Early evaluation of the Children and Young People's Mental Health Trailblazer programme

Interim report - summary

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Summary

Background

- The Children and Young People's Mental Health Trailblazer programme was launched in 2018 to take forward the proposals set out in the *Transforming Children and Young People's Mental Health Provision* Green Paper (published December 2017).

- The programme is jointly led by the Department of Health and Social Care, Department for Education and NHS England and Improvement, with support from Health Education England and Public Health England. It is being implemented in successive waves, with the first wave funding the creation of 58 mental health support teams (MHSTs) in 25 Trailblazer sites. The programme is aiming to have rolled out the new approaches to 35% of England by 2023.

- Across the 25 Trailblazer sites, 1,050 educational settings have been recruited to participate in the programme, each of which will receive support from an MHST. MHSTs have three core functions:

  1) providing direct support to children and young people with mild to moderate mental health issues;

  2) supporting educational settings to introduce or develop their whole school or college approach to mental health and wellbeing; and

  3) giving advice to staff in educational settings and liaising with external specialist services to help children and young people to get the right support and stay in education.

- A new professional role has been created for the programme: education mental health practitioner (EMHP). The first cohort of EMHPs commenced

their year-long post-graduate training programme in January 2019, and MHSTs became fully operational from the end of that year.

- The programme combines a national framework (including a set of key operating principles for MHSTs) with local flexibility so that Trailblazers can design approaches and models to best suit their existing provision, needs and circumstances.

- The NIHR BRACE Rapid Evaluation Centre and Policy Innovation and Evaluation Research Unit are undertaking an early evaluation of the Trailblazer programme to examine the development, implementation and early progress of the MHSTs in the Trailblazer sites. It is expected that this process evaluation will be followed by a longer-term assessment of the programme's outcomes and impacts.

Overview of the Trailblazer sites

- Each Trailblazer site has received funding to set up between two and four MHSTs. Some sites have received further funding in later waves of the programme, so have several teams at different stages of development.

- Demographic and mental health service profiles were constructed for all 25 sites, using publicly available data. The methodology, description of indicators used and full data tables can be found in a Technical Appendix that accompanies this report.

- Trailblazer sites had proportionally larger BAME (black, Asian and minority ethnic) populations (18.7%, versus 14.6%) and recorded slightly higher levels of deprivation, compared to the national average. There was substantial variation across the 25 Trailblazers for these two indicators. Average recorded prevalence of emotional disorders among 5-16 year olds was identical in the Trailblazer sites and for England overall, at 3.6%.

- On average, Trailblazer sites were spending more on children's mental health services per child (£69 in Trailblazer sites, compared to a national average of £59) and as a proportion of the overall CCG budget (1.03% in Trailblazer sites, compared to 0.92% national average).

- Across the indicators selected, the performance of NHS specialist children and young people's mental health services was better in Trailblazer sites, with

the exception of waiting times between referral and second contact. This is unsurprising given that the criteria for selecting Trailblazers included several requirements relating to local investment in children and young people's mental health services and performance of those services.

Methods

- The interim report summarises findings from the first phase of fieldwork, undertaken between November 2020 and mid-March 2021. This involved three main data collection activities:

  1) a survey of participating educational settings, with just under two-thirds (61%) of respondents indicating that they were the senior mental health lead for their setting (299 responses, 30% response rate);

  2) a key informants survey of local stakeholders who were playing or had played a central role in the design and implementation of MHSTs in their site (76 responses, 26% response rate); and

  3) group interviews with members of the regional teams that were supporting and overseeing implementation of the programme (27 people interviewed).

- The report also draws on wider data sources: including a baseline survey of mental health provision in educational settings participating in the Trailblazer sites, undertaken in 2019 by the Department for Education (693 responses); programme monitoring data and service metrics reported by Trailblazers to the national team on a quarterly basis; a review of documentation from the Trailblazer sites; and scoping interviews undertaken in early 2019 to gather information about the rationale, design, implementation and aspirations for the programme.

- Our data collection so far has focused on individuals in key strategic and operational roles – at the regional level, and in the Trailblazer sites. By virtue of their role, these individuals may be more connected to and have a greater sense of ownership of the programme and the MHST service model than other groups. There are some important groups that

we have yet to hear from, including frontline MHST staff. The next phase of fieldwork will include in-depth research with a wider range of stakeholders in six purposively selected Trailblazer sites and focus groups with children and young people.

Contexts, starting points and expectations

- Trailblazers described a wide range of services, activities and initiatives to support children and young people's mental health in their area before the programme commenced, including specific examples of mental health trained staff in educational settings. Broadly, the key priorities for children and young people's mental health in Trailblazer sites were around offering early intervention, and reducing waiting times and improving access to services.

- The overwhelming majority of key informants were confident that the Trailblazer programme was a good fit with and complemented their existing provision. Similarly, all but a small number of educational settings that replied to our survey were making plans to integrate MHSTs with existing mental health services and professionals working in their setting.

- Before the programme, children and young people were already able to access various forms of mental health support directly from their school or college, although levels of provision varied between educational settings. The most common forms of support provided were educational psychology (reported by 82% of educational settings) and counselling (61% of settings); fewer educational settings provided cognitive behavioural therapy (17% of settings) or clinical psychology (15% of settings). With the exception of clinical psychology, schools and colleges were most likely to be self-funding the different forms of mental health support on offer.

- Views and experiences of mental health and wellbeing services provided in the Trailblazer sites before the programme commenced were divided. Around half of respondents (46%) to the educational settings survey felt that children and young people could access help from NHS specialist services within an acceptable length of time, and that mental health services responded well to children and young people in crisis (52%). Just over one-third of respondents (35%) reported that the education and health sectors in their area worked well to deliver mental

health support. More positively, most schools and colleges (88%) knew how to get advice from local NHS services on emotional and mental health needs.

- There was a high level of reported commitment to whole school approaches among key stakeholders in Trailblazer sites and within educational settings. The Department for Education baseline provision survey provided further insights into the specific ways in which whole school approaches were being developed. A high proportion of settings reported that they organised activities to raise awareness of mental health and reduce stigma (80%), and taught mental health and wellbeing issues (77%). The least common activities were engagement with parents to develop the mental health and wellbeing offer (35%), and peer support for mental health (24%).

- All stakeholders consulted had high expectations of the Trailblazer programme. Our surveys posed a series of statements about the likelihood of the programme impacting on important outcomes, including: better support for children and young people with mild-moderate needs; more appropriate referrals to specialist services; a more joined up approach to mental health and wellbeing across education and the NHS; and preventing children developing more serious mental health problems. There was a high level of agreement with all the statements.

Setting up the Trailblazers

- Trailblazer funding was awarded to Clinical Commissioning Groups (CCGs), and they played a central role in the set up process, working with other key stakeholders including local authorities, NHS children and young people's mental health services, educational settings and voluntary sector organisations. The preparatory and set up work was considerable, and Trailblazers had to work quickly to achieve this in the twelve month period between being awarded funding and MHSTs going live. Several sites did not have project management in place at an early stage, and found it more difficult to make progress as a result.

- There was broad support for the principle of local flexibility and tailoring models and approaches to local contexts. At the same time, many also felt that this had increased the burden of work and responsibility for Trailblazers, and there were concerns about duplication of effort across sites.

- Establishing governance arrangements was an important early task. Governance bodies typically included representation from a range of stakeholder groups,

although very few involved children and young people, or parents and carers. Concerns were raised about the depth and extent of the involvement of participating educational settings in governance arrangements. There was also a view among some that the way in which the programme and funding arrangements had been set up nationally created an orientation towards NHS partners and perspectives, which could act as a barrier to fostering shared governance across health and education.

- One of the key operating principles for MHSTs it that they should *"co-produce their approach and service offer with users".* Trailblazers varied in the extent to which, and how, they were involving children, young people, parents and carers. Our early findings suggest that consultation or co-production with these groups was strongly informing the design and implementation of MHSTs in only a handful of sites.

- Educational settings were recruited to participate in the programme in two main ways: either through an open application process, or through targeting schools and colleges in areas of high deprivation and/or with particular need. Just over half of the educational settings responding to our survey (51%) reported that they had been involved in the planning and design of their local model; a higher proportion (65%) had been able to influence the day-to-day working of the MHST in their setting.

- The EMHP training and role had proven popular, but several Trailblazers reported challenges recruiting senior staff to teams. In some cases, senior team members were being recruited from local NHS children and young people's mental health services, which could potentially create knock-on staffing problems for those services. Early problems ensuring adequate supervision arrangements for EMHPs, reported by a small number of Trailblazers, appear to have been largely resolved by the time of our fieldwork.

- While most MHSTs had a similar core composition, they also included diverse 'other' roles including family support workers, counsellors, wellbeing practitioners, clinical or educational psychologists, family therapists, recruit to train therapists, speech and language therapists, peer support workers, outreach workers and youth workers. This may reflect that the Trailblazer sites were given greater flexibility in the composition of teams, compared to later waves. Interviewees drew a distinction between more clinically oriented teams and those with a stronger focus on educational settings and whole school approaches.

- Trailblazers widely reported that their local service model was underpinned by a clear understanding of local needs and service gaps (89%), and had been designed to take all groups of children and young people into account. They were

also confident that MHSTs were integrating with existing mental health provision for children and young people, both that provided in educational settings (82%) and in the wider community (68%). This integration was considered essential to the success of MHSTs.

- There were mixed views about the resources available for setting up and running MHSTs. Of the respondents to our key informants survey, 61% reported that MHSTs had sufficient financial resources to perform their core roles and responsibilities. Around two-thirds of respondents (65%) to the educational settings survey agreed that their setting had sufficient resources, including staff, to take full advantage of the opportunities that the new MHSTs offer. Given that a substantial amount of existing support for mental health within educational settings is funded by the setting itself, it was positive that the vast majority of schools and colleges (84%) did not foresee disinvesting in mental health provision once MHSTs were in place.

Progress and early outcomes

- Prior to Covid-19, Trailblazers appeared to be making good progress in implementing MHSTs. There was a strong sense that sites were learning and improving over time, and that some of the initial challenges faced had been worked on and were being resolved. The recruitment, training and transition into practice of the first cohort of EMHPs was widely regarded as a major achievement and, though not all MHST posts had been filled by early 2020, all teams were operational in some form by this time.

- Covid-19 had a major impact, both on programme implementation and on day-to-day delivery of the MHST service. Consistent with the pattern across children and young people's mental health services, there was a substantial fall in referrals to MHSTs. Educational settings were under huge pressure and dealing with many competing priorities. Coupled with the impact of lockdown, some MHSTs found it hard to build relationships with staff in schools and colleges and establish the new service. At the same time, many educational settings reported that they were seeing an increase in mental health problems: among children and young people, parents and carers, and their own staff.

- MHSTs were praised for their responsiveness and willingness to rapidly adapt their approach to try to overcome some of the barriers that lockdown presented. Broadly they responded in three main ways: using communications and working with other services to try to increase referrals; switching to remote delivery of support; and changing or expanding the support they could offer, in particular by developing resources or offering direct support to help parents and staff in educational settings manage their own mental health.

- It is likely that some of the changes MHSTs made in response to Covid-19 will endure. Trailblazers expect to continue with remote delivery for some elements of their work, although in a blended model with face-to-face approaches.

- Many of those who participated in our first phase of fieldwork shared examples of early outcomes they had observed. Better partnership working and collaboration between the organisations and sectors that were involved in the programme locally was frequently mentioned. Improvements reported by educational settings included more timely access to support; positive feedback from the children and young people who had been supported by the MHST; better signposting to external mental health services; staff feeling more knowledgeable and comfortable talking to pupils about mental health issues; and development of a more proactive and positive culture around mental health and wellbeing in their setting.

- We were told of a very small number of educational settings that had disinvested in their in-house support either before or once their MHST was in place. In these cases, the MHST had simply substituted for existing support, rather than being additional to it. The extent of disinvestment in mental health support appeared to be very small, but we will investigate this issue further in our next phase of fieldwork.

Challenges and enablers

- Aside from the impact of Covid-19, some issues and challenges were reported by Trailblazers. A common theme was around remaining gaps in support, with particular concerns raised about a lack of support for children whose needs were not 'mild to moderate' but also not serious enough to meet the referral criteria for specialist mental health support, or who needed support while they waited (often weeks, even months) for an appointment with specialist services.

- Many also shared the view that the 'standard' MHST intervention which EMHPs had been trained to deliver (brief, low-intensity CBT-informed therapy) was less suitable and effective for some groups including younger age children, children who were self-harming, children with special educational needs, and vulnerable and disadvantaged children.

- While there had been no issues recruiting sufficient numbers to the EMHP training programme and role, retaining EMHPs was widely reported as a challenge. It appears that the EMHP role is seen as a stepping stone into other careers, although there are likely to be several reasons why some EMHPs had left their post so soon after training. Trailblazers called for a stronger focus on career development and progression opportunities for EMHPs, to reduce attrition and promote workforce stability.

- Engagement of educational settings was a recurring theme. There was widespread acknowledgement that relationship building was a longer-term process and that, overall, progress was being made. Covid-19 had intensified pressures and demands on educational settings, and some lacked the time and headspace to engage with their MHST. Educational settings were keen to offer more mental health and wellbeing support to parents and carers, and to their own staff. It is not yet clear whether this can be provided by MHSTs, and this may be difficult for teams where demand is already exceeding their capacity.

- Some concerns were shared about the delayed roll-out of the training for senior mental health leads, and that some educational settings had not been adequately prepared for the programme and their MHST. It was suggested that educational settings that had – before the Trailblazer programme – made good progress towards a whole school approach were often able to make more of the opportunities offered by the programme than those that had not. This was because, for example, they already had strong support from the senior leadership team and/or an established structure for mental health promotion and support into which the MHST could fit.

- Early experiences of remotely delivered support pointed towards limitations in the reach and effectiveness of digital and online interventions. Some children and young people were unable to access support online, and these were often the same groups whose lives and mental health had been disproportionately affected by Covid-19 (for example, children living in poverty and/or in unstable home environments). Moreover, not everybody wanted to engage with digitally delivered support and, while technical challenges were being addressed, they had not been entirely overcome.

- Our findings point to several enablers and success factors for the programme: a receptive local context and, in particular, pre-existing experiences of partnership working across health and education; co-production of the MHST service and approach with children, young people, parents and carers; a stable and consistent workforce; collaboration between MHSTs and other local mental health services; MHSTs being flexible and adaptive; networking and sharing the learning; and taking a system-wide approach to implementation.

Discussion and next steps

- There was an apparent divergence in views and opinions between the quantitative and qualitative findings. Responses to the fixed choice survey questions – which largely probed people's intentions and expectations for the programme – were overwhelmingly positive. Interviewees focused on the day-to-day reality of delivering MHST services and were generally more critical, highlighting difficult challenges for the programme.

- There is an expectation that the programme will test out "different models" of MHSTs, but it is not clear what is meant by this and if or how this intention to make comparisons has guided the selection of sites (in the Trailblazer and later waves of the programme). It is clear from our research so far that Trailblazers vary, in their approach to implementation and in their MHST service model. Exploring this variation will be a key focus in the next phase of fieldwork, and we will explore the possibility of constructing a typology of Trailblazers, in order to identify the characteristics that are most likely to influence implementation and success.

- Trailblazer sites were not selected to be statistically representative of the country as a whole (either demographically, or in terms of their mental health or education systems). Rather they were chosen on the basis of particular characteristics that were thought likely to drive rapid progress and learning. This approach to implementation makes good sense but it is imperative that the programme also focuses on and helps to address longstanding inequalities in access to mental health support for children and young people. For many of the people who have participated in our research so far, this meant targeting support where it is most needed.

- Trailblazers have made good progress in establishing partnerships and an infrastructure to set up and deliver MHSTs but – at least in some sites – it appears that NHS partners are dominant in leadership and governance arrangements. This could be another example of the tendency of NHS organisations to play the dominant role in local partnership working arrangements and/or might be a reflection of the way that the programme and funding arrangements have been set up.

- The goal for Trailblazers to *co-produce* their approach with children, young people, parents and carers may be unrealistic in a nationally directed programme of this kind. But meaningful involvement is important and, especially given the demands of set up and implementation, this may be an area where Trailblazers would benefit from bringing in specialist expertise. National partners could also assess whether the overall approach in the programme is one that facilitates or impedes involvement, and what changes could be made to create a more enabling environment.

- Schools and colleges welcomed the additional capacity offered by MHSTs, which enabled them to extend the mental health support they could provide in-house. This additional capacity also came at a time when many educational settings were responding to an increase in mental health problems as a result of Covid-19. At the same time, there were concerns about what the additional capacity was for, and evident frustration that some children and young people were still falling between gaps in services and struggling to access appropriate support.

- While we expect that MHSTs will want to operate with clear eligibility and referral criteria, it is also very likely that they will be asked to support children whose mental health problems do not neatly fit into these criteria, for whom no other forms of support are available. Additional training for EMHPs may be needed so that they can tailor support appropriately, and work with children and young people who have more complex needs. Alternatively, senior and more experienced therapists in MHSTs might be best placed to provide support to children who have more serious mental health problems.

- Some educational settings reported an increase in mental health problems among parents as a result of the pandemic, and this is borne out by findings from recent research into the impact of Covid-19 on adult mental health. This may be an area where MHSTs can provide support, but this will come down to the issue of how teams balance the tension between managing their capacity and responding to needs for support.

- Staff retention emerged as a major theme, and was clearly a concern for Trailblazers. The EMHP role is based on similar para-professional roles in the

Improving Access to Psychological Therapies (IAPT) programme, for which staff retention and turnover problems also have been reported. One Trailblazer site had already developed a local career pathway for EMHPs to reduce staff turnover. In light of concerns raised about duplication of effort across Trailblazers, this is an issue which the programme's national partners might usefully seek to address.

- Much of what we learned about MHSTs related to direct support for children and young people (and parents and staff) with mental health problems. We heard less about if and how educational settings were developing a whole school approach to mental health and wellbeing, and what role MHSTs were playing in this. Some schools and colleges may need more help to prepare for and take full advantage of the opportunities presented by the programme. The senior mental health leads training could have played a role in helping to prepare educational settings, which may explain why there was disappointment about the delayed roll-out of this training programme.

- Given the impact of Covid-19, it is unsurprising that the switch to remote delivery of support was a key theme in our findings. This switch enabled MHSTs to continue to deliver some support, but early experiences show that there are limits to digital and online interventions, and that these might be poorly suited to many of the groups that are most at risk of developing mental health problems and/or least well served by existing services. Research has found that children and young people prefer a combination of face-to-face and digital support; this suggests that the blended delivery model which Trailblazers anticipate adopting post-Covid is the right one.

- As plans for post-Covid service models get underway, it is important that decisions about how much support MHSTs provide remotely are not driven solely by financial considerations. It is critical that these decisions are taken *with* children and young people, and take into account their diverse views and preferences.

- The findings in this report present a snapshot of the Trailblazer programme: data were collected over a four and a half month period (November 2020 to mid-March 2021), and for almost all of this time England was in either partial or full lockdown. Willingness to participate in the evaluation is likely to have been affected by these challenging circumstances, although we are pleased to have had responses from each of the 25 Trailblazers.

- As well as yielding important early findings for the programme, the first phase of fieldwork has been valuable in identifying themes and issues that merit further investigation in the work to come. These are summarised on pages 115 and 116 in the main report.