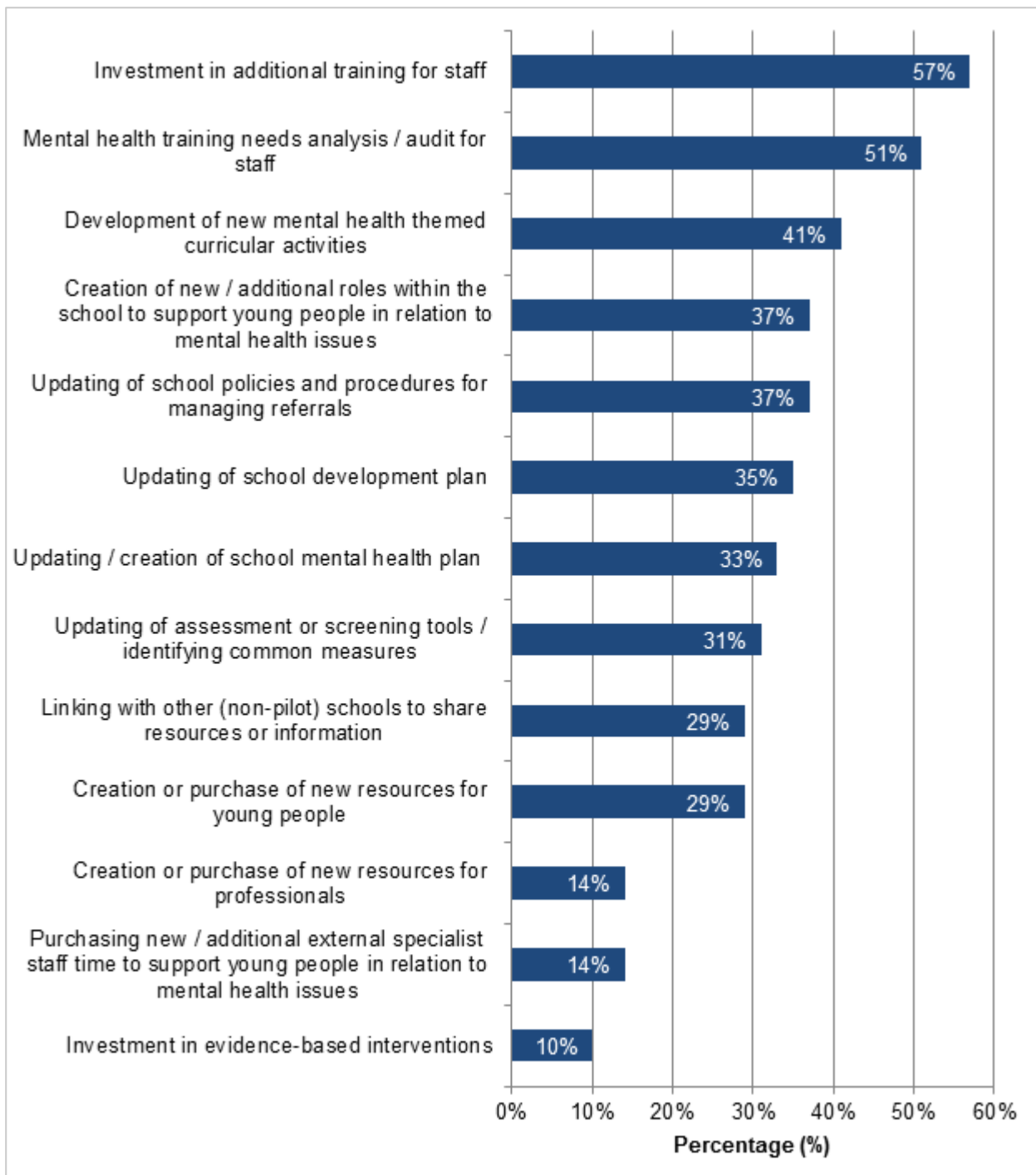
Base: 49 respondents.

Finally, the surveys explored the **significance of different potential barriers to mental health support in schools**, at baseline and +10 months. Overall, school lead contacts assigned a lower level of influence to all of the categories by the end of the pilot programme, with particular reductions in the influence of barriers relating to information-sharing and communication between different agencies, national policy and NHS CYPMHS capacity. They were also slightly more positive about the barriers presented by the recruitment and retention of specialist staff and the influence of school safeguarding policies, but the level of change was not significant when applying a paired t-test.

Respondents to the whole school survey concurred about the reduced influence of barriers relating to a lack of information about local support and negative attitudes of staff. However, they were more pessimistic about potential barriers relating to capacity within NHS CYPMHS and other mental health services, and communication between different agencies. These differences might be explained with reference to the more indirect relationship with mental health professionals through the pilot programme, compared with the school lead contacts. Like school lead contacts, respondents to the whole school survey remained concerned about barriers relating to the priority for mental health issues within school policies and difficulties with specialist staff recruitment.

NHS CYPMHS capacity-building

The qualitative evidence highlighted that the NHS CYPMHS services involved in the pilot had used the opportunity to build capacity in a wide range of different ways. Nearly all reported outcomes relating to improved working methods and processes, with the schools engaged through the pilot. Over and above this, a good number of the NHS CYPMHS teams had developed new school-specific resources, which they intended to use more widely. This included the following:

- templates for schools, including new joint assessment forms incorporating validated outcome measures for mental health (**Area C**)
- model 'whole school' policies for mental health and well-being (**Area E**, **Area G**)
- adjustments to protocols, to increase the flow of information to schools – in **Area B**, NHS CYPMHS workers now systematically ask parents for their consent to copy schools into key information about their child's treatment
- new streamlined referral protocols and feedback forms – in **Area E**, NHS CYPMHS has developed a CYPMHS-to-school feedback form, which is designed to share key information about the treatment plan and outcomes for accepted cases, where consent has been obtained
- new benchmarking schemes – the Mental Health Quality Mark in **Area G**
- new dedicated telephone or online contact points, offering a means of contacting specialist NHS CYPMHS directly without the need to book a consultation (**Area T**)

5.0 Sustainability of the pilot models

Key findings

Demand for sustaining NHS CYPMHS and school links

- Nearly all of the case-study areas had developed their pilot with a view to informing wider roll-out, as evidenced by the willingness to draw upon Transformation Plan budgets. A number of areas had rolled out their model to additional schools.

- There was a broad base of support across the pilot areas for finding ways to continue to maintain close links between NHS CYPMHS and pilot schools. However, there were mixed views on how single point of contacts might be sustained.

- Pilot schools and NHS CYPMHS had forged a close partnership in some areas, and there were concerns that progress would be lost if arrangements reverted back to the status quo. Others thought that a continuing in-school presence was unnecessary and were confident that the improved communication channels were sustainable.

Scaling up the models – challenges and potential solutions

- A number of significant challenges were identified for scaling up the pilot models. Principally, many areas felt that the ratio of NHS CYPMHS workers to schools was not replicable across an entire authority, owing to the numbers of schools.

- Many of the pilot areas were exploring options for working at scale, without spreading the contact time too thinly. This generally included a combination of the following:

    a) 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.

    b) Cluster or locality-based support, whereby NHS CYPMHS lead contacts linked with a number of schools via established local multi-agency teams.

    c) 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.

    d) 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.

> e) 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.

The pilot programme was funded for a period of 6 months initially, and the pilot areas were looking ahead to future arrangements when the final phase of evaluation fieldwork took place. In this chapter, we examine the demand at a local level for continuing with SPOC in NHS CYPMHS and schools. We compare and contrast the views of local stakeholders regarding those elements of the pilots that were considered to have the greatest long-term potential. We then consider the challenges for scaling up the models and how the areas had set out to address them. Finally, we present a number of case-study examples, where continuation funding had already been secured.

Demand for sustaining NHS CYPMHS and school links

Overall, there was widespread recognition among key stakeholders of the need to achieve sustainable improvements to the quality of communication between schools and NHS CYPMHS. Nearly all of the case-study areas had developed their pilot with a view to informing a wider roll-out, as evidenced by the willingness to draw upon Transformation Plan budgets in many areas. Very few had treated it as a stand-alone project.

There was also a **broad base of support for the principle of continuing the SPOC in schools and NHS CYPMHS**. Well over three-quarters of respondents to the combined surveys at the end of the pilot programme were either very confident (41%) or quite confident (41%) that these arrangements could help to meet the needs of staff and students in the longer term (base = 215), albeit with some variation in the average levels of confidence between individual pilot areas[32].

Opinions varied to a greater extent on what a single point of contact model should look like after the pilot programme. There was a common view that regular in-school contact time between NHS CYPMHS clinicians and school staff was an important part of the model and should be a prerequisite for any wider roll-out. This opinion was generally more apparent within areas where there had been higher levels of school-based work during the pilot. It was clear that the lead contacts had forged a close partnership in some areas and that they feared that the progress made during the past 10 months was at risk of being lost if arrangements reverted back to the status quo.

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[32] Average (mean) scores per pilot area ranged from 2.3 to 4.0, when the responses were coded on a 4-point scale from 1 = strongly disagree, to 4 = strongly agree.

"The real lesson, that's hard to admit with commissioning and with budgets, is that you need to develop relationships. There's no point if schools only ring up when they have a crisis. It's got to be a proper relationship, so that the clinician gets to know the school and is enhancing things from the bottom up."

(NHS CYPMHS lead contact)

"We misused the service [before the pilot]. We have a much better understanding now, and make appropriate referrals. But over time we'll lose the sense of perspective if we lose that contact … and then we'll be back to where we were".

(school lead contact)

Others disagreed that regular in-school face-to-face contact was necessary. They argued that clear lines of communication, well-defined referral pathways and feedback loops in place with schools were the hallmarks of a well-functioning NHS CYPMHS and schools link model. This view was more typical of areas where the pilot involved consultation, training and awareness-raising. However, some areas that had delivered regular in-school support also concluded that the levels of contact time they originally envisaged were unrealistic and unnecessary. Significant variations in demand were encountered in some areas at an individual school level, and having fixed contact time on a weekly or fortnightly basis was felt to be an inefficient way to target finite resources.

"Whenever [school lead contact] is stuck on something, he sends me an email, he says ... 'What happened with this referral, we haven't heard anything?' Or, 'This care coordinator didn't get back to me when I left a message.' Those are the little things that make a huge difference, but I'm not going in there every week and consulting with him; there is no point. We've got 15 secondary schools and huge numbers of referrals, but I can be available for him whenever he wants it."

(NHS CYPMHS lead contact)

"We want to communicate better … and have plenty of contact with all existing relationships. But are we in a position to give every one of the 66 schools a named person in CAMHS? We are not. There is too much staff change, too much upheaval at this precise moment."

(NHS CYPMHS manager)

Some schools also found that the planning and co-ordination time required for regular drop-in sessions by NHS CYPMHS was difficult to maintain, while others reported a diminishing need for regular contact following the initial work to embed working practices.

"For me it's about what you get out of that time, so that you can pick up a phone when you need to and say 'we've tried everything and it hasn't worked' … It doesn't need to be that intensive [weekly contact], but it does need to be quality."

(headteacher, pilot school)

It was clear overall, therefore, that schools' longer-term needs varied considerably and that greater differentiation might be needed to cater for this.

Scaling up the models – challenges and potential solutions

Although there was a real commitment to make longer-term improvements to joint working, **significant challenges were identified for scaling up the pilot models.** The principle of these related to the mismatch between staffing capacity within specialist NHS CYPMHS and numbers of schools within each area. Given the typical staffing complement in NHS CYPMHS, PMHW might need to cover between 30 and 50 schools. These ratios were generally considered unworkable for maintaining relationships with individual schools and posed a risk of displacing resources from other sources of referrals. In **Area B**, the CCG and NHS CYPMHS originally hoped to model their approach on the School Nurse Service, where Health Advisers have targets to ensure a minimum level of termly contact with individual schools. It soon became apparent that this was not possible with over 200 schools, without significant increases to the head-count in NHS CYPMHS.

There was a tension in some areas between the high value attached to having a single point of contact in NHS CYPMHS and the recognition that these arrangements were unlikely to be sustainable in their current format beyond the lifetime of the pilot programme. **Areas were exploring a range of potential options for working at scale without spreading the contact time too thinly**. It should be noted that these are not mutually exclusive, and most areas were using a combination of approaches to help with scaling up. Some of the main ones were as follows:

- **A traded offer to schools** – it was generally thought that a proportion of costs would need to be passed on to schools, to deliver at scale within available NHS CYPMHS resources. Several areas were in the process of developing a tariff system, with schools able to purchase additional support at their discretion, including a single point of contact in specialist NHS CYPMHS if they chose to have one. Many of the areas had offered traded services prior to the pilot and found that this worked well with primary schools, which tended to need lower amounts of specialist NHS CYPMHS input. One of the perceived drawbacks of a 'willing-to-pay' model was the risk that this could widen inequalities in young people's access to mental health support, with the already-engaged schools taking up the offer and others remaining disengaged. **Area I** was seeking to address this by providing a gold/silver/bronze model, with a universal offer of basic training and consultation at

no cost and a menu of additional specialist support layered on top of this (see case study).

- **Cluster or locality-based support** – most areas were seeking to ensure that specialist NHS CYPMHS was represented in locality teams and perceived this to be a good way to provide economies of scale while embedding the offer within multi-agency teams. It was recognised that the Early Help infrastructure is a significant focal point for multi-agency working and a forum for sharing information and providing feedback[33]. **Area G** hoped to develop a city-wide specialist NHS CYPMHS offer for schools, delivered via the 7 locality clusters. As each cluster includes approximately 25 schools, it was hoped that efficiencies could be achieved through a collective purchasing model, whereby schools in each locality pool budgets or top-slice to access a 'locality offer' of specialist NHS CYPMHS support. This arrangement would potentially make a single-point-of-contact model feasible, where there was sufficient buy-in from clusters of schools. **Area B** aimed to develop a similar locality model, with a commitment to match the adult mental health services offer in GP localities with an equivalent response for children and young people.

  In **Area D**, a cluster model was also seen as being a potential way to scale up within a framework that is not solely reliant in individual schools stepping forward. It was recognised that the timescales for the pilot heavily favoured schools that were already sold on the importance of mental health and well-being and that engaging some schools outside the pilot could be a very different proposition.

- **Single point of access** – a number of the areas were of the view that it was the direct access to specialist NHS CYPMHS for advice, information and training requests that proved the most beneficial during the pilot programme. The plan for roll-out was therefore to provide a single point of *access* for schools – via a professional telephone helpline and email contact address, with additional resources allocated to ensure that schools could discuss an issue with a specialist NHS CYPMHS clinician without necessarily requiring a formal consultation request. Areas adopting this approach were generally using a triage and duty system, with NHS CYPMHS workers responding on a rota basis. This arrangement was thought to offer a cost-effective means of improving accessibility to specialist NHS

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[33] The requirements for Early Help are outlined in the "Working Together" guidance on inter-agency working to safeguard and promote the welfare of children. HM Government. *Working Together to Safeguard Children: A Guide to Inter-agency Working to Safeguard and Promote the Welfare of Children*. 2013. Every local authority has a duty to lead on the development of an Early Help Strategy, to ensure that problem issues are addressed at the earliest stage, and to co-ordinate inputs from all key agencies. LGA. *Must Know 5: What You Need to Know About Early Help.* 2013. *London: Local Government Association.*

CYPMHS, but it stopped short of a commitment that each school would have a named contact.

Nonetheless, a single point of contact arrangement was planned within the *schools* in 2 of the case-study areas adopting this approach. In these areas, the schools were encouraged to continue with a named individual contact person, to help streamline the flows of information between the school and specialist NHS CYPMHS. The CCG in **Area B** had engaged with the Head Teachers' Forum, recommending that they identify a single point of contact for mental health and well-being within their school who would attend the monthly locality meetings and therefore maintain regular contact with the designated specialist NHS CYPMHS worker working with schools within that cluster. This arrangement would ensure that there was still regular contact between named individuals, albeit in a group setting rather than via individual school drop-ins. In **Area E**, the CCG and Director of Public Health wrote to all schools within the authority notifying them of the new single-point-of-access arrangements and invited them to nominate a named single point of contact for ongoing communications with NHS CYPMHS. This person would receive information on any changes to pathways or support, as well as being a conduit for feedback from specialist NHS CYPMHS on referral outcomes for individual young people.

- **Drawing upon the wider CYPMHS network** – the challenge of wider roll-out brought into focus the need to engage the entire network of CYPMHS. As discussed in Chapter 3, this had been a secondary focus during the pilot programme in some areas, with concerns expressed by partner organisations that the link model was too narrowly focused on links between schools and specialist NHS CYPMHS. There was a recognition that a scaled model would need to broker access to a wider range of expertise.

    "When this was offered nationally it was against the background of CAMHS not being responsive enough to schools … this was only partially true. The SENCO is a part of the CAMHS network. The educational psychologist is a part of the CAMHS network, and some of the teams in social care are part of the CAMHS network."

    (NHS CYPMHS manager)

    "This isn't about CAMHS being available to everybody … it is about accessing specialist CAMHS quickly. But without everyone in that pool, we'll not do it. If you throw everyone else out, there's only 1 in the pool instead of 10."

    (NHS CYPMHS worker)

    A number of areas were therefore reviewing the role and membership of mental health networks and forums, and were looking to strengthen referral pathways to include a stronger role for educational psychologists, school nurses and

practitioners working within the VCS. In **Area R**, for example, the pilot programme was used as an opportunity to create a new role for the School Nurse Service in delivering a post-treatment pathway. Under the new model, all young people will be provided with fortnightly follow-up meetings with a school nurse for a period of up to 3 months post-discharge from specialist NHS CYPMHS. It was hoped that this will build capacity within schools to provide support around mental health issues, while tapping into what was recognised to have been a comparatively underutilised source of expertise.

- **Training and capacity-building** – most areas also planned to include very comprehensive programmes of training and capacity-building as part of the menu of support for a rolled out offer to schools. A common theme was to offer all schools access to a foundation tier, which was typically subsidised by CYPMH and Wellbeing Local Transformation Plan budgets. **Area C** intended to keep open a rolling programme of workshops for schools and other local stakeholders, covering assessment, needs and risks, and serving as a gateway to the mental health forum, to help sustain local communities of practice. Several other areas planned a further roll-out of Mental Health First Aid training to schools that were not part of the pilot programme.

One of the challenges identified for scaling up was to incentivise schools to invest in mental health support, while avoiding dependency on specialist NHS CYPMHS. The pilot programme had achieved real progress in some areas, and there were concerns that arrangements would quickly fall back without the continuous joint working through the SPOC. Areas were approaching this issue in a number of ways.

- **Area M** were effectively using a form of 'soft compulsion'. There were plans to offer training to all 60 schools within the authority via a phased roll-out, but in order to receive the training, schools had to commit to working towards the Emotionally Healthy Schools accreditation. This was thought to have worked well during the pilot programme, as it acted as a guarantee for a minimum level of commitment by the school to improve internal practices, as well as widening access to external support.

- The **Area G** 'Healthy Minds Framework' will enable schools to benchmark their practice against the gold, silver and bronze standards. Schools have traditionally been required to make referrals to specialist NHS CYPMHS via GPs – a decision that was originally taken to address the problem of high volumes of inappropriate referrals. One of the changes with the new framework is that schools achieving a gold standard will be able to make direct referrals to NHS CYPMHS. It is hoped that the standard will therefore serve as a quality control mechanism for referrals into NHS CYPMHS, while providing an incentive to schools to raise their knowledge and competence to a position where they no longer have to refer via GPs.

Successful examples of early mainstreaming

A smaller number of the areas had already secured the funding and political commitment to scale up joint working between NHS CYPMHS and schools when the final phase of evaluation fieldwork took place. These examples provide a useful practical illustration of how the models were adapted and how a 'business case' was made to commissioners.

Here, we profile 3 examples in further detail, drawing upon the case-study areas. The first (**Area Q**) was the only example with the aspiration to continue to offer drop-in sessions to schools without fee-charging. The second (**Area I**) is an example of a large and ambitious model covering all schools within a major city, and the third (**Area M**) is an example of a model that has already been part-replicated within a neighbouring authority within the sub-region. It should be noted that a number of other case-study areas had also secured follow-on funding for parts of their original model, including one (**Area R**) that had earmarked Transformation Plan funding for 8 FTE specialist NHS CYPMHS posts to work with schools county-wide. The latter example included plans for ring-fenced time for school-based activity, although this was yet to be finalised.

The numbers of schools within an area would certainly appear to have been quite a significant factor in determining the options available for securing time from specialist NHS CYPMHS.

Case-study example 1: expanded school liaison service

In **Area Q**, communication between schools and specialist NHS CYPMHS was reported to have been poor before the pilot programme, with schools expressing frustration at high thresholds and a lack of feedback on referral outcomes. When the link workers first accessed pilot schools, they encountered a backlog of cases involving acute mental health issues. It was clear that schools had become accustomed to holding 'high-risk' young people and had stopped making referrals to specialist NHS CYPMHS.

The model developed through the pilot included fortnightly face-to-face contact between NHS CYPMHS and school lead contacts; a streamlined booking system and "*supervision of preventative practice*" – specialist workers supporting schools to embed strategies for more effective internal management of mental health issues. The results were impressive, with the initial backlog of high-risk cases cleared and a drop in average referral times from 12 to 7 weeks, which was largely attributed to the pilot.

Following the success of the pilot, the CCG has made a 5-year commitment of *c*.£300,000 per year to roll-out the school link model. This amount will cover the costs of 4 additional FTE specialist NHS CYPMHS workers, who will have a mandate to support schools on themes of 'access' and 'prevention'. It was recognised that even this additional capacity would not be sufficient to work authority-wide, however, and the expanded core team will also include NHS CYPMHS workers in a school liaison role, access points via Early Help hubs and closer links with adult mental health services.

The CCG acknowledged that expanding the core team posed some risks, given that the original pilot programme was delivered by a smaller number of highly experienced NHS specialist CYPMHS staff. The new school liaison service will therefore be covered by the expanded programme of CYP IAPT training, for which provision was made in the CYPMH and Wellbeing Local Transformation Plan. These arrangements will be monitored as roll-out gets under way.

Case-study example 2: city-wide model of tiered support to schools

In **Area I**, specialist NHS CYPMHS was historically located within a city-wide advisory service, which included a role providing mental health outreach to schools. In 2010, specialist NHS CYPMHS was devolved to locality teams and moved to a triage system, which was the existing arrangement at the start of the pilot programme.

The local pilot was implemented using the Choice and Partnership model. There were originally 2 FTE specialist NHS CYPMHS workers supporting 21 schools through weekly drop-in sessions, alongside staff training and workshops for pupils and parents. This was subsequently boosted to 3 FTE staff, following concerns that the pilot had diverted resources away from other schools and that the service was overstretched.

The pilot was widely considered to have been a real success, with a high level of demand from schools and positive feedback from pupils and parents. A cluster of the pilot schools in the south of the city has taken the decision to commission follow-on support from one of the NHS CYPMHS workers who supported the original pilot.

Following the pilot, CCGs within the region collectively agreed to ring-fence £100k per annum, for a phased five-year roll-out to all (>500) schools across the city. The funding was matched by the Education Partnership as part of a strategic agreement, with NHS CYPMHS to provide clinical interventions and preventative work, and the Education Partnership to deliver the education and resilience components. The joint venture will be managed by the city's umbrella organisation for mental health and well-being.

The model includes 3 tiers, with some traded services as follows:

1. *Bronze*: this will form a city-wide universal offer. A Tier 3 NHS CYPMHS specialist will work with 20 schools at a time, over the course of a school term, providing intensive, fortnightly, 3-hour sessions. The offer will cover induction, signposting and referral, and basic mental health awareness training. Four further visits will be completed per school, to embed the model and upskill the designated school lead.

2. *Silver*: schools wising to extend the Bronze offer will be able to purchase from a bespoke menu of support, including continuation of the bronze offer year on year, bespoke training (for example, emotional first aid, attachment, self-harm, ASD and challenging behaviour) and/or workshops for young people and parents.

3. *Gold*: this traded offer will include more intensive regular supervision and reflective practice sessions for school staff and delivery of evidence-based interventions (for example, DBT, CBT or solutions-focused therapy).

One of the challenges encountered during the pilot programme was that the preventative work in schools uncovered a higher-than-expected number of cases requiring a referral. While many of these cases were taken on by NHS CYPMHS lead workers during the pilot phase, it was recognised that this would not be feasible during

roll-out. The model will therefore be supported by the wider network of CYPMHS, to ensure that there is capacity to respond to identified needs.

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Case-study example 3: mainstreaming via multi-agency hub teams

In **Area M**, relationships with NHS CYPMHS were said to vary between individual schools before the pilot programme. The main tensions centred on the fact that NHS CYPMHS operates a tariff-based contract, requiring high volumes and restricting the available contact time for schools, and that referrals could only be made via a health professional.

The pilot adopted a relationship-building approach, starting at the workshops and followed by consultation with individual schools. The consultations informed the redesign of referral pathways, to include a much clearer role for Educational Psychology, the School Nurse Service and other organisations within the CYPMHS network. The pilot also provided the leverage that was needed to update protocols, allowing schools to make direct referrals, on the condition that they had implemented a mental health policy, completed mental health awareness training and appointed a single point of contact.

A mark of the pilot's success is that the model has been replicated by another authority within the sub-region. Drawing on the multi-agency working from the pilot, this authority has placed specialist NHS CYPMHS workers within larger multi-agency teams in a "hands-on" role, which includes some outreach to schools and attending MARAC[34] meetings. The aim is to remove silos between health and educational support.

Funding had also been secured for a 2-year roll-out in **Area M**, with a second phase to cover 20 schools, followed by a final phase covering the remaining 60 schools within the authority. It was reported that the extension will include the same model of training and accreditation, and guaranteed access to a duty practitioner from specialist NHS CYPMHS, although there will not be a single point of contact per se. The roll-out will be underpinned by the THRIVE model for CYPMHS, to provide a common framework.

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[34] Multi-Agency Risk Assessment Conference (MARAC) – a practice model used in domestic abuse cases.

6.0 Conclusions and recommendations

This report has presented the findings from an independent evaluation of the *Mental Health Services and Schools Link Pilot Projects,* drawing upon evidence from quantitative and qualitative data collection and analysis carried out between October 2015 and November 2016. In the previous chapters, we looked at how the pilots were designed and developed, the role of the joint planning workshops and the lessons learned from implementation. We then went on to consider the evidence for the impacts and outcomes from the pilot programme and the prospects for ensuring their sustainability.

In this final chapter, we draw together the main findings from the report and conclude upon whether the programme achieved its original aims and objectives. We end with some key messages for the potential future development of the pilot models.

Overall achievements

The pilot programme gave the opportunity for 22 local areas to examine how best to strengthen joint working between schools and specialist NHS CYPMHS, to improve schools' identification and capability regarding mental health issues and improve local knowledge and referral pathways to specialist services. Overall, the evaluation indicates that the pilots were largely successful in meeting these aims. A wide range of local models were set up and implemented, and a wealth of learning was generated by the programme within a challenging timescale.

Effectiveness of programme implementation

The pilots were funded to test joint working arrangements on a controlled scale, focusing primarily on the links between specialist NHS CYPMHS and a group of (usually 10) schools. By starting small and targeting the resources in this way, the objective was to 'accelerate' the learning. Although there were delays with getting staff in post at the start of the pilot programme, this model was generally well suited to the timescales for the pilot. It meant that NHS CYPMHS were able to work rapidly to identify schools' needs, and to monitor and adjust time and resources accordingly. Many of the areas used the opportunity to test elements of a model that might be workable on a larger scale, although it was generally accepted that the pilot arrangements were exceptional.

The original 'single point of contact' concept was subject to a wide variety of interpretations. Some areas had a single named worker in NHS CYPMHS working with their counterpart in school(s), while others assigned time from multiple workers, and others still stopped short of a 'SPOC' model altogether, instead offering a central point of access to specialist support. These variations were driven in part by capacity issues – some areas were unwilling to commit to a level of resource that would be unsustainable beyond the pilot programme. However, different objectives also exerted an influence. Whereas some pilots thought it important to provide a 'hands-on' role to transfer

knowledge to schools through staff training, support and consultation and direct work with young people, others focused on improving communication channels and referral pathways and undertook lighter-touch work in individual schools. Concerns were expressed in some areas about creating expectations and a dependency on external specialist support that there was no commitment to sustain in the longer term.

The workshops and CASCADE framework provided an important role in kick-starting the pilots, and the independent facilitation was welcomed in many areas. It was generally acknowledged that the initial workshops suffered from a lack of available planning time and that this prevented more active participation by strategic leaders from local CYPMHS networks in their preparation. It was also evident that the needs of local stakeholders varied quite considerably between areas, as did their prior level of joint working. Nonetheless, nearly all pilot areas were fully engaged by the time the second workshops took place. The CASCADE framework provided a valuable benchmarking tool, and the workshops helped to focus decision-making and to push local stakeholders to set meaningful objectives. The subsequent national learning events were welcomed by the pilot sites and highlighted a real demand for sharing practices and experiences.

Overall, there is some evidence that the pilots had more impact where pre-existing arrangements were less well developed in terms of communication between schools and NHS CYPMHS at the start of the pilot programme, a willingness to engage in a meaningful two-way learning process, and a supportive framework and senior management backing to protect the time that was needed for staff to attend training and engage in ongoing joint working. The benefits were often less apparent where the schools and NHS CYPMHS reported high levels of pre-existing contact, or where the joint working model represented less of a departure from established working arrangements. It was comparatively rare for schools or NHS CYPMHS to hold an overall negative perception of their local pilot, but there were a few exceptional cases where schools' expectations for training were mismatched, or where levels of contact time were felt to have been insufficient to meet schools' needs.

Impacts and outcomes

Together, the surveys and qualitative interviews provide convincing evidence that the pilot programme achieved many of the intended primary outcome measures.

There were strong and statistically significant outcomes relating to improvements in schools' knowledge and awareness of mental health issues, understanding of referral routes and confidence in supporting children and young people among the school lead contacts. It is promising that these outcomes were also reported by the wider group of school-based professionals responding to the 'whole school' survey. This provides an indication that the models developed for the pilot had some success in cascading knowledge and awareness beyond the gate-keepers within each school. The qualitative research further underlined that the extra support provided by the NHS CYPMHS worker

– particularly through direct support and consultation as well as training – was often hugely reassuring to school staff and helped to reduce their anxiety and frustration at managing mental health issues that they felt ill equipped to deal with. In the best examples, the pilots were reported to have played an important role in building capacity for preventative work, although it usually required an investment in face-to-face contact time between NHS CYPMHS and school staff to affect these changes.

There was also clear evidence that the pilot programme contributed towards improvements in the frequency and quality of communication between schools and NHS CYPMHS within many of the pilot areas, although school-based mental health specialists nevertheless remained the 'go to' source of expertise for most schools at the end of the programme. Improvements in communication were achieved through a combination of the initial joint planning workshops and the ongoing lead contact arrangements. School staff consistently reported finding it easier to contact specialist NHS CYPMHS when they needed to and greater satisfaction with the quality of feedback provided. This closer communication was widely considered to have resulted in improvements to the quality of referrals from schools to NHS CYPMHS, although there was no evidence that the pilot had impacted upon overall numbers of referrals to specialist NHS CYPMHS.

The outcomes were slightly less pronounced regarding changes to whole school policies, resources and staffing within the pilot schools, although this would largely seem to reflect the timescales for the pilot programme, with school-level 'systems changes' anticipated to occur further down the line. Moreover, some schools reported already having quite well-developed policies before the pilot. The actions agreed by schools at the joint workshops certainly show a groundswell of planned activity around further waves of mental health awareness training and updating of school development plans. In rarer cases, the pilots were also used to introduce evidence-based interventions and to support schools to adopt common outcome measures, although it would be fair to say that this did not prove to be a major focus of the pilots in most areas.

The outcomes captured via the evaluation must be caveated, of course. The pilot programme was set up and implemented at pace, and there was some evidence that the timescales favoured CCGs where there was already a good level of strategic engagement between health and education partners and schools that were receptive to policy messages about mental health provision. This was necessary, to some extent, given the need to fund areas with the potential to generate learning within the available window. It does mean, however, that the schools within the pilot programme are not necessarily 'typical' of the wider population of schools. The baseline survey certainly seems to suggest that pilot schools were – on average – comparatively well resourced and offering a good range of mental health support. It is important to be mindful in this respect that the evaluation findings may underestimate the time and effort needed to reach schools that are *not* yet on board with mental health policy messages.

It must also be noted that there was quite a significant amount of parallel activity relating to children and young people's mental health within many of the pilot areas and schools. It is not possible to completely untangle the influence of the pilots from the implementation of CYPMH and Wellbeing Local Transformation Plans, and indeed it was not uncommon for CCGs to use this funding to match the funds received from NHS England for the pilot. Other areas were delivering, or planned to deliver, the CYP IAPT change programme, THRIVE or other CYPMHS quality frameworks. It was quite often the work of the schools and NHS CYPMHS through the pilot, in combination with these other resources, which proved successful.

Key messages for policy and practice

Looking beyond the pilot programme, the evaluation has shown that there are real benefits from strengthening links between specialist NHS CYPMHS and schools at a local level and that improving communication, the availability of specialist advice and support, establishing clear pathways and protocols, and securing the engagement of senior leaders from health and education are key ingredients for a successful local model.

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.

Critical success factors

Although it is clear that no single model emerged from the evaluation as being singularly more effective and that local context was important, it is possible to identify some common features of successful joint working arrangements (see box overleaf).

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 single point of contact 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

Considerations for service development

As we discussed in chapter 5, the models that were developed during the pilot were not necessarily those that areas planned to take forward in the longer term. The evidence from the case studies suggests that resourcing a named single point of contact will be challenging to achieve at scale across the wider schools and colleges community, and that an element of 'willingness to pay' is almost certainly part of the equation in most areas, given finite capacity within specialist NHS CYPMHS. Future work might consider the cost effectiveness and potential return on investment for schools and colleges in having named single points of contact – both in terms of cost reduction and educational gain. This was beyond the remit of the current evaluation to explore fully .

Providing economies of scale, supported by strategic co-ordination and/or linking with clusters of schools and working via multi-agency panels, would seem to offer a promising model for widening access to specialist NHS CYPMHS, while a tiered offer of support with more bespoke training and interventions offered on a traded basis offers a means of meeting schools' varying needs.

A number of key themes emerge, which might inform future practice development. We now go on to briefly explain and describe each in turn.

Building schools' capacity within an appropriate, sustainable level of external support

The pilot programme underlined the importance of links between schools and NHS CYPMHS having a mutually transformative purpose. The best local examples were not simply concerned with making it easier for schools to access specialist mental health support; they also encouraged self-reflection and challenged preconceptions of what different professionals are able to offer. In going forward, this willingness for schools to adapt and raise the quality, their capability for internal mental health support, is a critical aim alongside the ability to access specialist support when needed.

We saw that the pilots sought to achieve this through measures to improve accountability. This sometimes involved a minimum requirement for schools to commit to establishing a mental health policy, or embarking on accreditation (for example, the Emotionally Healthy Schools framework) to ensure that they were taking ownership and embedding good practices, rather than simply making greater use of external specialist support. Most of the pilots included a strong 'capacity-building' element – working with school staff to build their knowledge and competence to begin to meet the mental health and well-being needs of their pupils at the more preventative and early intervention end of the scale. This sometimes also included support for school staff to deliver light-touch interventions.

Ensuring strong local strategic engagement from health and education

The pilots helped to demonstrate the potential added value of joining up health and education provision and providing a more seamless offer to children and young people. The scoping work for the pilots showed that schools were often already very engaged with children and young people's social and emotional well-being, and were receptive to resilience-based interventions and support. The ability for specialist NHS CYPMHS to provide clinical mental health expertise added a further dimension and offered real synergies. While this health and education partnership working often took place at a school level, several of the pilot areas had looked to mirror this at a strategic level at the stage of rolling out their local model. The **Area I** example of a city-wide joint funding commitment to work with all schools through a partnership between the strategic health body, the CCG and an Education Partnership, supported by the local authority, is a particularly exciting example of how this was achieved, and one that might offer a blueprint to other areas if the roll-out is a success.

Effectively utilising the wider CYPMHS network in supporting schools and colleges

While the link between schools and the specialist community NHS CYPMHS understandably provided the focal point for the pilot programme, there was an acknowledgement from the outset that all pilots would need to draw in the full range of support from the wider "CYPMHS network". This was particularly embodied in the CASCADE framework and the joint planning workshops.

Beyond the workshops, this wider-system aspect of the pilots was developed with varying degrees of success. Some areas took a strong multi-agency approach from the outset and engaged VCSOs, educational psychologists, school nursing services and children's social care in their joint planning workshops, and in the subsequent implementation of the pilot. This was not consistently the case, however, and the research conducted for the evaluation found some partner organisations feeling frustrated at a more peripheral role. There were concerns in some areas that the emphasis on schools and specialist NHS CYPMHS had perpetuated a narrower view of CYPMHS among schools at the expense of using the opportunity to make the most of existing resources.

By the end of the pilot programme, there was a growing recognition that all CYPMHS providers would need to play a significantly more active role within a scaled up model of the linking arrangements with schools. Several pilot areas were exploring the option of bringing a wider range of professionals from across the network into a comprehensive, joined up support offer (for example, an educational psychologist or VCSO mental health specialist providing extra support to schools). This idea was relatively underexplored during the pilots but could be explored alongside an understanding of the critical success factors – knowledge of mental health itself, the specialist mental health services and the mutual fertilisation from this, as one of a number of options for working at scale.

Acknowledging the benefits of school-based specialist NHS CYPMHS support

Setting aside questions of affordability, the pilot programme clearly demonstrated that there are potential benefits from ongoing face-to-face contact time between NHS CYPMHS workers and schools. Having a regular presence in schools, at least during the initial stages, gave NHS CYPMHS workers insights into the school environment, demands and expectations placed on school staff and allowed them to observe and engage with young people in a school setting. This often proved invaluable in testing the temperature for mental health awareness within the schools and provided a check-and-challenge to school staff on how they were responding to presenting behaviours among young people. As we discussed in Chapter 5, it was only by getting into schools that NHS CYPMHS uncovered issues of schools holding high-risk young people in one area, while in other areas the time spent with the NHS CYPMHS worker helped schools to fine-tune their judgement about how and when a specialist referral was necessary.

These findings sit somewhat uncomfortably alongside the financial reality within many of the pilot areas, where an offer of even minimal levels of contact time in schools was a non-starter when faced with the prospect of stretching or redeploying a relatively small existing specialist NHS CYPMHS resource across upwards of 300 or 400 schools. And indeed, there were tensions within several of the pilots, where school staff had greatly valued the more intensive joint working during the pilot programme and were dismayed at the prospect that this would be withdrawn with the non-recurrent investment.

Although, in all likelihood, any schools wishing to access this type of support would need to do so on a traded basis, the fact that the evaluation found such clear benefits would seem to warrant further exploration of how financial barriers might be overcome. This might include a further modelling of the return on investment and educational gains that schools and colleges might see in the light of the prevalence of the mental health challenges, and the costs in staff time, and other outgoings incurred.

Ensuring capacity to meet previously unmet needs

Having established contact with pilot schools and undertaken visits to meet with staff and young people, it was not uncommon for NHS CYPMHS workers to identify a number of more acute cases of young people with moderate to severe mental health issues who were not previously on the radar of NHS CYPMHS. This ranged from more isolated cases, to instances where individual schools were found to be holding a number of 'high-risk' young people and had not been making referrals.

While it was often possible to make a referral for specialist support, NHS CYPMHS workers had sometimes been concerned about waiting times and lack of capacity within the team, and had therefore taken on more urgent cases themselves. One focus group with NHS CYPMHS workers had revealed the 'moral dilemma' this presented to the lead contacts, who were aware that their role in working with schools was not originally intended to be a case-holding one but had become so out of necessity.

These examples sound a note of caution for other areas seeking to develop a similar model, that the improved links and contact with individual schools can result in the identification of previously unmet needs and that provisions might be necessary to respond in this eventuality.

Embedding school liaison within local networks

The pilots consistently highlighted the importance of having a wider supporting infrastructure around the links between NHS CYPMHS and individual schools, to create a network and to provide opportunities for peer to peer support between schools. During the pilot, this function was provided to some extent by the joint workshops and the national learning events, although many areas already had well-established local mental health forums, while others had set up a pilot working group.

In looking ahead to developing sustainable local arrangements, this supporting infrastructure is likely to be important to provide an opportunity to share learning, to benchmark and to identify collective training and development needs. The tried-and-tested model in **Area C**, combining NHS CYPMHS and school liaison with a quarterly CYPMHS stakeholder forum, website, single point of access for advice or resources and foundation training run 3 times a year, provides a good working example of what this might look like.

Appendix 1: Further sampling information

Table 9 Profile of pilot areas featured within the evaluation report

Area	Socio-demographic profile	English region(s)
Area A	Urban metropolitan	Greater London
Area B	Urban metropolitan	West Midlands
Area C	Urban metropolitan	Greater London
Area D	Urban metropolitan	North East
Area E	Urban metropolitan	Greater London
Area F	Rural county	South West
Area G	Urban metropolitan	Greater London
Area H	Urban metropolitan	Yorkshire & Humberside
Area I	Urban metropolitan	West Midlands
Area J	Urban metropolitan	North West
Area K	Rural county	South East
Area L	Rural county	East
Area M	Urban metropolitan	North West
Area N	Rural county	North West
Area O	Urban metropolitan	North West
Area P	Rural county	South East
Area Q	Rural county	East
Area R	Rural county	South West
Area S	Rural county	Yorkshire & Humberside
Area T	Urban metropolitan	North West

Table 10 Achieved sample for qualitative fieldwork

	CCG representatives	NHS CYPMHS representatives	School representatives	Other key stakeholders
Autumn 2015 exploratory interviews	n/a	15 (T)	n/a	n/a
Summer and autumn 2016 case-study research				
Area I	1 (FTF)	4 (FTF)	11(FTF)	0
Area G	2 (FTF)	3 (FTF)	6 (FTF)	2 (FTF)
Area D	1 (FTF)	4 (FTF)	9 (FTF)	2 (FTF)
Area C	1 (FTF)	1 (FTF)	4 (FTF)	0
Area Q	1 (FTF)	3 (FTF)	6 (FTF)	0
Area R	1 (FTF)	6 (FTF)	9 (FTF)	7 (FTF)
Area M	2 (FTF)	2 (FTF)	6 (FTF)	3 (FTF)
Area B	1 (FTF)	3 (FTF)	5 (FTF)	2 (FTF)
Area E	1 (FTF)	2 (FTF)	3 (FTF)	3 (FTF)
Area L	1 (FTF)	3 (FTF)	2 (FTF)	1 (FTF)
Total respondents	12	46	61	20

Key: T = telephone, FTF = face to face (combined individual, paired, focus group).

Table 11 Comparison of baseline and follow-up survey schools – by pilot area

Pilot area	Wave 1 Percentage of schools	Wave 2 Percentage of schools
1	5.08	8.16
2	8.47	10.2
3	3.95	0
4	4.52	0
5	5.65	6.12
6	6.78	10.2
7	2.82	0
8	9.6	8.16
9	3.95	6.12
10	4.52	10.2
11	2.82	4.08
12	3.39	2.04
13	5.08	4.08
14	3.39	4.08
15	2.82	2.04
16	5.65	8.16
17	1.69	0
18	5.65	2.04
19	5.65	6.12
20	2.26	4.08
21	3.95	2.04
22	2.26	2.04
Total achieved sample (%)	**100**	**100**

Table 12 shows that the percentage of schools by pilot area was largely comparable between the 2 waves, although 5 of the 22 pilot areas were not represented in the follow-up sample. This reflects the sample attrition and is likely to include a combination of turnover in named lead contacts, along with a proportion of respondents from baseline stage electing not to complete the follow-up survey.

Table 12 Comparison of baseline and follow-up survey schools – by school type

	Wave 1	Wave 2
	Percentage of schools	**Percentage of schools**
All through school	1.13	2.04
Alternative/specialist	1.13	0
Primary	53.67	51.02
Pupil referral unit	2.26	0
Secondary	29.38	30.61
Secondary with sixth form	7.34	10.2
Special school	5.08	6.12
Total	**100**	**100**

The samples were also similar regarding school type (see Table 13), with primary schools making up 54% and 51% of the sample at baseline and follow-up respectively. Secondary schools made up a similar proportion of the schools between the waves, at 29% and 31% of the baseline and follow-up sample respectively.

Reflecting on the results from the comparisons, therefore, the type and location of schools taking part in the follow-up were similar to the baseline, and there does not appear to be any significant bias in the follow-up data, owing to the lower response rate.

Appendix 2: CASCADE framework for collaborative working between schools and mental health providers

Table 13 Comparison of baseline and follow-up survey schools – by school type

	Major challenge	Good elements of practice	Widespread good practice	Gold standard
Clarity on roles, remit and responsibilities of all partners involved in supporting CYP mental health	No shared knowledge of the range of support available and poor links between partners	Some shared knowledge of the range of support available some links between partners	Shared knowledge of the range of support available and good links between partners	Full mapping of all sources of support kept up today and accessible with strong links between all partners
Agreed point of contact and role in schools and CYP mental health services	No identified points of contact	Some identified points of contact with some partners	Agreed and shared points of contact with most partners	Agreed and shared points of contact with all partners that are kept up to date as staff change
Structures to support shared planning and collaborative working	No structures to support shared planning and collaborative working	Steering group/partnership agreement or other structure to support shared planning and collaborative working, but membership attendance patchy or frequently cancelled	Steering group/partnership agreement or other structure to support shared planning and collaborative working but not fully linked to other groups	Steering group/partnership agreement or other structure to support shared planning and collaborative working, embedded well with other relevant groups
Common approach to outcome measures for young people	No shared outcome measures and no sharing of information	Some overlap of outcome measures but no shared information	Most shared outcome measures and limited sharing of outcomes	Routine use of shared outcome measures that are routinely shared
Ability to continue to learn and draw on best practice	No forum for shared learning	Some sharing at joint events with some partners or access to good practice networks but limited	Widespread sharing of best practice with most partners but not always acted upon	Widespread sharing of evidence-based best practice with all partners that drives initiatives
Development of integrated working to promote rapid and better access to support	Little to no integrated working and complicated and/or slow path(s) to support	Some integrated working with partners to improve access	Widespread integrated working with most partners to	Widespread integrated working with all partners to improve

	Major challenge	Good elements of practice	Widespread good practice	Gold standard
		despite complicated and/or slow paths to support	improve access with clear path to support	access with clear and/or rapid path to support
Evidence-based approach to intervention	Little or limited training available to support intervention and not grounded in evidence	Some routine training available, but not always evidence-based; some interventions in place	Most staff accessing regular targeted training with interventions in place	Clear training programme for all staff with some joint training alongside interventions

Source: Developed by the Anna Freud National Centre for Children and Families. © Miranda Wolpert (2015).