



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

Interim report

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A note on terminology

This report uses the term 'children and young people's mental health services' to describe all services that support children and young people who have difficulties with their mental health and wellbeing. These services encompass prevention and universal provision, through to specialist and crisis support, including in-patient care. They are provided by a range of professionals and agencies, including NHS trusts, general practice, local authorities, children's services, charities, schools and colleges, community paediatric teams, private companies and others. Some participants in the study refer to 'child and adolescent mental health services' (CAMHS), which is an older term for specialist NHS mental health services for 0-18 (or, in some areas, 0-25) year olds. We also use the term 'whole school approach' to describe the ways in which schools and colleges can promote and support the emotional health of all children and/or young people in their setting. In wider literature and debate, these activities are also referred to as holistic, universal, graduated or school-wide approaches to mental health and wellbeing.

List of abbreviations

BAME	Black, Asian and minority ethnic
CAMHS	Child and adolescent mental health services
CBT	Cognitive behavioural therapy
CCG	Clinical Commissioning Group
CQC	Care Quality Commission
CYPMHS	Children and young people's mental health services
DfE	Department for Education
EMHP	Education mental health practitioner
IAPT	Improving Access to Psychological Therapies
MHST	Mental health support team
PPE	Personal protective equipment
SEN	Special Educational Needs
VCSE	Voluntary, community and social enterprise

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.

1. Introduction

Key points

- The Children and Young People's Mental Health Trailblazer programme was launched by the Department of Health and Social Care and Department for Education 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 first wave of the programme is funding the creation of 58 mental health support teams (MHSTs) in 25 'Trailblazer' sites. Across these sites, 1,050 educational settings have been recruited to participate in the programme, each of which will receive support from a 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 National Institute for Health Research (NIHR) BRACE Rapid Evaluation Centre and the Policy Innovation and Evaluation Research Unit (PIRU) are undertaking an early process evaluation of the Trailblazer programme. This aims to examine the development, implementation and early progress of the MHSTs in the Trailblazer sites.

Background

The proportion of children and young people experiencing mental health problems is considerable and increasing. A 2020 national survey reported that one in six children had a "probable mental disorder", up from one in nine in 2017 (NHS Digital 2020). Over half of mental ill health experienced in adulthood starts before the age

of 14 (Kessler et al 2007). Yet children and young people frequently face difficulties accessing the support and/or treatment they need, with mental health services often experienced as fragmented and over-stretched, and many reporting that their problems significantly worsened before they got help (CQC 2017; Crenna-Jennings 2021; Young Minds 2018). There has been growing recognition that children's mental health services have, for too long, been marginalised and that *"children's mental health [is] the area with the biggest gap between what patients need and what the NHS was providing"* (Children's Commissioner 2021).

It is in this context that governments have, in recent years, made the transformation of children's mental health services a national priority, and committed substantial investment to achieve this (Parkin and Long 2020). Alongside action to improve access to specialist and crisis services for children and young people with serious needs and acute problems, there has been a growing focus on promotion, prevention and early intervention. A key aim is to ensure that children get early support – to reduce distress more quickly and prevent problems escalating, thereby avoiding more damaging and long-term impacts. These ambitions were set out in 2015's *Future in Mind*, which called for integrated approaches to mental health prevention and support *"through strong collaborative working across the statutory, independent and voluntary and community sectors"* (Department of Health and NHS England 2015). In particular, *Future in Mind* identified the key role that schools and colleges play in children's lives and their wellbeing. It promised to *"do more to help schools develop knowledge about mental health, identify issues when they arise and offer early support"*, including strengthening links between schools and specialist mental health services. Educational settings were also encouraged to develop whole school approaches to promoting resilience and improving emotional wellbeing.

Shortly after *Future in Mind* was published, Public Health England set out a framework for a whole school approach, wherein mental health is woven into all aspects of school or college life and seen as 'everybody's business' (Public Health England 2015). The ultimate goal is to improve the mental health of all children and young people within the setting, not just those with identified mental health problems. The approach is graduated: from universal and low-intensity strategies, through to more targeted and specialist forms of support for those who need it. The framework comprises eight key principles (Figure 1), with strong and visible leadership at the heart of the approach. From September 2020, all primary and secondary schools are required to provide compulsory health education, following a national curriculum that includes mental health and emotional wellbeing.¹ Topics include *"teaching children*

1 Due to Covid-19, schools have permission from the Department for Education to delay teaching the new PHSE curriculum until the summer term of 2021.

how to describe emotions, discuss their anxieties and worries, and develop coping strategies" (PHSE Association 2019). For older children, they also cover eating disorders, self-harm and depression and anxiety.

Figure 1. Whole school approach to emotional health and wellbeing



Source: Public Health England, 2015

The commitments made in *Future in Mind* – and later re-iterated in the *Five Year Forward View for Mental Health* (Independent Mental Health Taskforce to the NHS in England 2016) – were followed in December 2017 by the publication of the *Transforming Children and Young People's Mental Health Provision* Green Paper (Department of Health and Department for Education 2017). This set out proposals for improving the services and support available to children and young people with

mental health problems, with a particular focus on enhancing provision for those with “mild to moderate” needs. The proposals had three main elements (Box 1).

Box 1. The *Transforming Children and Young People's Mental Health Provision* Green Paper proposals

1. We will incentivise every school and college to identify a Designated Senior Lead for Mental Health to oversee the approach to mental health and wellbeing. All children and young people's mental health services should identify a link for schools and colleges. This link will provide rapid advice, consultation and signposting.
2. We will fund new Mental Health Support Teams, supervised by NHS children and young people's mental health staff, to provide specific extra capacity for early intervention and ongoing help. Their work will be managed jointly by schools, colleges and the NHS. These teams will be linked to groups of primary and secondary schools and to colleges, providing interventions to support those with mild to moderate needs and supporting the promotion of good mental health and wellbeing.
3. As we roll out the new Support Teams, we will trial a four week waiting time for access to specialist NHS children and young people's mental health services. This builds on the expansion of specialist NHS services already underway.

The government committed to taking forward all three proposals in the Green Paper, and announced that there would be phased implementation through a national Trailblazer programme, with an emphasis on testing, learning and evaluating to understand what works. A further commitment was made to roll-out the Link Programme nationally, which aims to bring together education and mental health professionals working in the same local area, using an approach that combines workshops and online learning.² Mental health support teams (MHSTs) featured prominently in the NHS Long Term Plan, and are central to the promise made in the Plan that, by 2024, an additional 345,000 0-25 year olds will be able to access support from NHS-funded mental health services. The Long Term Plan also extended the Green Paper proposals by promising that *“Teams will receive information and training to help them support young people more likely to face mental health issues – such as Lesbian, Gay, Bisexual, Transgender (LGBT+) individuals or children in care, and as they are rolled out, we will test approaches to support children and young people outside of education settings.”*

2 For more information on the Link Programme, see <https://www.annafreud.org/schools-and-colleges/research-and-practice/the-link-programme-new/schools-and-colleges/>.

The Covid-19 pandemic has compounded the need to improve children and young people's access to mental health support. Recent research suggests that Covid-19 and the experience of lockdown restrictions has disproportionately affected the mental health of children and young people, in particular among vulnerable and disadvantaged groups (Bunn 2021). A summary of this research can be found in Box 2.

Box 2. Impact of Covid-19 on children and young people's mental health and access to support services

- Several studies report that Covid-19 has had a variable impact on children's mental health. For example, England's Mental Health of Children and Young People survey reported that 54% of 11-16 years olds with mental health problems felt lockdown had made their lives worse, while 27% felt it had made their lives better (Newlove-Delgado et al 2021).
- In terms of positive effects, the Children's Commissioner for England (2021) noted that *"Some children, particularly those in families who were not impacted directly by the crisis, have enjoyed more time at home together; other children find school a source of anxiety, and this was eased when they were learning at home. This could lead to a reduction in low level stress and anxieties."*
- However, Covid-19 and the measures that were introduced to control infection rates have disproportionately affected the lives and mental health of vulnerable, marginalised and disadvantaged groups. Recent analysis suggests that among the groups most affected are children and young people living in low-income households, who have special educational needs and disabilities, who are from black and minority ethnic groups, who are in care, and LGBTQ+ children and young people (Jeffery et al 2020; Public Health England 2020).
- In a 2021 survey of 2,438 13-25 year olds who have a history of mental health needs, 67% believed that Covid-19 would have a long-term negative impact on their mental health (Young Minds 2021). Loneliness and isolation was the most common reason given for poorer mental health during lockdown, reported by 58% of respondents.
- The pandemic has also affected access to services. There was a sharp decrease in referrals to NHS children and young people's mental health services during the first lockdown. Since then, referrals have rapidly risen beyond pre-Covid levels (Children's Commissioner 2021). Many of the groups whose mental health has been most affected by Covid-19 are also groups that face the greatest difficulties accessing appropriate support (Allwood and Bell 2020).

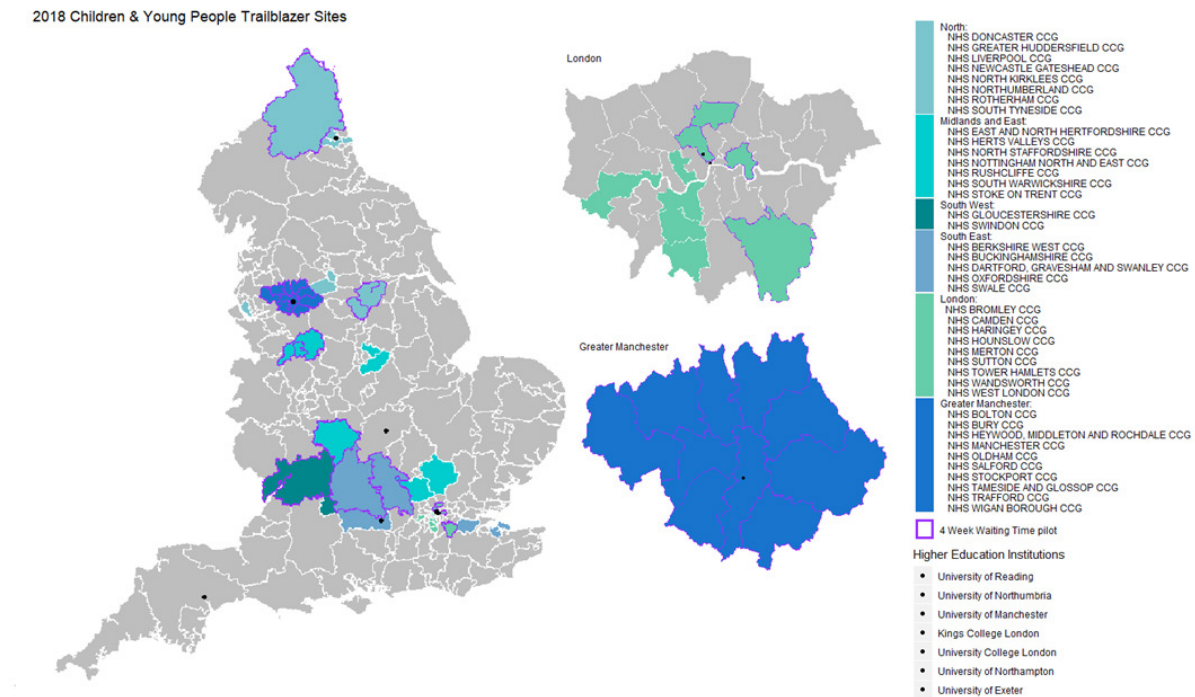
The Children and Young People's Mental Health Trailblazer programme

The Trailblazer programme was launched in 2018 and 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 involving 25 'Trailblazers' in 41 Clinical Commissioning Group (CCG) areas (Figure 2); these are henceforth referred to as the Trailblazer sites. Ten more waves will follow the Trailblazers, with a target that the new approaches are rolled out to 35% of pupils in England by 2023/24.³ A detailed programme timeline can be found in Appendix 1.

Key selection criteria for selecting Trailblazers included: demonstrable levels of investment in children and young people's mental health services; knowledge of the mental health needs of children and young people in the area; demonstrable progress to date in meeting targets for increasing access to mental health services for children and young people; and strong leadership in mental health. The rationale given for these qualifying criteria was to ensure selected areas had the capacity and capability for implementation at sufficient pace to inform testing and learning. National partners also selected to ensure some demographic diversity (e.g. deprivation, social mobility). Seven higher education institutions (HEIs) were initially appointed to provide accredited programmes to train education mental health practitioners (EMHPs).⁴ Proximity to one of these HEIs also guided selection of the Trailblazers, which resulted in some geographical clustering. Subsequently the number of HEIs offering EMHP training has increased, allowing for more evenly distributed coverage across England as the programme has progressed. Twelve of the 25 Trailblazers also incorporate pilots testing what it would take to deliver a four week waiting time target.

3 The original goal was for MHSTs to be rolled out to 20-25% of pupils in England by March 2023. In March 2021, the government announced it was increasing funding for mental health support for children and young people by £79 million (the new funding was part of the £500 million already announced for mental health support in the 2020 Spending Review). This funding is being used to increase the number of MHSTs, and improve access and reduce waiting times for community mental health support.

4 These were University of Exeter, University College London, University of Northampton, Northumbria University, University of Reading, King's College London and University of Manchester. In January 2020, the number of HEIs providing EMHP training increased from seven to 13.

Figure 2. The Trailblazer sites⁵

The overall goal of the programme is defined as follows: “*Children and young people have better mental health and wellbeing, supported and promoted by schools, colleges, parents/carers and the health system. When children and young people experience poor mental health, this is recognised, and appropriate support is identified and provided quickly.*” This is articulated in terms of three key objectives, against which the long-term success of the programme will be assessed:

- Better mental health and wellbeing amongst children and young people
- Children and young people feel better equipped and supported
- Schools and colleges feel better equipped and supported.

Local implementation of the programme is being overseen and supported by NHS England and Improvement, Health Education England and Department for Education regional teams; the last of these was newly created for the Trailblazer programme,

⁵ CCGs listed are the lead CCGs at the time that funding was awarded. Some CCGs have subsequently merged. More details can be found in Table 2 below.

aligned to the NHS regional structure. Trailblazers are expected to put in place arrangements for local governance and leadership, to include representation from the health, education and community sectors. This function can either be undertaken by an existing governance structure or a governance board/oversight group established specifically for the programme. A local project lead, working with the MHST service manager(s) in their site, is responsible for day-to-day management of the programme.

Educational settings and senior mental health leads

In the Trailblazer sites, 1,050 educational settings have been recruited to participate in the programme. These include a mixture of primary and secondary schools, all-through schools, further education (FE) colleges and other settings (Table 1). Of the 1,050 educational settings, 4.8% are special schools, 41.5% are academies or free schools, and 1.6% are pupil referral units.

Table 1. Educational settings participating in the Trailblazer sites

Region	Primary	Secondary	16 plus	All-through	Other ⁶	Total
East of England	14	9	2	0	7	32
London	150	61	2	4	15	232
Midlands	95	31	2	0	11	139
North East and Yorkshire	186	44	3	1	26	260
North West	77	46	5	1	12	141
South East	103	25	2	2	7	139
South West	73	27	3	1	3	107
Total (in Trailblazer programme)	698 (66.48%)	243 (23.14%)	19 (1.81%)	9 (0.86%)	81 (7.71%)	1050 (100%)
Total (in England)	16,787 (68.56%)	3237 (13.22%)	308 (1.26%)	159 (0.65%)	3994 (16.31%)	24,485 (100%)

Educational settings are encouraged to identify a senior mental health lead to have strategic oversight of the establishment or further development of a whole school approach to mental health in their setting. This is not a mandated role and schools

6 'Other' settings are those that do not straightforwardly align with any of the four main phase categories (i.e. primary, secondary, post 16 and all-through). The 81 settings categorised as 'other' are a mixture of independent schools, alternative provision, pupil referral units and special schools.

and colleges may choose whether and how to embed it.⁷ Senior mental health leads are expected to be a member of, or supported by, the senior leadership team in their setting. Educational settings are required to identify an MHST coordinator to work closely with the MHST, including agreeing the support that will be provided to their educational setting. This is primarily a logistical and administrative role, and may or may not be performed by the senior mental health lead.

Training will be available to senior mental health leads, to develop the knowledge and skills to work with colleagues to promote emotional wellbeing for all children in their setting and ensure that effective processes are in place to identify and support to children with mental health problems. Originally, a national training programme was planned, to be rolled out from the summer of 2020. This was subject to significant delays, and eventually the plans were halted. In the meantime, the government launched an £8 million programme in August 2020, *Wellbeing for Education Return*, to help educational settings respond to the mental health impacts of the Covid-19 pandemic and support emotional wellbeing as pupils and staff transitioned back into full school or college routines following lockdown. The initiative comprised a nationally developed training package and funding for local experts to tailor and deliver training to schools and colleges in their local area and provide support. The programme ran until the end of March 2021, but a further £7 million has since been invested to extend it – re-named Wellbeing for Education Recovery – in order that local authorities can continue to support schools and colleges. In June 2021, the Department for Education announced that educational settings could apply for a grant of “around £1,200” to purchase training for their senior mental health lead (or another senior member of staff) from a list of approved training providers. Around one-third of all state schools and colleges will receive a grant in the current financial year (up to the end of March 2022), with the goal that all will have been able to access training by 2025.

Mental health support teams

In the Trailblazer sites, the programme has funded the creation of 58 MHSTs, with each team estimated to cover a population of around 8,000 children and young people across 10-20 schools and colleges.⁸ Funding to plan, set up and run MHSTs was allocated from NHS England and Improvement to NHS CCGs with the service

7 Many educational settings had a mental health lead prior to the Green Paper and Trailblazer programme. In a national survey in 2017, 70% of schools reported having a mental health lead. A year later, 77% of post-16 educational settings reported having a lead for mental health.

8 Later waves of the programme have been based on MHSTs covering an average population of 7,000 children and young people.

itself delivered by a local organisation or organisations working in partnership. Partnership working between CCGs, schools and colleges, children and young people's mental health services, local authorities and others on the application process, and subsequently to design and implement the MHST service, was encouraged. Trailblazer sites received different levels of funding depending on what was bid for, and whether the site was also piloting the four week waiting time. For subsequent waves of the programme, the funding has been standardised so all sites receive the same amount for each MHST: basic funding of £360,000 per year, with additional funding for "higher cost areas" (British Psychological Society 2019).

Each MHST is expected to have three core functions (Box 3), while allowing sites flexibility to tailor its delivery model and interventions to local needs and existing provision. Indeed, it is an explicit intention of the Trailblazer programme that different local models will emerge, and should be compared and tested; as the Green Paper noted:

"This mix of provision will look very different in different areas, and we do not believe there is a single model that should be implemented nationally. The Trailblazer approach to the initial phase of implementation will allow us to test how best to deliver this new service through local innovation and differentiation, and understand how its benefits can extend to all children and young people, including the most vulnerable. We will invite a range of areas to develop and evaluate different models of delivering the teams, at the heart of a collaborative approach. The aim will be for Trailblazers to provide implementation support to other areas as the additional resource rolls out."
(Department of Health and Department for Education 2017)

Box 3. Mental health support team core functions

- Delivering evidence-based interventions to children and young people with mild to moderate mental health issues
- Supporting the senior mental health lead in each education setting to introduce or develop their whole school or college approach to mental health and wellbeing
- Giving timely advice to education setting staff, and liaising with external specialist services, to help children and young people to get the right support and stay in education.

In terms of the first of these functions, MHSTs will provide three broad types of intervention (NHS England 2019):

- Individual face to face work: for example, effective, brief, low-intensity interventions for children, young people and families experiencing anxiety, low mood, friendship or behavioural difficulties, based on up to date evidence
- Group work for children and young people, pupils or parents for conditions such as self-harm and anxiety
- Group parenting classes to include low intensity group approaches to issues around conduct disorder and communication difficulties.

Data on the outcomes of these interventions, along with other aspects of service activity and performance, will be routinely collected and reported by the teams. MHSTs are expected to submit data to the Mental Health Services Dataset (MHSDS) from the point at which they start receiving referrals. In parallel to this – and as an interim measure while arrangements for reporting to MHSDS are established⁹ – these data (and broader information on areas such as recruitment and staffing, spend, and governance arrangements) are reported directly to NHS England and Improvement through a quarterly monitoring process.

Across all three functions, teams are expected to plan and deliver support in collaboration with school and college staff, and existing sources of support – both within educational settings and across the wider area. A set of operating principles has been developed to underpin and guide the work of the MHSTs. The second of these principles states the MHSTs must be “*additional and complementary to existing support*” (Box 4). The operating principles also place strong emphasis on the need for robust local partnership arrangements to agree the MHST service model and oversee its implementation; co-production of that model with children, young people, families and carers; and for explicit consideration to be given to equality of access and targeted support for disadvantaged groups. Detailed guidance to support local implementation of MHSTs is provided in the form of a manual, developed by the National Collaborating Centre for Mental Health (NHS England 2019).

⁹ Currently, when MHSTs submit data to MHSDS, they do so using the team type ‘Mental Health in Education Service’. It is expected that a specific ‘Mental Health Support Team’ code will be added to MHSDS in October 2021, which will enable easier extraction and tracking of MHST activity and outcomes (as the ‘Mental Health in Education Service’ code includes other NHS funded mental health interventions in educational settings, not just MHSTs).

Box 4. Mental health support team operating principles**1. There should be clear and appropriate local governance involving health and education**

The MHST project board/oversight group should include representatives from health and education backgrounds working collaboratively. As a minimum, governance should include representation from the leadership of local NHS funded mental health care providers, education leaders from MHST education settings, commissioners, local authorities, children and young people, families and carers. Governance could also helpfully include representation from voluntary, community and social enterprise organisations (VCSE), Public Health England, school and college heads or principals, and/or governors and representatives from the wider education sector. Governance arrangements should have clear feedback and escalation processes in place.

2. MHSTs should be additional to and integrated with existing support

MHSTs are trained to deliver specific mental health support to children and young people and to support schools and colleges. The team's contribution should always be considered additional and complementary to existing support available in education settings and the wider community. The MHSTs should work with the mental health support that is already provided by existing professionals, such as school or college-based counsellors, educational psychologists, school nurses, pastoral care, educational welfare officers, voluntary, community and social enterprise organisations, local authority provision, primary care and NHS CYPMH services.

3. The approach to allocating MHST time and resources to education settings should be transparent and agreed by the local governance board

The allocation of MHST time and resources should be agreed by the governance board, in partnership with education settings and should be broadly based on pupil and student numbers. This could be adjusted for disadvantage or inequality or other factors known to influence prevalence such as age, gender and other demographic indicators if the governance board agrees there is a case to do so.

4. MHST support should be responsive to individual education settings needs, not 'one size fits all'

MHSTs should work with the senior mental health lead in each education setting to scope and design – within the skills, capabilities and capacity of the MHST staff – the support offer, gaining an understanding of the characteristics relevant to the particular setting and needs of their children and young people.

5. Children and young people should be able to access appropriate support all year (not just during term time)

The MHST service provider will ensure that children, young people and their families and carers who require interventions during educational holidays receive them, where possible from an MHST. Where this is not possible, the MHST should make the necessary arrangements to ensure the continuity of treatments where this is clinically indicated. The location of support given out of term will be determined by the resources available to the MHST.

6. MHSTs should co-produce their approach and service offer with users

MHSTs approach should be planned, developed and delivered in true partnership with children and young people, and their families and carers, to adequately reflect the needs of the individual, their support network, the education setting needs and the wider community.

7. MHSTs should be delivered in a way to take account of disadvantage and seek to reduce health inequalities

MHSTs should work to consider ways in which health needs and inequalities are addressed and that take account of disadvantage. They may need to develop specific protocols for working with particular groups to achieve this.

Mental health support team workforce and supervision

The Trailblazer programme promises a significant expansion of the children and young people's mental health workforce, and the creation of a new professional role: education mental health practitioner (EMHP). Estimates suggest that 8,000 new mental health staff would be required for the MHST model to be rolled out across England (Department of Health and Social Care and Department for Education 2018). That would represent a more than 50% growth in the children's mental health workforce, which currently stands at just under 15,000 whole time equivalents (Health Education England 2019).

It is envisaged that each MHST will be made up of eight members. The indicative team composition is four EMHPs, a NHS Band 5 (Band 4 during training) role which is based on the children's wellbeing practitioner role developed in the Children and Young People's Improving Access to Psychological Therapies (IAPT) programme. A further three posts are allocated to more experienced practitioners (NHS Band 7-8a, or equivalent), who act as senior therapists and/or – after undertaking specific training – fulfil a supervisory role to EMHPs. The remaining post is split into one 0.5 full time equivalent team manager and a 0.5 full time equivalent administrator role. The Trailblazer sites were given greater flexibility in the composition of teams, compared to later waves.

EMHPs undergo one year, full-time postgraduate training, combining classroom-based learning and supervised placements in educational settings. The academic element of the training follows an agreed national curriculum, and is comprised of six core modules:

- Fundamental Skills: Children and Young People's Mental Health Settings – Content and Values
- Fundamental Skills: Assessment and Engagement
- Evidence-based Interventions: Theory and Skills
- Working, Engaging and Assessing in Educational Settings
- Common Problems and Processes in Educational Settings
- Interventions for Emerging Mental Health Difficulties in Educational Settings.

To fulfil the direct support element of their role, EMHPs are trained to deliver brief low-intensity psychological interventions, grounded in cognitive behavioural therapy (CBT) and guided self-help principles, including one-to-one and group-based interventions. The training focuses on four types of interventions (Ludlow et al 2020):

- Parent-led guided self-help for primary-school-aged children with mild-to-moderate anxiety disorders
- Guided self-help for mild-to-moderate adolescent depression, based on behaviour activation principles
- Guided self-help for mild-to-moderate adolescent anxiety disorders, based on CBT principles
- Parent-led guided self-help for mild-to-moderate behaviour problems (primary-school-aged), based on social learning theory.

Typically, interventions will be delivered over up to eight sessions. EMHPs are supervised by more senior and experienced colleagues from the team. The competency framework for EMHP supervisors specifies that supervisors must have a minimum of two years of experience “*working therapeutically, clinically or consultatively within a CYP Educational or Mental Health Setting*”, and experience of CBT-informed supervision; experience of delivering mental health interventions in educational settings is considered desirable (Health Education England 2020). By April 2021, more than 680 EMHPs had been trained or were in training.

The early evaluation of the Trailblazer programme

In early 2019, the BRACE Rapid Evaluation Centre and Policy Innovation and Evaluation Research Unit (PIRU) agreed to undertake an early evaluation of the Trailblazer programme. This is a mixed-methods, process-oriented study, which aims

to examine the development, implementation and early progress of the MHSTs in the Trailblazer sites. Detailed study aims can be found in Box 5. The evaluation is exploring how service delivery models and implementation strategies differ across Trailblazer sites, highlighting the factors that are inhibiting or promoting success and drawing out the practical implications of the findings for the ongoing development and delivery of the programme (at a national and local level). The four week waiting time pilots, EMHP training programme and senior mental health leads training are outside the formal scope of the evaluation. The evaluation is funded through the BRACE and PIRU core grants, which are provided by the National Institute for Health Research (NIHR) Health Services and Delivery Research programme and Policy Research Programme respectively.

Box 5. Aims of the evaluation

1. Understand the baseline position and contextual features of the Trailblazer sites, including the accessibility, quality and effectiveness of existing mental health services and support in educational settings and perceived gaps in provision prior to the programme commencing.
2. Describe and understand the emerging delivery models, their leadership and governance, and explore how these vary across the Trailblazer sites and the potential implications of this variation for future effectiveness of the programme. This includes examining how new roles and services are working in practice, what is working well and what is not, and barriers and facilitators to successful implementation.
3. Describe the experience of MHSTs, educational settings, clinical commissioning group (CCG) and local authority commissioners, children and young people's mental health services and others of taking part in the delivery of the programme.
4. Capture views about the progress being made by Trailblazers towards the goals of the programme, early impacts and any unanticipated consequences in the initial phases of the programme.
5. Identify measures and data sources of relevance to assessing programme outcomes and costs as well as appropriate comparator areas and educational settings in order to assess the feasibility and develop the design of a long-term outcome and economic evaluation.
6. Conduct formative and learning-oriented research, producing timely findings and highlighting their practical implications to inform ongoing implementation and support roll-out to sites in later waves of the programme.
7. Understand how MHSTs adapted their services and ways of working in response to the Covid-19 pandemic, and explore experiences of and learning from these changes, as well as their legacy.

While this early evaluation is not a summative evaluation, as it is too soon in the programme timescale to make a formal assessment of impact, it is exploring with key groups their views and experiences of the programme, including what they think it is achieving in its early stages. It is intended that this initial study will be followed by a longer-term assessment of the programme's outcomes and impacts, including if feasible, an economic evaluation. Scoping design options and informing the specification for a longer-term impact evaluation is a key aim of this early study (see aim 5 in Box 5 above). The delay to commencing fieldwork for the early evaluation, primarily due to Covid-19, has meant that the commissioning of a longer-term impact evaluation is likely to take place in parallel to this study, rather than following on from it.

Following detailed scoping work and the development of a study protocol, the evaluation commenced in October 2019, and was expected to finish in May 2021. However, the study was formally paused in March 2020, at the point at which the research team was ready to commence fieldwork. It resumed in October 2020, and this report summarises data gathered between November 2020 and mid-March 2021. For most of this time, England was in lockdown and educational settings were only open to vulnerable children and those whose parents were key-workers, with the remainder being schooled at home. MHSTs, still in their infancy, had to rapidly adapt their approaches and ways of working so that they could continue to operate. As discussed in detail in Chapter 6, this included switching from face-to-face to remotely delivered support. Therefore, the findings in this report represent the early experiences of MHSTs operating in challenging circumstances, very different from those envisaged when the programme started, and should be interpreted in this context.

2. Overview of the Trailblazer sites

Key points

- Each Trailblazer has received funding to set up between two and four mental health support teams. 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 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, compared to a national average of £59) and as a proportion of the overall CCG budget (1.03%, compared to 0.92% national average).
- Across the indicators selected, the performance of NHS specialist mental health services was better in Trailblazer sites, compared to the national picture, 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.

Trailblazer characteristics

The first 25 Trailblazer sites were announced by the Department of Health and Social Care and Department for Education in December 2018. The first cohort of education mental health practitioners (EMHPs) commenced their training in January 2019, with the goal that the 58 mental health support teams (MHSTs) created in these sites would become fully operational from the end of the year. A Trailblazer site is defined geographically by the boundary of the Clinical Commissioning Group (CCG) or CCGs awarded the funding. Each site was funded to create between two and four MHSTs, each team supporting a cluster of educational settings located within that

boundary. Some of the Trailblazer sites successfully bid for funding in later waves of the programme, and so have several teams at different stages of development.

Key characteristics of the Trailblazer sites are presented in Table 2. By the time our fieldwork started in November 2020, Stoke-on-Trent and North Staffordshire had effectively combined into a single Trailblazer, with a single project lead and shared MHST model delivered by the same NHS trust. These two sites were also jointly awarded funding to pilot the four week waiting time.

Table 2. Key characteristics of the Trailblazer sites

Trailblazer site	Region	Lead CCG ¹⁰	MHST service provider(s)	Number of MHSTs funded in Trailblazer wave	Number of educational settings supported by MHSTs	Children and young people population covered by MHSTs ¹¹	4WW time pilot ¹²	MHSTs funded in subsequent waves ¹³
Berkshire West	South East	Berkshire West CCG	Berkshire Healthcare NHS Foundation Trust; Brighter Futures for Children	2	40	14,180	✗	✗
Bromley	London	South East London CCG*	Oxleas NHS Foundation Trust; Bromley Y	2	48	29,441	✓	✓
Buckinghamshire	South East	Buckinghamshire CCG	Oxford Health Foundation Trust	2	29	17,441	✓	✗
Camden	London	North Central London CCG*	Tavistock and Portman NHS Foundation Trust	2	27	15,101	✓	✓
Doncaster and Rotherham	North East and Yorkshire	Doncaster CCG	Rotherham, Doncaster and South Humber NHS Foundation Trust	4	57	32,968	✓	✗
Gloucestershire	South West	Gloucestershire CCG	Gloucestershire Health and Care NHS Foundation Trust; TIC+	4	70	38,597	✓	✗

10 Since Trailblazer status was awarded, a number of CCGs have been involved in mergers. These CCGs are indicated with *. The lead CCGs for these Trailblazer sites were originally as follows (in order of the table): Bromley CCG; Camden CCG; Haringey CCG; Hounslow CCG; North Kirklees CCG; Swale CCG; Nottingham North and East CCG; South Warwickshire CCG; Wandsworth CCG; Swindon CCG; Tower Hamlets CCG and West London CCG.

11 For Trailblazer sites where participating educational settings include further education colleges, the 'Children and young people population covered by MHSTs' figure might – if those colleges accept mature learners – include adults aged 19 and above. Publicly available data on registered student populations in further education colleges does not separately report students aged 16-18 and those aged 19 and above.

12 Stoke on Trent and North Staffs were jointly awarded funding to be a four week waiting time pilot site.

13 If MHSTs have been funded, in subsequent waves, in areas covered by post-merger CCGs.

Trailblazer site	Region	Lead CCG ¹⁰	MHST service provider(s)	Number of MHSTs funded in Trailblazer wave	Number of educational settings supported by MHSTs	Children and young people population covered by MHSTs ¹¹	4WW time pilot ¹²	MHSTs funded in subsequent waves ¹³
Greater Manchester ¹⁴	North West	Greater Manchester Health and Social Care Partnership	Manchester University NHS Foundation Trust; 42nd Street; Manchester Mind; Place2be	2	64	44,525	✓	✓
Haringey	London	North Central London CCG*	Barnet, Enfield and Haringey Mental Health Trust	2	37	32,321	✓	✓
Hertfordshire	East of England	Herts Valleys CCG	Hertfordshire Partnership University NHS Foundation Trust	2	32	25,953	✗	✓
Hounslow	London	North West London CCG*	West London NHS Trust	2	24	16,997	✗	✓
Kirklees	North West	Kirklees CCG*	South West Yorkshire Partnership NHS Foundation Trust	2	38	16,776	✗	✓
Liverpool	North West	Liverpool CCG	Alder Hey Children's NHS Foundation Trust	3	24	8,788	✗	✓
Newcastle	North East and Yorkshire	Newcastle Gateshead CCG	The Children's Society	3	105	47,392	✗	✗
North Kent	South East	Kent and Medway CCG*	North East London NHS Foundation Trust	2	36	31,172	✗	✓

¹⁴ The approach in Greater Manchester has been markedly different from the other Trailblazer sites. Under their devolution agreement, Greater Manchester had already established a programme focused on preventing mental health problems through schools-based interventions: the Mental Healthy School Pilot. The additional funding from the Trailblazer programme was initially invested in this pilot, and supported teams that were delivering similar functions to MHSTs (including a focus on delivering direct support to children with mild-moderate mental health problems) but that were different in composition and approach. Since early 2020, the approach in GM has become more closely aligned with the national MHST model.

Trailblazer site	Region	Lead CCG ¹⁰	MHST service provider(s)	Number of MHSTs funded in Trailblazer wave	Number of educational settings supported by MHSTs	Children and young people population covered by MHSTs ¹¹	4WW time pilot ¹²	MHSTs funded in subsequent waves ¹³
North Staffordshire	Midlands	North Staffordshire CCG	North Staffordshire Combined Healthcare NHS Trust	2	23	6,921	✓	✓
Northumberland	North East and Yorkshire	Northumberland CCG	Cumbria, Northumberland Tyne and Wear NHS Foundation Trust	2	27	9,224	✓	✓
Nottinghamshire	Midlands	Nottingham and Nottinghamshire CCG*	Nottinghamshire Healthcare NHS Foundation Trust	2	41	16,625	✗	✓
Oxfordshire	South East	Oxfordshire CCG	Oxford Health NHS Foundation Trust; Response	2	34	16,803	✓	✓
South Tyneside	North East and Yorkshire	South Tyneside CCG	South Tyneside and Sunderland NHS Foundation Trust; Cumbria, Northumberland Tyne and Wear NHS Foundation Trust	2	33	18,074	✗	✓
South Warwickshire	Midlands	Coventry and Warwickshire CCG*	Coventry and Warwickshire Partnership NHS Trust	2	45	16,890	✓	✓
South West London	London	South West London CCG*	South West London and St George's Mental Health NHS Trust	3	44	25,954	✗	✓
Stoke on Trent	Midlands	Stoke-on-Trent CCG	North Staffordshire Combined Healthcare NHS Trust	2	28	24,237	✓	✓

Trailblazer site	Region	Lead CCG ¹⁰	MHST service provider(s)	Number of MHSTs funded in Trailblazer wave	Number of educational settings supported by MHSTs	Children and young people population covered by MHSTs ¹¹	4WW time pilot ¹²	MHSTs funded in subsequent waves ¹³
Swindon	South West	Bath and North East Somerset, Swindon and Wiltshire CCG*	Barnardo's	3	37	35,854	✖	✓
Tower Hamlets	London	North East London CCG*	East London NHS Foundation Trust	2	22	16,349	✓	✓
West London	London	North West London CCG*	Hammersmith and Fulham Mind	2	30	12,440	✖	✓

Demographic and mental health service profiles

Data on a range of indicators have been collated to create demographic and mental health service profiles for each of the 25 Trailblazer sites. There were two key aims in compiling these profiles:

- To produce a dataset of key indicators, in order to characterise and compare Trailblazers, both to one another and to national averages. This would enable an assessment of the extent of (e.g. ethnic) diversity across the 25 sites, and also of how representative the Trailblazers are of England as a whole.
- To inform the selection of the six case study sites for in-depth research. The team sought to purposively select a diverse range of sites, and this process included consideration of several of the indicators listed below, including: % black, Asian and minority ethnic (BAME) population, Index of Multiple Deprivation scores, CCG spend on mental health per child, and Care Quality Commission (CQC) ratings for specialist community mental health services for children and young people.

For each indicator, data were gathered for the lead CCG for the programme in Trailblazer sites and the main NHS provider of specialist children and young people's mental health services in the area. We used data reported closest to December 2018, to create a snapshot of population characteristics and service performance at the time that the Trailblazer sites were announced. The methodology, description of indicators used and full data tables can be found in the Technical Appendix that accompanies this report.

This section provides an overview of the data, including Trailblazer and national averages, and describes the highest and lowest values for each indicator to give a sense of the diversity across the 25 sites.

Table 3. Comparison of national and Trailblazer averages for key demographic and mental health service indicators

Indicator	Reporting period	National average	Trailblazer average	Highest value for a Trailblazer site	Lowest value for a Trailblazer site
Black and Minority Ethnic Population (%; by CCG)	2018/19	14.6%	18.7%	54.8%	1.6%
Index of multiple deprivation (by CCG; <i>larger scores indicate higher deprivation</i>) ¹⁵	2019	21.7	22.2	42.4	10.0
Estimated prevalence of emotional disorders: ages 5-16 (% of population; by CCG)	2017/18	3.6%	3.6%	4.2%	3.1%
Estimated prevalence of common mental disorders: ages 16 and above (% of population; by CCG)	2018/19	16.9%	17.6%	22.8%	13.3%
The percentage of referrals to NHS CYPMHS that are closed before treatment (by CCG)	2018/19	34.0%	30.1%	46%	12%
Average waiting time between referral to NHS CYPMHS and second contact (by CCG)	2018/19	53 days	59 days	90 days	29 days
Total number of children referred to NHS CYPMHS as a proportion of the under-18 population (by CCG)	2018/19	3.6%	3.52%	6.20%	2.32%
Mental health spend per child (by CCG)	2018/19	£59.22	£68.75	£140.18	£39.32
CCG spend on children's mental health as a percentage of total CCG budget	2018/19	0.92%	1.03%	1.82%	0.67%
Provider in SOF segment 3 or 4 during the year (by NHS CYPMHS provider) ¹⁶	2018/19	SOF 3: 28% of providers SOF 4: 9% of providers	SOF 3: 12% of providers SOF 4: 0% of providers	NA	NA

15 Index of Multiple Deprivation is a measure of relative deprivation and combines information on seven domains of deprivation: income; employment; education; skills and training; health and disability; crime; barriers to housing services; and living environment.

16 The Single Oversight Framework (SOF) is intended to help NHS England and Improvement identify NHS trusts that may be in need of support. The score for each trust is based on an assessment across five domains: quality of care, finance and use of resources, operational performance, strategic change and leadership and improvement capability. SOF segment 3 is "providers receiving mandated support for significant concerns"; segment 4 is "providers in special measures".

Indicator	Reporting period	National average	Trailblazer average	Highest value for a Trailblazer site	Lowest value for a Trailblazer site
CQC Trust rating: overall (by NHS CYPMHS provider)	2017-2018	Outstanding: 6%	Outstanding: 16%	NA	NA
		Good: 60%	Good: 76%		
		Requires improvement: 31%	Requires improvement: 8%		
		Inadequate: 3%	Inadequate: 0%		
CQC Trust rating: specialist community mental health services for children and young people (by NHS CYPMHS provider) ¹⁷	2015-2018	Outstanding: 9%	Outstanding: 17%	NA	NA
		Good: 65%	Good: 67%		
		Requires improvement: 24%	Requires improvement: 17%		
		Inadequate: 2%	Inadequate: 0%		

17 No rating is available for Greater Manchester Mental Health NHS Foundation Trust pre-2019, as specialist community mental health services for children and young people was added as a core service to the trust only in April 2018.

Routine data, especially on service performance, can be difficult to interpret without additional contextualising information, and therefore some caution should be exercised when comparing the figures presented in the tables above. Notwithstanding, some general observations can be made:

- Trailblazer sites had proportionally larger BAME populations (18.7%, versus 14.6%) and recorded slightly higher levels of deprivation, compared to the national average. There was also substantial variation across the 25 Trailblazers for these two indicators. For example, the percentage of local populations from BAME groups ranged from a low of 1.6% to a high of 54.8%. IMD (Index of Multiple Deprivation) scores ranged from a low of 10.0 to a high of 42.4.
- Average recorded prevalence of emotional disorders among 5-16 year olds was identical in the Trailblazer sites and for England overall, at 3.6%. Prevalence of common mental disorders among those aged 16 and above was slightly higher in the Trailblazer sites (17.6%) compared to the national average (16.9%).
- 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).
- Similarly, 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. In terms of overall CQC ratings for the trusts providing children and young people's mental health services in the Trailblazer sites, 92% were rated outstanding or good (compared to 66% of trusts in England overall). At the time that data were reported, 37% of all NHS trusts providing mental health services to children and young people were considered to have significant support needs or were in special measures, compared to only 12% in the Trailblazer sites.
- Some of the indicators reported above are particularly difficult to interpret, including 'The percentage of referrals to NHS CYPMHS that are closed before treatment' and 'Total number of children referred to NHS CYPMHS as a proportion of the under-18 population'. Trailblazer averages for both of these indicators were slightly lower than the national average, but there may be several explanations for this. For example, the smaller proportion of children and young people being referred to NHS services in Trailblazer sites might be reflective of child and parental preferences for support, local referral practices and thresholds, or the availability of non-NHS services in the areas concerned (e.g. services provided by voluntary sector organisations or local authorities).

The stronger performance of specialist NHS services in the Trailblazer sites, compared to the national picture, is to be expected. As we noted in Chapter 1, 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. For example, the selection criteria explicitly excluded CCGs in special measures, and NHS provider trusts rated by the CQC as 'inadequate'.

3. Methods

Key points

- This interim report shares findings from the first phase of fieldwork, undertaken between November 2020 and mid-March 2021. This fieldwork included a survey of participating schools and colleges, a survey of other key informants in Trailblazer sites, and interviews with regional teams and local project leads.
- Other sources of data that informed the analysis include a review of documentation for Trailblazer sites; programme monitoring data; and data from a 2019 baseline survey of mental health provision in educational settings undertaken by the Department for Education.
- Response rates varied, and the Covid-19 pandemic is likely to have affected people's willingness and ability to take part. That said, we received survey responses from all 25 Trailblazer sites, and interviewed members of all seven regional teams.
- A second phase of fieldwork is now underway, and includes in-depth research with six Trailblazer sites, and focus groups with children and young people. Follow up surveys are planned for late 2021.

The overall aim and detailed objectives of the evaluation are presented in Box 5 (Chapter 1) above. To meet these aims and objectives, a mixed-methods evaluation was designed that combined quantitative and qualitative data collection across all 25 Trailblazers with in-depth qualitative insights from six purposively selected Trailblazers. This design enables an analysis of starting points and development across the programme as a whole and provides the kind of information which is essential not just for assessing whether progress is being made, but also for teasing out the *underlying mechanisms*: where there is solid progress, how is this being achieved; where there is not, why is this so? Underpinning the study is an evaluation framework which identifies four key levels of investigation: children, young people and families; mental health support teams (MHSTs); educational settings; and wider local systems (see Appendix 2 for more details).

The overall evaluation has been designed to combine breadth and depth in data collection and comprises three work packages:

- **Work package 1:** Establishing the baseline and understanding the development and early impacts of the Trailblazers. This involves high-level research across all 25 Trailblazer sites.
- **Work package 2:** In-depth research with a range of stakeholders in six purposively selected Trailblazer sites, and focus groups with children and young people.
- **Work package 3:** Scoping and developing an evaluation protocol for a longer-term summative assessment of the programme's outcomes and impacts.

This interim report outlines the early results of work package 1 only. Specifically it presents the findings from data collection undertaken between November 2020 and mid-March 2021. Work package 2 commenced in March 2021, and the findings from this will be shared in our final report, to be published in summer 2022. Detailed work to identify options for and explore the feasibility of a longer-term impact evaluation (work package 3) has been undertaken during 2020 and 2021. A paper outlining this work and proposing recommendations for the design and commissioning of that evaluation was shared with the national programme team and NIHR in April 2021. In addition, the team has scoped and developed a proposal for a preliminary impact evaluation study using routine education and health data, which is currently under consideration.

Ethical and Health Research Authority approval

This study has been approved by the Research Ethics Committees at the University of Birmingham (ERN_19-1400 - RG_19-190) and London School of Hygiene and Tropical Medicine (Ref: 18040) and by the Health Research Authority (IRAS 270760).

Data collection

Regional lead interviews

Between November 2020 and January 2021, we invited all NHS England and Improvement and Department for Education regional programme leads to participate in an interview. Participants were given the opportunity to be interviewed alone or with the other lead(s) from their region, and to invite other regional colleagues to join the interview if they wished. The main rationale for offering the option of a group interview was to encourage regional leads to explore their shared experiences of the programme, across health and education. Group interviews can

also encourage reflection and sense-making, in so doing producing richer insights than one-to-one interviews.

Eight group interviews were conducted with a total of 27 individuals (ranging from 3 to 7 participants per interview). Group interviews were held either with individuals from the same region, or with individuals in the same role across multiple regions. The breakdown of interviewees' roles was as follows:

- NHS England and Improvement regional leads: 12
- Department for Education regional leads: 10
- Health Education England regional leads: 3
- Other regional colleagues: 2

Interviews were semi-structured and followed a topic guide which covered a range of themes including (see Appendix 3 for copies of all research tools):

- regional and local contexts
- progress to date
- the impact of Covid-19 on plans and approaches
- experiences of Trailblazer development and delivery
- what was working well and less well.

They were all around one hour in length and were conducted remotely, via Microsoft Teams or Zoom. With participants' consent, they were audio recorded for transcription. The two research team members who carried out the interviews each independently reviewed and themed their transcripts, initially guided by a set of themes deductively generated from the literature and programme documentation review and capturing the main study aims. The two researchers met regularly during the analysis process, and additional themes emerging inductively from the data were added. These meetings supported a process of sense-making, which paid attention both to commonalities across the data, and divergent accounts and experiences. A list of topics and issues that merited further investigation in the second phase of data collection was also generated, and discussed with the wider team.

Surveys

Two online surveys were conducted during late 2020 and early 2021: i) a survey of participating educational settings in the Trailblazer sites; and ii) a key informants survey of local stakeholders involved in the programme. A second round of surveys will commence in late 2021. In addition, the research team drew on data from

a baseline survey of mental health provision in the educational settings in the Trailblazer sites, which was undertaken by the Department for Education in 2019. Further details of this survey can be found in Table 7 below.

Educational settings survey

The first survey to be conducted targeted educational settings participating in the Trailblazer programme. The questionnaire was designed with input from a range of experts and stakeholders, including a number of local project leads and other key personnel in sites participating in the programme (both Trailblazer sites and later waves); members of the national programme team from the Department for Education; and specialist advisors to the evaluation team with expertise in mental health promotion and provision within educational settings. The survey was open between November 2020 and February 2021. Contact details for the senior mental health leads (or MHST coordinator, where this role was not in place) in participating educational settings were obtained from the project leads for that Trailblazer site. All contacts were sent an invitation to complete the survey by email, and up to three reminders. The research team also asked if project leads could contact the educational settings in their site to encourage completion of the survey, and several agreed to do so. The survey was administered using the online platform Qualtrics. The content of the survey questionnaire is summarised in Box 6.

Box 6. Content of the educational settings survey questionnaire

- Questionnaire included 32 closed and open-ended questions.
- Topics included:
 - Mental health programmes and resources in place pre-programme
 - Educational setting's commitment to the whole school approach
 - Expectations for the Trailblazer programme
 - Governance and involvement in the Trailblazer programme design
 - Readiness to implement the programme
 - Availability of resources to implement the programme
 - Impact of Covid-19 on educational setting's ability to provide mental health support for children and young people, and wider impact on mental health and wellbeing in the setting.

In total, 1,008 invitations were sent to staff in educational settings across 24 Trailblazer sites; the survey was not conducted in Greater Manchester.¹⁸ In total, 299 responses were received (29.6% of those invited to take part), with the number of respondents per site ranging from three to 29. The response rates for each site are summarised in Table 4 and a breakdown of respondents' roles in Table 5. As is typical of these types of survey, variation in response rates is likely due to several factors including the willingness of project leads and other key people in Trailblazer sites to raise awareness of the evaluation and encourage participation; the timing of the survey; potential clashes with other local activities (e.g. data collection for locally commissioned evaluations); the size and complexity of the Trailblazer; degree of understanding and support for evaluation; and whether the individuals on our contact lists were still in post at the point at which the survey was administered.

Table 4. Summary of response rates per site for the educational settings survey

Trailblazer site	Invitations sent	Responses received	Response rate (%)	% of total responses
Berkshire West	41	4	9.7	1.3
Bromley	48	23	47.9	7.7
Buckinghamshire	43	20	46.5	6.7
Camden	26	3	11.5	1.0
Doncaster & Rotherham	38	13	34.2	4.3
Gloucestershire	70	29	41.4	9.7
Haringey	37	15	40.5	5.0
Hertfordshire	31	9	29.0	3.0
Hounslow	20	5	25.0	1.7
Kirklees	37	14	37.8	4.7
Liverpool	24	10	41.6	3.3
Newcastle	109	25	22.9	8.4
North Kent	35	12	34.2	4.0
North Staffordshire & Stoke on Trent	65	23	35.4	7.7
Northumberland	33	7	21.2	2.3
Nottinghamshire	43	5	11.6	1.7

18 The research team was advised by the programme team in Greater Manchester that local educational settings were experiencing additional burden as a result of the Covid-19 pandemic, and hence the timing of the survey was not conducive to eliciting a high response.

Trailblazer site	Invitations sent	Responses received	Response rate (%)	% of total responses
Oxfordshire	36	7	19.4	2.3
South Tyneside	60	18	30.0	6.0
South Warwickshire	50	6	12.0	2.0
South West London HCP	64	26	40.6	8.7
Swindon	43	12	27.9	4.0
Tower Hamlets	25	8	32.0	2.7
West London	30	5	16.6	1.7
Total	1,008	299	29.6	100.0

Table 5. Breakdown of respondents' roles for the educational settings survey

Role	Number ¹⁹
Senior mental health lead for Trailblazer programme	185
Lead for mental health, not specifically in relation to the Trailblazer programme	111
Special education needs coordinator or equivalent	100
Pastoral Lead	75
Other member of senior leadership team	71
Deputy head teacher/vice principal or equivalent	62
Support staff (e.g. inclusion, safeguarding)	50
Head teacher/principal or equivalent	46
Mental health support team coordinator	41
Other role	34
Other teaching staff	17
Year head	4

It was originally intended that the survey would capture information about the Trailblazers before MHSTs became operational but, due to delays in commencing the survey, it was administered some months after that point, well into the second wave

¹⁹ This adds up to more than the total number of survey responses as respondents could select more than one option.

of the Covid-19 pandemic. In order that the survey provide information about local contexts for and expectations of the programme before Covid-19 and the introduction of lockdown measures, the introduction to the survey included the following guidance to respondents: *“When answering, please think about the period before restricted opening of educational settings as a result of the Coronavirus (COVID-19) pandemic, unless asked otherwise in the question.”*

Answers to the closed-ended questions were exported to Excel for quantitative analysis, while responses to open-ended questions were analysed and grouped into themes for reporting. An initial set of themes was developed after reading all the free-text responses and these were further refined during discussions with the research team. Given the large amount of qualitative data and range of themes emerging from the free-text responses, a list of the key themes for each question was produced and used for cross-analysis and reporting.

Key informants survey

The survey of other key informants was sent to individuals who were playing or had played a central role in the design and implementation of the MHSTs in their area. As with the educational settings survey, the key informants survey was designed and refined in collaboration with a range of stakeholders, including specialist advisors to the evaluation team and a small number of MHST service managers (from Trailblazer sites, and sites participating in later waves of the programme).

Trailblazer sites were asked to provide a list of contacts, and we suggested that this list include the project lead, senior responsible officer, local authority education lead, organisation (or organisations) providing the MHST service, MHST manager(s), and programme contacts/leads from the Clinical Commissioning Group (CCG), local authority, specialist NHS children and young people's mental health service and any voluntary sector organisations involved. All stakeholders were asked the same core set of questions, with additional questions posed to specific groups (e.g. MHST managers, education leads and project leads) to obtain further details on specific aspects of the programme locally, such as around resourcing. The survey was administered using the online platform SmartSurvey. The content of the survey questionnaire is summarised in Box 7.

Box 7. Content of the key informants survey questionnaire

- Questionnaire included 55 questions for local project leads and 28 questions for other stakeholders.
- Core questions covered the following topics: expectations for the programme; local context; how the services and approaches are being implemented; progress made so far; any factors that are helping or hindering progress; and the impact of Covid-19 on the programme.
- Project leads were asked additional questions on: priorities for children and young people's mental health in their area, and whether/how the programme fits with these; whether a local evaluation of the programme is planned or underway; which organisation(s) is providing the MHST service; how educational settings were recruited; level of involvement of different stakeholder groups; whether/how the service model is designed to meet diverse needs; recruitment and training; resourcing; and programme outcomes.

The survey commenced in December 2020 and was closed in May 2021. A total of 291 individuals across the 25 Trailblazer sites received an invitation to participate, followed by one reminder. Responses submitted up until the end of March 2021 have been analysed for this interim report; four additional responses were received after this time, and these will be included in the analysis for the final report. The evaluation team used a number of ways to encourage participation. This included asking regional programme leads and local project leads to contact stakeholders in their area and encourage them to complete the survey. In addition, project leads who themselves had not responded to the survey by the end of February were given the alternative option of participating in an interview, to complete the survey with a member of the evaluation team and, at the same time, share their wider views and experiences of the programme. This allowed gaps in survey responses to be filled in, as well as exploring additional themes in a more qualitative manner during the interview. Interviews were held with three project leads in February and early March 2021.

The survey was completed by 15 project leads, including the three who completed via telephone, and 61 other key stakeholders (26% response rate). The profile of the 76 respondents – by site and role – is summarised in Table 6 below. As this shows, we received at least one response from each Trailblazer site and, broadly, there was a good spread of responses across the different roles, although only two surveys were returned from people working in specialist NHS mental health services. Data were exported to Excel for analysis. Fixed-response questions were quantitatively analysed in Excel. Responses to open-ended questions were grouped and thematically analysed.

Table 6. Breakdown of key informants survey respondents by site and role

Trailblazer	Total no. responses	Role	Total no. responses*
Berkshire West	3	Project lead	15
Bromley	5	Senior responsible officer	6
Buckinghamshire	1	CCG lead	10
Camden	1	MHST manager	15
Doncaster and Rotherham	4	Education lead	10
Gloucestershire	2	Specialist NHS mental health service	2
Haringey	9	Local authority (not education lead)	6
Hertfordshire	4	Voluntary sector	11
Hounslow	1	Other**	4
Liverpool	3		
Greater Manchester	5		
North Staffordshire and Stoke on Trent	5		
Newcastle	1		
North Kent	6		
Kirklees	2		
Northumberland	1		
Nottinghamshire	3		
Oxfordshire	5		
South Tyneside	4		
South Warwickshire	2		
South West London HCP	4		
Swindon	3		
Tower Hamlets	1		
West London	1		
Total	76		

*Respondents could select more than one role.

**Where 'other' responses aligned with existing categories, they were reassigned to the appropriate existing option (e.g. the response of 'charity' was reassigned as the voluntary sector)

Cross analysis and synthesis of data

Initially, each dataset was independently analysed by the research team member(s) leading that element of data collection. A detailed summary of significant findings was produced for each data collection activity to support cross-comparison and synthesis, and shared with all members of the team. These summaries were discussed at three data analysis workshops, where insights from the different sources of data were compared, recurrent themes were identified, key themes for reporting were agreed and a list of priority topics for further investigation in the next phase of fieldwork was generated. As well as looking for commonalities, attention was also paid to identifying and exploring divergence: between the views and experiences reported and between the different types of data. What emerged from this comparative analysis was an apparent divergence between the quantitative and the qualitative data. Specifically, people's intentions and expectations for the programme – reflected in the quantitative survey data – were generally positive. In the interviews and free-text responses to the survey, there was a greater focus on the challenges that had arisen during the design and implementation of the programme. This points to the value of the mixed-method design, which has provided a more balanced picture of the programme and how it has been received and implemented locally than would have been the case with either a purely qualitative or quantitative study.

Other sources of data that have informed analysis

In addition to the data collection activities described above, the evaluation team collected and reviewed data from a number of other sources to inform the team's understanding of the programme and the analysis. These additional sources of data included:

- Scoping interviews
- Familiarisation visits
- Trailblazer document review
- Programme monitoring data
- Department for Education baseline provision survey
- Mental health and service profiles for each Trailblazer from administrative data.

Each of these is summarised in Table 7 below:

Table 7. Additional sources of data

Scoping interviews	Scoping interviews to gather information about the rationale, design, implementation and aspirations for the Trailblazer programme were undertaken between January and March 2019, the findings from which informed the evaluation design and protocol. These interviews were carried out with more than 30 key informants, including members of the national programme team, policymakers and experts involved in the design of the national Trailblazer programme, as well as wider stakeholders (e.g. national voluntary sector organisations and professional bodies). This was supplemented by a review of programme and relevant national policy documentation.
Familiarisation visits	Members of the evaluation team went on in-person visits to three schools (one primary, one secondary, one special school), and attended Trusted Adult training sessions, in Sandwell (West Midlands). These were used to obtain a better understanding of emotional and mental health-related issues from the perspective of educational settings and, in particular, the insights from these visits informed the development of the research tools.
Trailblazer document review	The national programme team provided a range of documentation for each of the 25 Trailblazer sites including, for example, expressions of interest to participate in the programme, project plans, financial specifications, governance and management structures, and local needs assessments. The number of documents reviewed for each Trailblazer varied. A structured data extraction template was developed for the review to ensure that data were recorded in a systematic and consistent way.
Programme monitoring data	On a quarterly basis, Trailblazers report service activity data for their MHSTs and provide a general update on progress using a structured template (which prompts for information on a range of topics including workforce, governance, issues and challenges, risks and mitigations, and whole school approach). Individual quarterly returns for each Trailblazer are shared with the evaluation team, although it should be noted that quarterly reporting was suspended for several months in 2020 due to the Covid-19 pandemic (as a part of an NHS-wide pause on 'non-essential' monitoring). In March 2021, the programme team also shared an aggregated analysis of service activity data, based on quarterly returns submitted by 18 Trailblazer sites for the period July-September 2020 (the seven Trailblazer sites in the north of England did not submit data during this period, due to pressures caused by Covid-19).

Department for Education baseline provision survey	<p>A baseline survey of mental health provision in the educational settings participating in the Trailblazer sites was carried out by the Department for Education between March and June 2019. This survey was distributed to individuals acting as the MHST coordinator for their setting, many of whom (63%) reported that they also held the mental health lead role. A total of 693 educational settings responded: of which 69% were primary schools, 21% were secondary schools, and 10% were 'other' settings.</p> <p>The survey posed a series of questions relating to: the mental health lead role in the setting; the level of mental health support being provided in the setting (including direct support to children and young people with mental health problems, and universal support aimed at all pupils); mental health activities within the setting and the extent to which mental health is integrated into day-to-day operation; how the setting works with external providers of specialist support, including referrals into NHS children and young people's mental health services; if and how the setting assesses mental health need; and planning and preparation for the commencement of the MHST service. Descriptive analysis of the data was carried out by the Department for Education, and both the raw data and a summary report of the analysed findings was shared with the evaluation team.</p>
Mental health and service profiles from administrative data	<p>A demographic and mental health service profile was compiled for each Trailblazer, drawing on routinely available data. These profiles were intended to summarise salient and comparable data with which to characterise the 25 sites, and (where possible) compare them to the national picture. Data to create these profiles were collected from a variety of sources, including: Public Health England's Children and Young People's Mental Health and Wellbeing Profiling Tool (on the Fingertips website), consolidated NHS provider accounts for 2018/19, the Children's Commissioner report on the state of children's mental health services in England and individual NHS trust websites. Data were gathered for the lead CCG for the programme in each Trailblazer site and the main NHS children and young people's mental health service provider in the area, for the reporting period closest to the time that the Trailblazers were announced (December 2018). NHS data were used rather than local authority data because some Trailblazers span more than one local authority area. The profiles, and a detailed description of the data sources used, can be found in the Technical Appendix that accompanies this report. A summary of the analysis is presented in Chapter 2.</p>

Limitations and caveats

There are a number of limitations and caveats to consider from this first stage of the evaluation. Firstly, the impact of the Covid-19 pandemic led to significant delays getting underway with data collection, as well as changes to local timetables for programme implementation. As a result of the pandemic, the scope of the evaluation was expanded to include an aim to understand how MSHTs have adapted in response to Covid-19, experiences of these changes and their legacy. It is very likely that dealing with the challenges of the Covid-19 pandemic limited the ability of some respondents to participate in interviews or surveys. This might explain why ten project leads did not respond to our survey (and subsequent invitations to take part in an interview), despite the centrality of their role in the local implementation of the programme.

Secondly, the regional lead interviews were often held with representatives from both the health and education sector. Interviewees were asked how the partnership had been working during the programme's implementation, and it is possible that there may have been caution in describing any challenges faced in working together. In addition, it may be possible that some individuals did not want to share views or experiences that went against what others had already described during the interview.

Thirdly, while there was a good number and range of respondents to our surveys, response rates did vary between Trailblazers. There was also variation in the number and types of documents that we were given for each Trailblazer site. In consequence, we had more information about the programme in some sites than others. There are also several elements of the programme about which we have limited information – for example, the amount of funding that was awarded to each Trailblazer and what this was expected to be used for. This limited our ability to draw out and explore differences across the 25 sites, a key aim of the evaluation.

Finally, the sample for the key informants survey was focused on obtaining the views and experiences of those within strategic and management roles in the programme, rather than individuals working in frontline positions (above all the members of the MHSTs themselves). There is also the limitation that a single respondent is unlikely to be familiar with all aspects of the programme in their site. We sought to mitigate this risk by sending the survey to individuals with a range of roles from various organisations and leaving the survey open for a long period, with reminders, to obtain as many responses from each Trailblazer as possible. In our next phase of fieldwork, we will be speaking to a wider range of stakeholders in six case study Trailblazer sites and undertaking focus groups with children and young people, to ensure that our assessment of the programme is a rounded and inclusive one.

4. Starting points and expectations

Key points

- A number of mental health and wellbeing initiatives were in place in the Trailblazer sites before the start of the programme, including in the educational settings where the programme was being introduced. With the exception of clinical psychology, schools and colleges were most likely to be self-funding in-house mental health support.
- Respondents expressed confidence in the ability of educational settings and localities to identify children and young people with emotional and mental health needs and in getting advice from their local NHS on such needs.
- A clear commitment to the whole school approach was reported across educational settings and localities. Findings from the Department for Education baseline provision survey indicate that some activities to support a whole school approach are more widespread than others. Educational settings were least likely to report engaging with parents to develop the mental health and wellbeing offer, and peer support for mental health.
- Areas where stakeholders were least satisfied with existing services were the length of time needed to access help from specialist NHS mental health services; the response to children and young people in crisis; and joint working across the education and health sector to deliver mental and emotional health support for children and young people.
- Stakeholders had high expectations of the Trailblazer programme. There was overwhelming agreement that the programme will lead to a number of positive outcomes including improved support for children and young people with mild to moderate needs; more appropriate referrals to specialist services; and preventing children from developing more serious mental health problems.

Mental health provision prior to the Trailblazer programme

There were a range of activities and sources of support in place across sites before the Trailblazer programme commenced. Respondents to the key informants survey provided 192 examples of different programmes, initiatives and approaches for supporting children and young people's mental and emotional health in educational settings in their localities. Many respondents highlighted the use of mental health

interventions, workshops, sessions and more general learning about mental and emotional health, as well as development of mental health resources. Some of those highlighted were large-scale programmes (e.g. Schools Link, HeadStart, Emotional Literacy Support Assistants), while others mentioned more general approaches (e.g. cognitive behavioural therapy (CBT), group work, one-to-one interventions). Many respondents mentioned support from the voluntary sector, or specific initiatives run by voluntary sector organisations.

Some respondents noted the presence of mental health trained staff in schools (e.g. school nurses, mental health champions, educational psychologists) as further examples of mental health and wellbeing resources available to children and young people. Relatedly, multiple respondents highlighted primary mental health teams and the availability of school counsellors, as well as more specialist forms of support available through the NHS and local authorities. Finally, a small number of respondents commented on the provision of mental health support online (e.g. Kooth and other digital resources).

From the educational settings' perspective, more than two-thirds of respondents (65%) stated that their educational setting had a mental health lead prior to the Trailblazer programme, either as a stand-alone role or incorporated into a wider role. More than half (59%) of the settings that had a lead prior to the programme stated that this role had been in place for three years or longer. Further information on mental health leads was provided by the Department for Education (DfE) baseline provision survey, undertaken between March and June 2019 (see Chapter 3 for further details). This found that different staff members took up the role of lead for mental health in their setting (Table 8), with the special education needs coordinator (or equivalent) being the most likely person to take the role in primary schools, whereas in secondary schools, this role was most likely to be taken up by a member of the senior leadership team who was neither the Head teacher nor the Deputy head teacher.

Table 8. Title of staff taking up the role of lead for mental health

Staff	Primary (%)	Secondary (%)	Other (%)	All (%) ²⁰
Head teacher/ Principal or equivalent	17	2	10	13
Deputy head teacher/ Vice Principal or equivalent	18	24	38	22
Other member of Senior Leadership Team	10	32	22	16
SENCO or equivalent	27	16	6	22
Other teaching staff	7	5	8	6
Support staff (e.g. inclusion, safeguarding)	7	10	2	7
Other	14	11	14	13
Total (n)	381	119	63	563

[Source: DfE baseline provision survey; n=563]

The DfE baseline provision survey also asked respondents about the types of direct support available to children and young people in their educational setting. Educational psychologist support was the most common type of direct support provided, followed by “counselling provided by trained counsellor” (Table 9).

Table 9. Types of direct support provided by educational settings

Type of support*	Primary (%)	Secondary (%)	Other (%)	All (%)
Educational psychological support	85	84	57	82
Counselling provided by trained counsellor	54	84	60	61
Other therapy (e.g. art or music therapy)	45	41	49	44
Other support (e.g. Thrive, TaMHS)	30	30	26	30
Cognitive behavioural therapy (CBT)	13	31	21	17
Clinical psychological support	14	16	19	15
Total (n)	472	140	68	680

[Source: DfE baseline provision survey; n=680]

* Direct support was defined as “support aimed at pupils/students with an identified mental health need”

The DfE baseline provision survey also enquired about how direct support was funded (Table 10). For most types of support, self-funding by the school or college was most common. The exception to this was clinical psychologist support, which was most likely to be funded by the NHS.

Table 10. Sources of funding for direct support provided by educational settings²¹

Source of funding	Counselling support (%)	Cognitive Behavioural Therapy (%)	Other therapy (%)	Clinical Psychological support (%)	Educational Psychological support (%)	Other support (%)
School/college funds	70	27	55	12	73	34
Local authority	10	7	9	8	30	6
Voluntary/ Charity organisations	15	4	8	0	0	6
Parents/ families	5	2	4	3	2	3
NHS funding	9	12	6	25	2	4
Other	3	0	4	1	1	2
Don't know	3	11	5	8	2	6
Total* (n)	515	338	505	391	600	585

[Source: DfE baseline provision survey; n=585]

* Settings that have this type of support

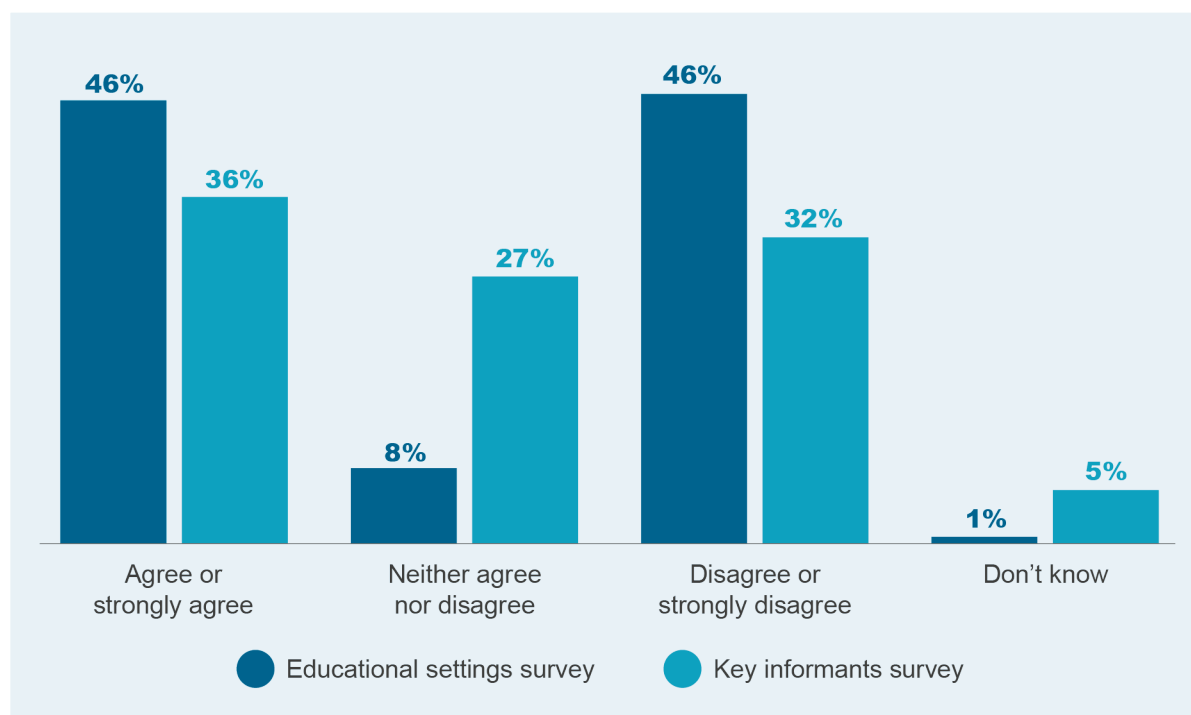
Views on existing mental health and wellbeing services

In our surveys, we posed a series of questions to explore views and experiences of mental health and wellbeing services provided in the Trailblazer sites.²² Respondents were divided in their opinions on whether children and young people could access help from NHS mental health services within an acceptable length of time. Respondents from educational settings were slightly more likely to consider waiting times for specialist services to be unacceptably long (46%); a similar percentage of respondents to the key informants survey disagreed with the statement (32%) as agreed with it (36%) (Figure 3). A small majority of respondents (52%) from educational settings agreed with the statement that specialist mental health services responded well to children and young people in mental health crisis. Similarly, 61% of the key informants agreed with the statement.

21 Respondents could indicate more than one source of funding for each type of support.

22 As we note in the previous chapter, respondents were asked to answer questions for the period of the programme prior to the start of the Covid-19 pandemic.

Figure 3. Views about whether children and young people can access help from local NHS mental health services within an acceptable length of time



[Source: Educational settings survey; n = 299. Key informants survey; n = 73]

The DfE baseline provision survey asked respondents how satisfied they were with the relationship and joint working with NHS children and young people's mental health services. Overall, 52% reported being either very satisfied or fairly satisfied; there was a higher level of satisfaction in secondary schools, compared to primary schools and 'other' settings (Table 11).

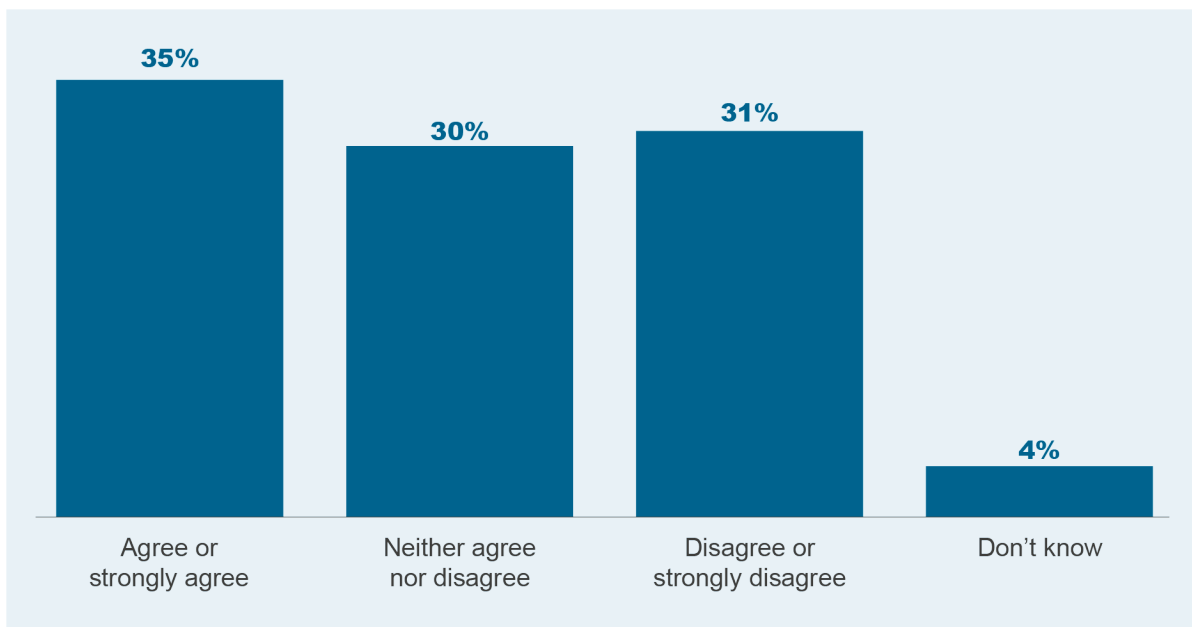
Table 11. Satisfaction with joint working with NHS children and young people's mental health services

Response	Primary (%)	Secondary (%)	Other (%)	All (%)
Very satisfied	7	6	3	7
Fairly satisfied	40	61	52	45
Not at all satisfied	44	29	27	39
Don't know	9	4	19	9
Total (n)	461	137	64	662

[Source: DfE baseline provision survey; n=662]

We posed a similar question in our key informants survey, asking respondents to rate how well the education and health sectors in their area worked together to deliver mental and emotional health support for children and young people, prior to the Trailblazer programme. Only 35% responded positively, with 31% disagreeing with the statement that the two sectors worked well together (Figure 4).

Figure 4. Views about whether health and education worked well together to deliver mental and emotional health support for children and young people prior to the Trailblazer programme



[Source: Key informants survey; n=74]

The DfE baseline provision survey also enquired about links between individual educational settings and NHS children and young people's mental health services. The large majority of respondents (84%) reported that they had an identified point of contact in their setting to link to specialist NHS services, but under half (48%) responded that there was an equivalent point of contact in these services that they could approach for advice and support. Secondary schools were more likely to report having both points of contact in place, as well as having joint meetings with NHS children and young people's mental health services to discuss individual needs (Table 12).

Table 12. Links between educational settings and NHS children and young people's mental health services

Response	Primary (%)	Secondary (%)	Other (%)	All (%)
Identified point of contact in educational setting	84	86	77	84
Identified point of contact in NHS children and young people's mental health services	47	56	40	48
Has joint meeting with NHS children and young people's mental health services to discuss individual needs	38	58	46	43
Total (n)	463	137	65	665

[Source: DfE baseline provision survey; n=665]

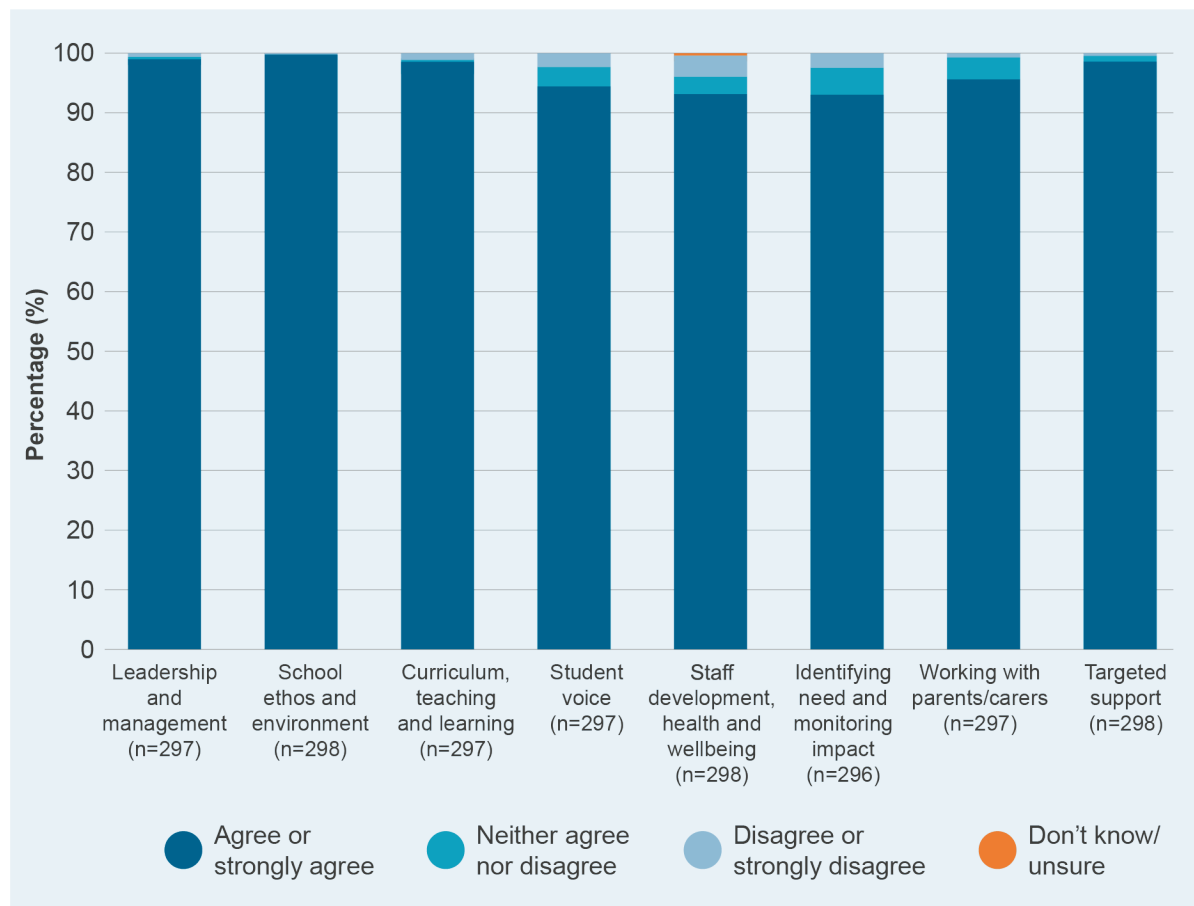
Almost two-thirds (61%) of respondents to the key informants survey agreed that their locality's approach to children and young people's mental health ensured there was an appropriate balance between prevention and intervention. A far higher proportion (92%) agreed that the Trailblazer programme aligned with existing emotional and mental health support for children and young people in their area.

Within educational settings, the overwhelming majority (95%) of respondents agreed with the statement that their setting had good systems in place for the identification of children and young people with emotional and mental health needs. Over three quarters (76%) of key informants surveyed also agreed with this statement. A large majority of respondents from educational settings (88%) reported that they knew how to get advice from their local NHS children and young people's mental health services on emotional and mental health needs. The same percentage of key informants agreed with this statement.

Views on commitment to mental health and wellbeing

Consistent across the educational settings survey, key informants survey and DfE baseline provision survey were high levels of reported commitment to a whole school approach. Of the respondents to the educational settings survey, over 90% agreed that their setting was committed to all eight principles of the whole school approach (Figure 5). The highest percentage of approval was in response to the statement on school ethos and environment, where there was almost unanimous agreement among respondents that their educational setting was pursuing that principle.

Figure 5. Educational settings' views about their commitment to whole school approach principles



[Source: Educational settings survey, n= recorded in bars of chart]

Similarly, the large majority of key informants (81%) agreed with the statement that there had been prior work in their area to develop whole school approaches to emotional and mental health. There was a strong view that children and young people's emotional and mental health was seen as 'everybody's business': reported by 97% of respondents in educational settings, and 82% in the key informants survey. Further insights are offered by the DfE baseline provision survey, which explored the extent to which settings were engaged in specific activities that comprise a whole school approach, and whether this varied by phase of education (Table 13). They observed that activities to raise awareness of mental health and wellbeing and reduce stigma were most prevalent, reported by 80% of settings overall. Peer support, on the other hand, was the least commonly reported activity, reported by only 24% of settings overall. There was also variation in activities by

phase of education, with respondents from secondary schools more likely to report engaging in all activities compared with primary schools, with the exception of monitoring of the impact of health and wellbeing provision.

Table 13. Activities as part of a whole school approach

Activity	Primary (%)	Secondary (%)	Other (%)	All (%)
Activities to raise awareness of mental health and wellbeing and to reduce stigma	74	98	83	80
Teaching knowledge about mental health and wellbeing	72	91	80	77
Teaching skills to support mental health	71	76	68	72
Communication to pupils and parents on the mental health support on offer	61	78	78	66
Teaching or sessions on particular mental health and wellbeing issues	50	84	76	59
Training offer for all or most staff on promoting mental health and wellbeing in setting	53	64	67	57
Events to support staff mental health and wellbeing	52	62	75	56
Engagement with staff on the mental health and wellbeing offer	53	62	58	55
Monitoring of impact of mental health and wellbeing provision	56	55	47	55
Systematic approaches to identify those who need targeted mental health support	43	56	61	47
Engagement with pupils on development of the mental health and wellbeing offer	38	65	56	45
Measurement of pupil mental health and wellbeing to support decisions about provision	41	52	61	45
Engagement with parents on development of the mental health and wellbeing offer	35	38	31	35
Peer support for mental health	19	43	23	24
Total (n)	460	135	65	660

[Source: DfE baseline provision survey; n=660]

Project leads were asked to comment on the main priorities for children and young people's mental and emotional health in their area. In total, 13 responses were received to this question and answers varied across sites. Common themes included offering early intervention for children and young people, and reducing waiting times and improving access to services. Some respondents noted a focus on partnership

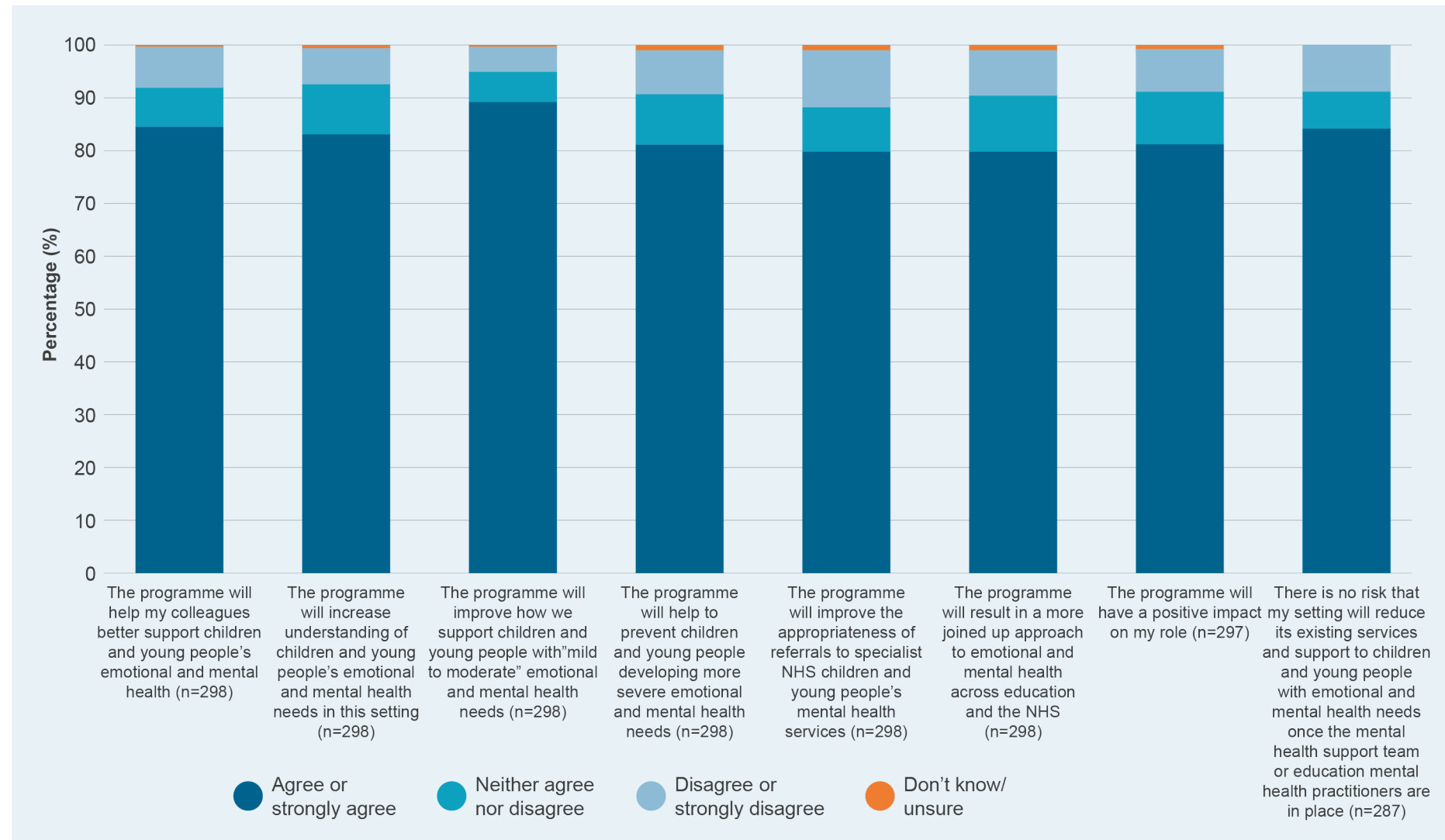
working and collaboration to deliver mental health services. A small number commented that supporting schools with mental health was a priority for their area:

“...improving accessibility to getting advice, help and risk support in a timely way for children, young people and their families in the community. Building partnership working with agencies, taking a joined up approach to improve the outcomes for our children and young people.” (Key informant survey respondent)

Expectations of the Trailblazer programme

Our findings show that schools and colleges have high expectations of the Trailblazer programme (Figure 6). For example, 89% of respondents to the educational settings survey expected that the programme would improve how children and young people with 'mild to moderate' emotional and mental health needs are supported.

Figure 6: Educational settings' expectations of the Trailblazer programme



[Source: Educational settings survey, n= recorded in bars of chart]

We also asked respondents to describe what impact they expected the Trailblazer programme to have in their setting. Their responses could be broadly grouped into three themes: provision of support, culture and impact on parents (Table 14).

Table 14. Educational Settings Survey: expected impacts of the Trailblazer programme

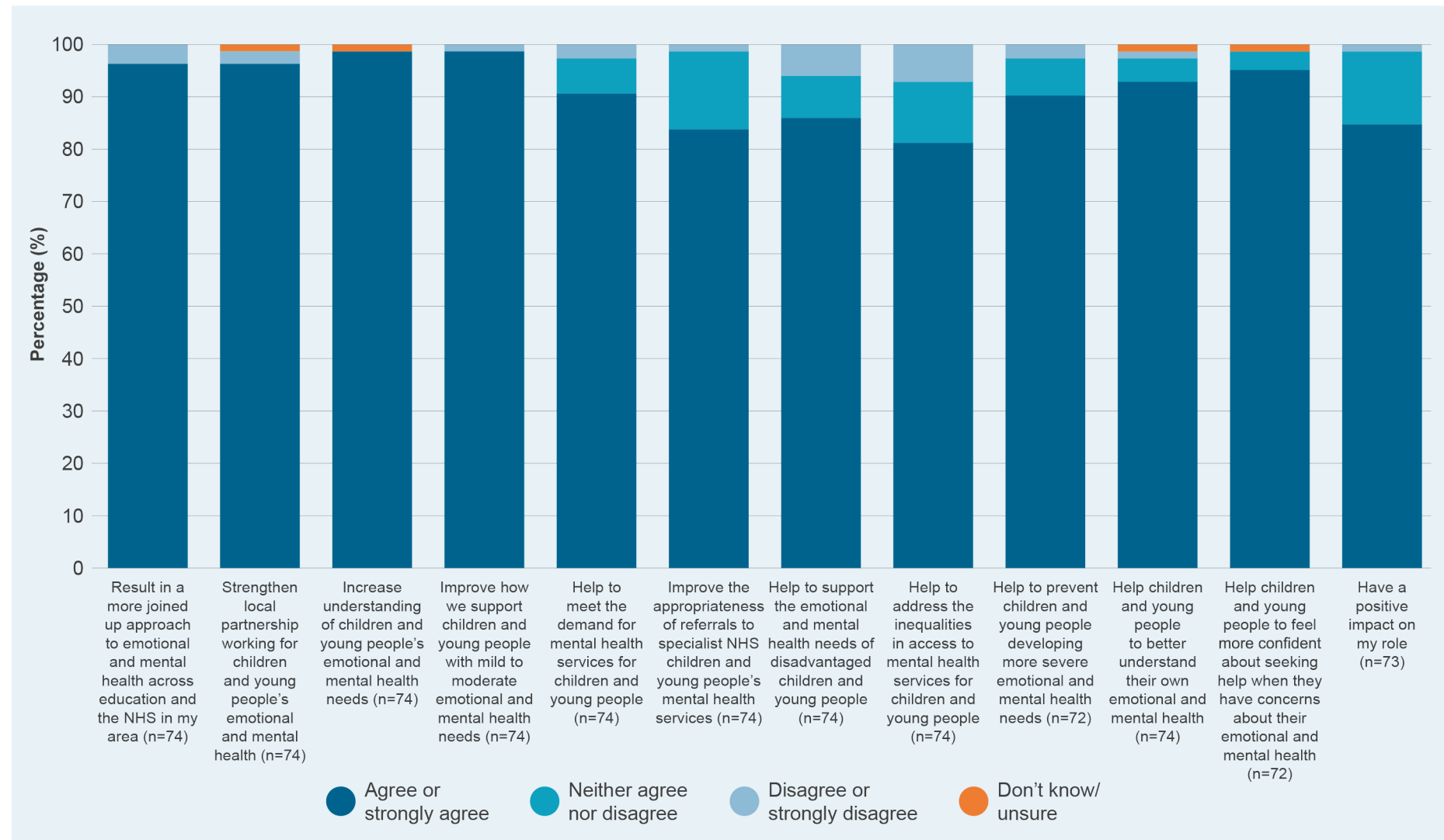
Themes	Sub-themes
Provision of support	<ul style="list-style-type: none"> • Improved access to support • Early intervention/prevent needs from escalating • Enhance schools' Thrive Framework support • Bespoke package of support to complement existing provision and interventions • More training for staff • A more joined up/collaborative approach to supporting mental wellbeing • Provision of a holistic pastoral support team • Fast tracking assessments • Mentoring/informal discussions with staff • Support for staff to identify need earlier • To be freed up to work with young people with less serious issues
Culture	<ul style="list-style-type: none"> • Promote importance of mental health and wellbeing • Help with whole school understanding/approach to mental health and wellbeing
Impact on parents	<ul style="list-style-type: none"> • Ability to educate and support parents • Better understand where to refer parents

Similarly, respondents to the key informants survey indicated overwhelmingly that they had positive expectations of the programme (Figure 7). Finally, in response to being asked how the programme would fit with existing priorities, approaches and sources of support in their area, project leads were most likely to highlight the potential for the programme to contribute to the whole school approach to mental health and/or to further encourage and support joint working:

“Provides a whole school approach within the participating education settings. MHSTs are integrated with children and young people’s mental health services and focus on early intervention, prevention, support and guidance for children, young people, families and schools.” (Key informant survey respondent)

“The Trailblazer programme is an excellent fit within the existing priorities and further enhances the services commissioned by the CCG, local authorities and other strategic partners.” (Key informant survey respondent)

Figure 7: Key informants' expectations of the Trailblazer programme



[Source: Key informants survey, n= recorded in bars of chart]

5. Setting up the Trailblazers

Key points

- The work involved in setting up the Trailblazers was considerable, and sites had to work quickly to achieve this in the twelve month period between being awarded funding and mental health support teams (MHSTs) going live. Several sites did not have project management capability and skills in place at an early stage, and found it more difficult to make progress as a result.
- Governance bodies had 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 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.
- Educational settings were recruited to participate in the programme in two main ways: either through an open application process, or through targeting of schools and colleges in areas of high deprivation and/or unmet need. Just over half of the educational settings responding to our survey reported that they had been involved in the design of their local model and approach.
- The education mental health practitioner (EMHP) training and role had proven popular, but several Trailblazers reported challenges recruiting senior staff to the teams. Most teams had a similar core composition, but some included diverse 'other' roles including family support workers, clinical or educational psychologists and youth workers.
- Views about the resources available for setting up and running the MHST service were variable. Of the respondents to our key informants survey, 61% reported that MHSTs had sufficient financial resources to perform their core roles and responsibilities. The majority of educational settings (84%) reported that there was no risk they would reduce existing services and support for emotional and mental health needs once the MHST or EMHPs were in place.

Establishing an infrastructure

As soon as applications to be a Trailblazer site were approved, the process of setting up the Trailblazer infrastructure began. Clinical Commissioning Groups (CCGs) played a leadership role in this process, as was to be expected given that they held the funding awarded by NHS England and Improvement to create mental health support teams (MHSTs). But the process itself was in collaboration with other key partners, with local authorities, NHS children and young people's mental health services and educational settings most frequently mentioned. For many sites, the voluntary sector was also involved and, to a lesser extent, public health services.

The programme was not prescriptive about the infrastructure required to support Trailblazer set up, although the MHST manual set out clear expectations in terms of governance and oversight:

“Local governance structures should be established, linking with existing structures, to provide operational and strategic governance and service quality assurance. There is an expectation that there is a project board/oversight group in place where there isn't an existing governance structure...The project board/oversight group should consist of representatives from NHS CYPMH services, the VCSE sector, the Local Authority(ies), Public Health England, school and college representatives, commissioners, representatives from already existing support services within education settings, local councillors and children and young people, parents and carers.” (NHS England, 2019)

In terms of operational governance, regional leads commented that there was considerable variation in how quickly resources and processes for day-to-day project management had been established. The importance of having a good project management infrastructure in place from the outset was stressed, and it was noted that the Trailblazers that did not have this struggled to make progress as a result. One interviewee felt that there should have been more national focus on the need for this:

“There was project initiation funding but disappointingly it never specified that you had to have a project manager in the team make-up, or in the guidance. I tried to encourage them [the national team] at one point to say can we not put it in there because we saw the difference.” (Regional leads, 007)

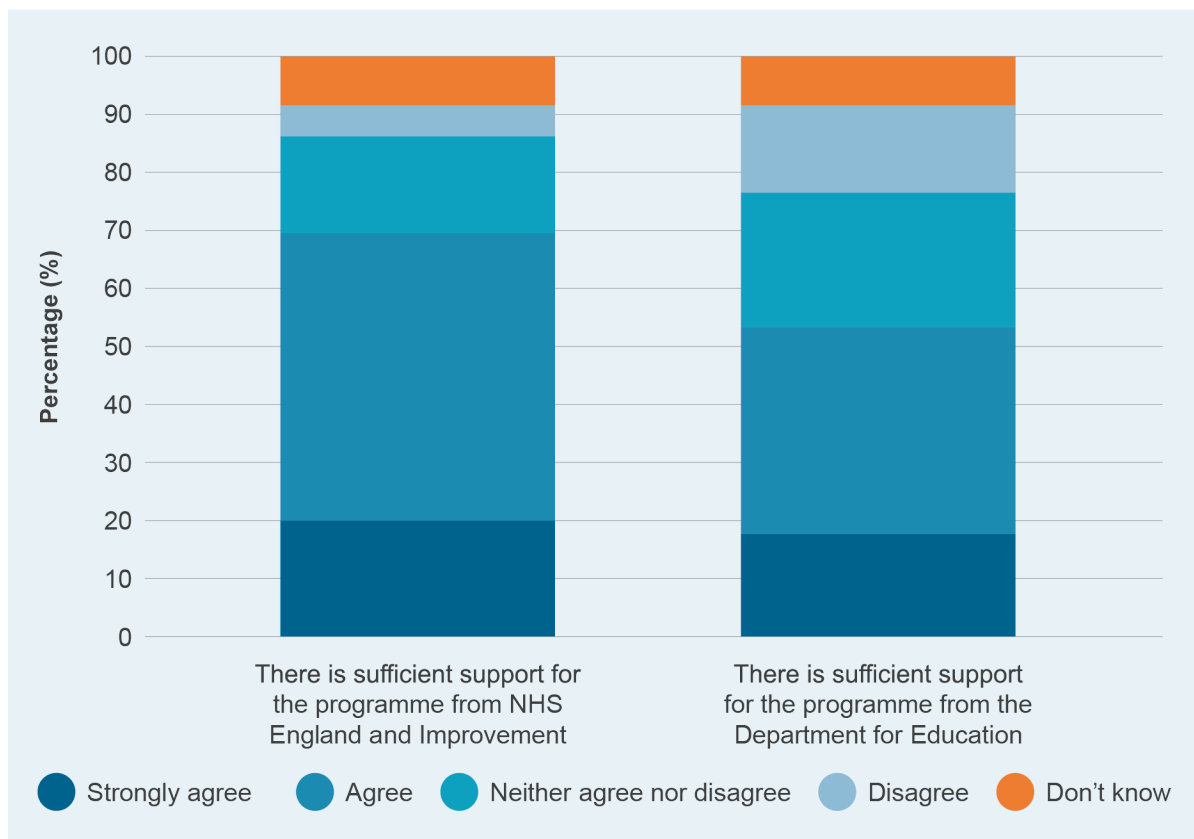
We heard that the flexibility for sites to develop approaches suited to their local circumstances was important, but equally it had increased the amount of work involved in the set up phase:

“I hadn't really appreciated the enormity of the task. I mean from my perspective it seems like there's lots of freedom for sites to make some decisions themselves but I guess with that comes the burden of how to make decisions.” (Regional leads, 003)

Despite these challenges, the work which had gone into setting up local infrastructure and processes appeared to have been successful. The overwhelming majority of respondents to the key informants survey (86%) reported that there was clear and effective leadership for the Trailblazer programme locally. An even higher proportion (92%) felt their area had a clear strategy to deliver the key elements of the programme.

The survey also explored views about support from the two national partners most involved in programme delivery: NHS England and Improvement and the Department for Education (Figure 8). Over two-thirds of respondents agreed that there was sufficient support from NHS England and Improvement (70%); the figure was lower (54%) for the Department for Education, although only 15% of respondents felt that the support provided by the Department for Education was insufficient.

Figure 8. Support from the Department for Education and NHS England and Improvement



[Source: Key informants survey; n=73]²³

23 There were no responses reporting 'strongly disagree'.

The Department for Education had created new regional roles to support the programme; these posts were recruited after the Trailblazer wave had commenced. Interviewees remarked about there being uncertainty initially as to how the role should function:

“So as the DfE coming in I’d say on reflection it was definitely a challenge trying to get into those [Trailblazer] sites and clarify what our role was, what we brought to the table really and how we can support them...I think it was certainly easier coming in and establishing those relationships with the [later] sites. They were brand new sites and we were able to be part of those conversations and build those relationships from the get-go really, whereas coming in at a later stage with [area x] and [area y] definitely posed additional challenges.” (Regional leads, 008)

Some considered that a major element of the Department for Education regional role would be to support the roll-out of senior mental health leads training, which had been delayed. Over time, however, Department for Education regional leads appeared to have settled into their roles and, by early 2021, there was a sense that most regional teams were operating well.

A common theme emerging from the data was the scale and complexity of the work required to establish the programme infrastructure and new service; Figure 9 illustrates the expected structure for MHSTs. The amount of work involved was recognised by several respondents:

“I think what we’re asking them to do is really difficult and really complex because we are setting up new therapeutic spaces in spaces that are not designed as therapeutic communities.” (Regional leads, 003)

Some also felt that twelve months was a relatively short amount of time to go from being awarded funding to teams becoming operational:

“I think the only negative is the chaos of trying to do something so quick and so new and so changing.” (Regional leads, 005)

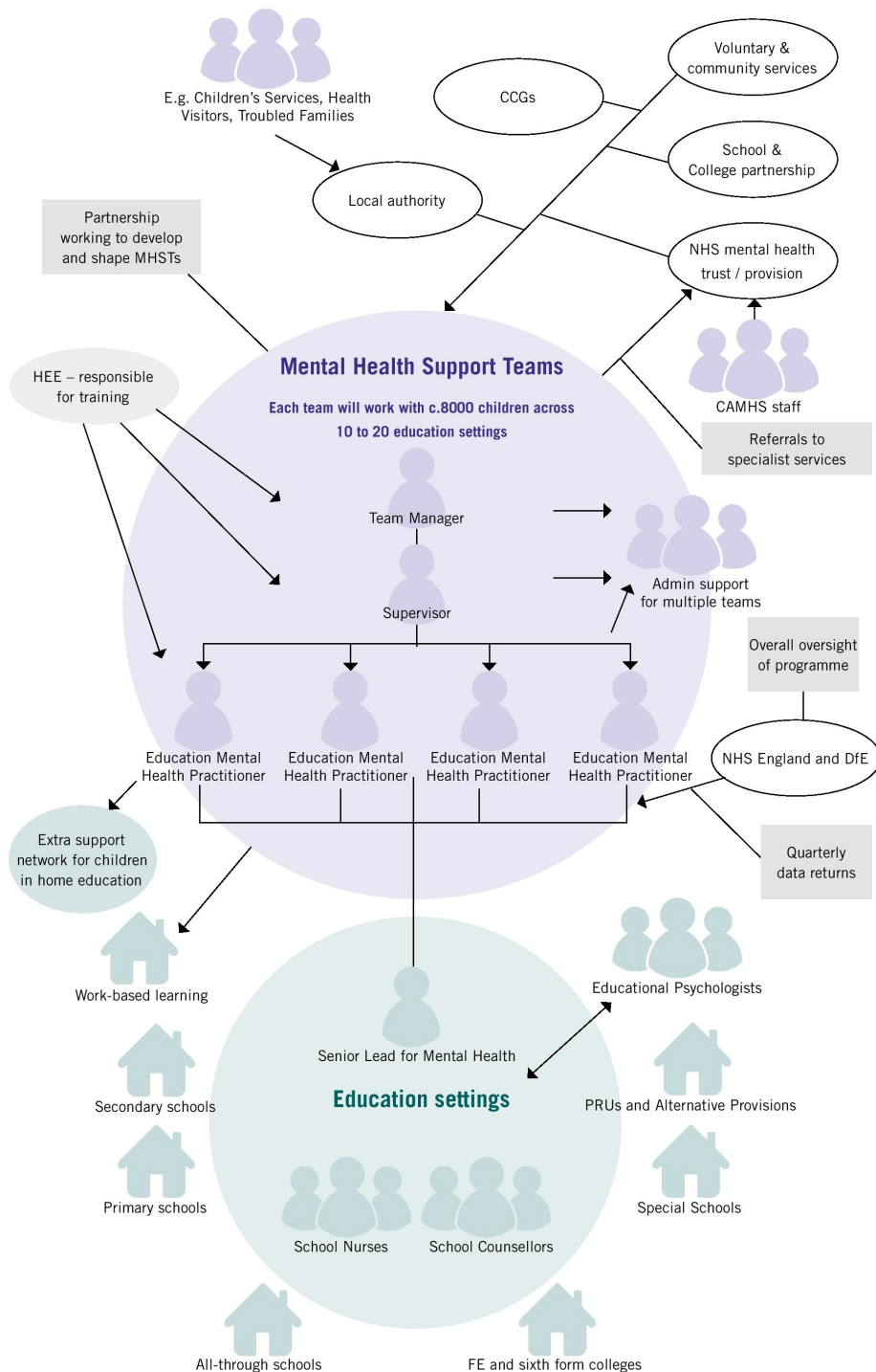
Trailblazer sites had to work quickly to set up the programme, and this work typically involved recruiting programme and MHST staff; setting up governance bodies and processes; engaging with educational settings about the MHST model and to agree the allocation of MHST staff time; consultation with wider stakeholders (including children, young people, parents and carers); establishing processes, making arrangements and – where necessary – providing training for data recording and reporting requirements; and numerous employment and operational issues (e.g.

developing induction and supervision arrangements for education mental health practitioners (EMHPs)).

Governance and partnership working

Funding for the Trailblazers flowed from NHS England and Improvement to local CCGs, with CCGs having responsibility for strategic governance and oversight to plan for, set up and run MHSTs. As perhaps would be expected given the emphasis on local flexibility in the programme approach, there appeared to be differences in governance and partnership arrangements. In particular, our findings suggest that there was variation in the extent of partner and stakeholder involvement in governance bodies, and in the degree to which governance arrangements for the programme were integrated into wider local strategies, structures and initiatives (such as the former regional Sustainability and Transformation Partnership, now Integrated Care Systems). It was observed that more inclusive and integrated governance arrangements could sometimes slow down decision-making but, at the same time, they provided a more solid foundation for the programme, and had enabled sites to make better progress overall:

“For [name of area]...they had from the very beginning sought to engage the education system, so they’ve worked with schools on everything they do, their action plans, recruitment, job descriptions for senior mental health leads in schools, all of that stuff they tried to set it up and do it with the schools. So they set up school clusters that are led by head teachers in the specific borough and all of that stuff goes through their formal governance through the CAMHS Partnership Board Programme and all that kind of thing. So yeah, as [other interviewee] said, it takes a bit longer [to work this way] but from my perspective there’s a partnership there that means the schools have bought into it all the way through, which they would argue in the long run is a more helpful model really.” (Regional leads, 006)

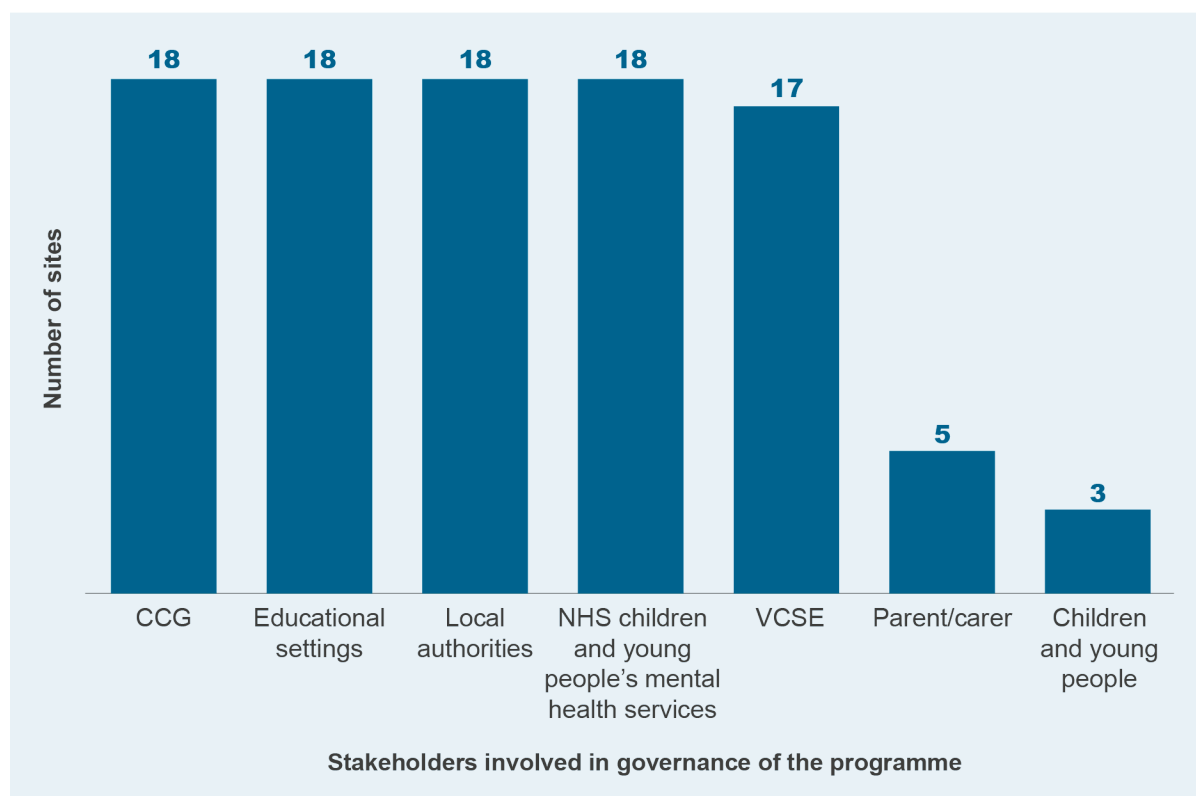
Figure 9: Expected structure of mental health support teams

Source: British Psychological Society, 2019

[Reproduced with the permission of the British Psychological Society]

Programme monitoring data reported by Trailblazers to NHS England and Improvement provides further details about the extent of stakeholder membership in governance bodies. The most recent data (for 18 Trailblazers, reported for the period July-September 2020) indicates that all governance bodies had representation from CCGs, educational settings, local authorities and NHS children and young people's mental health services, and that all bar one included representation from the voluntary sector. Relatively few by comparison involved parents and carers, or children and young people (Figure 10). In our key informants survey, project leads were asked to report whether there were any groups not involved in the governance of the programme that they thought should be. For those leads who identified gaps, these were most commonly reported as being parents and carers, schools and colleges, children and young people, the voluntary sector and wider health and wellbeing services.

Figure 10. Stakeholders represented in local governance arrangements



[Source: Programme monitoring data; n=18 Trailblazer sites]

Some regional leads commented on the variable, and sometimes limited, involvement of the education sector in governance arrangements. Their view was that some areas had not given sufficient thought to this issue, and so the representation of educational settings had felt tokenistic:

“I think the only thing that still stands out as an issue for me is...what is true governance and what is actually just having maybe an ongoing working group with a few heads or a few school leads and sort of ticking that box... how much is that influencing all those crucial meetings where the decisions are made and how consistent are they in getting the views of a collective number of [educational] settings?” (Regional leads, 008)

At the same time, there was acknowledgement of the difficulty of collectively representing what may be a large number of different educational settings in governance arrangements.

We also heard from some regional interviewees that the way in which the programme and funding arrangements had been set up nationally – with delivery led by NHS England and Improvement and funding issued to CCGs – created an orientation towards NHS partners and perspectives, which could act as a barrier to fostering shared governance across health and education:

“...it sometimes feels like you can be a bit back to square one with brand new sites around why we're here because obviously they're aware the money flows from NHS England, the CCGs. It's a very NHS dominated space... trying to bring education to the forefront of every discussion because it does obviously get lost in health – we talk about finance, we talk about recruitment”. (Regional leads, 008)

Involvement of young people, parents and carers

It was an aspiration of the programme that involvement of young people, parents and carers would extend beyond involvement in governance arrangements and be evident throughout the design and delivery of MHSTs. Our findings suggest that there was substantial variation in whether and how these groups had been involved. The majority of respondents to the key informants survey (66%) reported that their area was using co-production to develop approaches and services with children, young people, parents and carers. A different picture emerged from the interviews. These suggested that, only in a small number of sites, were the principles of consultation or co-production well established, reflected in close working with organisations representing these groups, or in their direct involvement in key aspects of the programme set up and implementation process. Over half of respondents (60%) to the educational settings survey indicated that their setting had involved, or planned

to involve, children, young people or their families in decisions about what the MHST would provide. More generally, the vast majority of respondents (96%) to this survey reported that their setting worked in partnership with parents and carers to promote emotional health and wellbeing.

Project leads were asked to specify how young people, parents and carers had been involved in the design and delivery of the Trailblazer programme. Some of the examples shared – drawn from information provided by ten project leads – are shown in Box 8 below.

Box 8. Examples of how young people, parents and carers had been involved in the design and delivery of the Trailblazer programme in their area

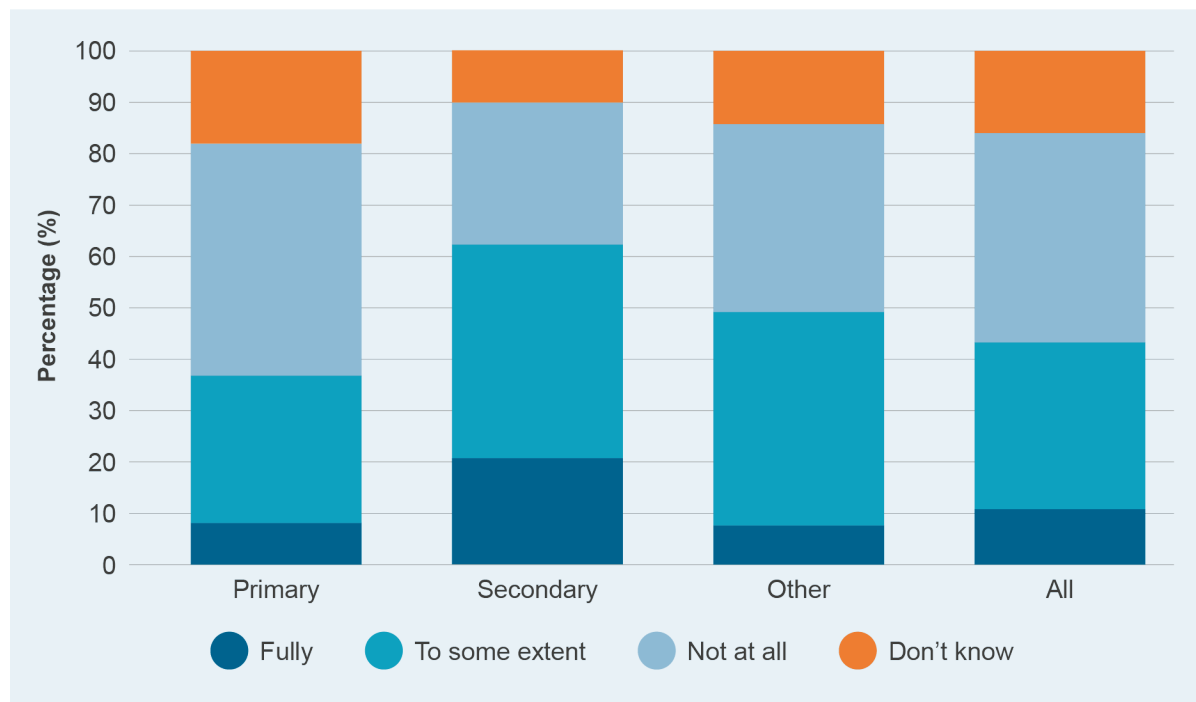
- Creating a parent and carer forum (or engaging with an existing group) to input into design, implementation and governance.
- Creating a service user forum (or engaging with an existing group) to feed back on how the service is being delivered.
- Collecting feedback from pupils and parent/carers, e.g. by conducting focus groups and surveys on design of the programme, expectations and on how the service is being delivered.
- Involvement of children and young people in designing logos and agreeing a local name for the MHST service.
- Pupils appointed as mental health and wellbeing champions in their school.
- Young people and/or parents sitting on EMHP recruitment panels.

Recruitment and engagement of educational settings

An important element of establishing the Trailblazer sites was the recruitment of educational settings. We heard that the Trailblazers were expected to have all their participating schools and colleges selected prior to submitting their bid, which sometimes appears to have driven a 'quantity over quality' approach to engagement, in which the focus was more on obtaining the required number of settings, and less on building relationships. Some sites had also over-recruited the number of educational settings required, unsure of the population size that MHSTs would typically be expected to cover. Regional leads confirmed that these early experiences had led the national team to change its requirements, with areas seeking to join the programme in later waves no longer expected to have all educational settings secured at the application stage. This was universally welcomed.

Project leads were asked to provide a brief overview of how educational settings had been recruited to be part of the Trailblazer programme. Two main approaches were outlined: i) an open recruitment process where all settings in a site were invited to submit an expression of interest to participate in the programme; and ii) direct approaches to educational settings in areas of high deprivation and/or with particular need. Some sites reported they had used a combination of these approaches. A variety of educational setting types had been recruited, including primary, secondary and special schools, FE colleges, and various forms of alternative provision, such as pupil referral units. The DfE baseline provision survey explored with those settings the extent of their involvement in the design and planning of the Trailblazer programme in their area. Overall, 44% of educational settings reported some involvement, although only 11% felt that they had been fully involved (Figure 11). This proportion was higher among respondents from secondary schools (21%). Seventeen months later, the findings from a similar question posed in the educational settings survey were a little more positive. Overall, 51% reported that their setting had been involved in the design of the programme locally; again, this proportion was still higher among respondents in secondary schools (60%).

Figure 11. Educational settings' involvement in the local design and planning of the Trailblazer programme



[Source: DfE baseline provision survey; n=655]

The majority of respondents to the educational settings survey agreed that:

- They understood what would be delivered by the MHST or EMHPs (85%)
- Their setting had been able to shape the day-to-day working of its MHST or EMHPs (65%)
- The MHST or EMHPs would be responsive to the specific needs of pupils in their setting (81%).

Workforce recruitment, training and composition

There was a widespread view that the EMHP role had been popular and finding applicants to undertake the training programme and join MHSTs had been relatively straightforward. People had been attracted to the role from a variety of backgrounds, including some with NHS mental health or teaching experience. That said, challenges were also reported. Only a limited number of universities had been providing EMHP training at the time of the Trailblazer cohort, which had resulted in a number of trainees having to travel substantial distances between their home, university and placement area. This was proposed as a possible reason why a number of EMHPs had left their post within the first 12 months of training (see 'Challenges and issues' in Chapter 7 for more discussion of staff retention). Another impact of this approach was that trainees had been recruited from all over the country and often ended up working in areas that they were not familiar with, and so lacked the kind of local knowledge that might have helped them adjust to and more effectively fulfil their role. Participants in several areas noted they had learned from this in subsequent waves when recruiting EMHPs. In addition, later waves had also benefited from more universities being able to provide training, thus reducing the problems of travelling and re-location that had particularly affected the first cohort of EMHPs.

Recruitment of more senior therapists was often seen as more difficult than recruiting to the EMHP role:

“Recruitment of specialist posts have been an ongoing issue for the MHST; really hard to find Band 7s and Band 8as and the demand for them on supervision is very high with the trainees, there is limited capacity for them to take on a clinical caseload of their own.” (Key informant survey respondent)

It was suggested that this might, at least in part, be because the list of criteria and experience required was long, but the salary not very competitive in relation to other comparable roles. We heard that this had been raised nationally and the requirements for senior posts subsequently modified, although many sites were still experiencing challenges with recruitment:

“So there has been some flex, it just – it feels like a continual struggle for the sites...They’re going out to advertise two or three times or changing job descriptions and things like that, so it never feels straightforward – and considering the rapid roll out for the programme that is tough for them.” (Regional leads, 001)

Others expressed concerns that MHSTs were recruiting experienced staff from other parts of the local mental health system which they were specifically expected not to do, potentially creating staffing problems for other services.

Some interviewees noted the challenge of mentoring and supporting EMHPs when there were vacancies in senior roles. In one site, supervision of EMHP trainees had initially been provided by experienced practitioners from the NHS children and young people's mental health service locally, which had put further stress and pressure on already stretched staff. In another site, EMHPs had been without mentoring for a period of time:

“We’ve got one set of sites that has gone through a whole year without any supervision within the MHST so it’s just been completely provided by the university...And I would never wish that journey on anyone.” (Regional leads, 001)

Supervision outside the MHST was not seen as optimal and could potentially impact on retention of staff in EMHP roles. By the time of the key informant survey, all MHST managers who responded felt that EMHPs were receiving an appropriate level of clinical supervision to support them to undertake their role effectively.

Our findings suggest that there was some variation in workforce composition between sites. Many teams appeared to have a similar core workforce, primarily made up of EMHP and senior therapist roles with administrative and management support. But we also noted a number of ‘other’ roles in some MHSTs, 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. An interview with one group of regional leads pointed to a distinction between more clinically oriented teams, and others which had stronger focus on working with schools and education partners to develop whole school approaches:

“...there is a difference I think between a sort of health led model and a local authority or third sector led model, you can see the differences in terms of, you know, health based models tend to be very clinical focused, local authority based models tend to try and stretch boundaries around clinical interventions and have a more sort of connection with local authority partners that do whole school approach.” (Regional leads, 001)

Service models

The design of the national Trailblazer programme sought to balance central direction (e.g. core functions for MHSTs, a set of operating principles, national training programmes for EMHPs and senior mental health leads) with local flexibility so that service models and approaches could be shaped to suit local needs and circumstances. While interviewees were not specifically probed on this aspect of programme design, there was broad support for the approach being taken and the encouragement given to local sites to tailor their MHSTs. Only one regional team felt that there had been too much scope for local flexibility and tailoring. They noted that there had been a lot of “muddling through” in the Trailblazer sites in their region, with each site separately designing their own service models, workforce compositions, recruitment processes and so on. This team suggested that more national guidance and consistency would have helped Trailblazers progress more rapidly and avoid duplication of effort.

Most local stakeholders (89%) agreed their local approach was built on a good understanding of local needs and gaps in children and young people's emotional and mental health support. As we described in Chapter 4, MHSTs were being introduced into areas where there were many existing services, programmes and initiatives for children and young people's mental health. Interviewees stressed the importance of ensuring that MHSTs complemented, rather than replicated or substituted, existing local provision:

“...we have to be really careful so that we don't replace mental health support teams with something that was there already. This isn't seen as a way of rationalising resource, so if something's previously been delivered by a third sector organisation, actually how can the mental health support teams work to enhance that so a) it doesn't duplicate but b) it doesn't replace.” (Regional leads, 002)

Local stakeholders were broadly positive about the fit between MHSTs and existing sources of support. Of those responding to the key informants survey, 82% agreed that the Trailblazer programme was integrated with existing mental health support within educational settings, and 68% agreed it was integrated with existing support in the wider community. Almost all (96%) educational settings reported that they were making plans to ensure that their MHST would be well integrated with existing services and professionals supporting mental health in their setting.

Among project leads, there was a strong view that the Trailblazer programme and MHSTs in their area had been designed to take into account all groups of children and young people, including those who were disadvantaged and under-served by existing mental health services. Leads were asked to provide detail on how diversity

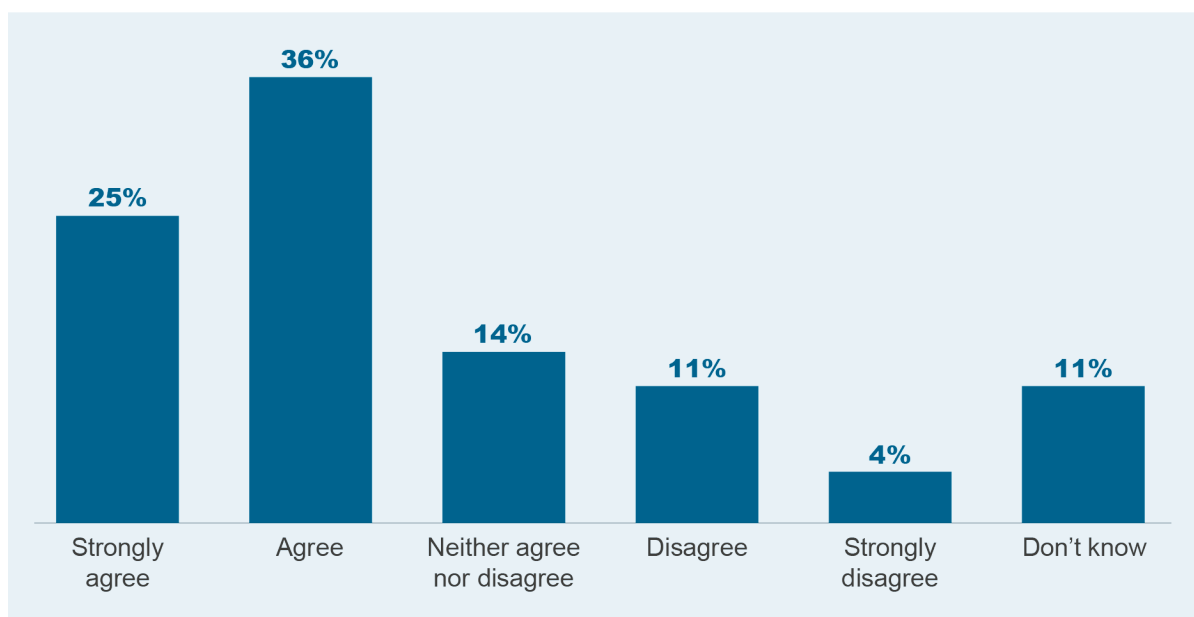
and inclusion considerations were guiding their service model. Broadly responses could be clustered into three main themes:

- Recruitment of educational settings with higher numbers of disadvantaged pupils, as well as areas with higher deprivation or more rural locations.
- MHSTs developed to work with specific under-served groups where there were high levels of unmet need (e.g. children outside of education or particular cultural groups).
- Support offered in additional languages.

Funding and resources

Views about resourcing were explored through our key informants survey. Respondents were asked whether MHSTs had sufficient financial resources to perform their core roles and responsibilities (Figure 12). Nearly two thirds of respondents agreed with this statement (61%), while 15% disagreed. Many local stakeholders were unsure if the allocation of MHST time and resources to educational settings was transparent, with more respondents (50%) neither agreeing nor disagreeing with the statement, than agreeing outright (43%).

Figure 12. Views about whether MHSTs have sufficient financial resources to perform their core roles and responsibilities



[Source: Key informants survey; n=73]

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 MHST or EMHPs offered. A higher proportion (84%) were of the view that there was no risk their setting would reduce its existing mental health services and support once the MHST or EMHPs were in place. A similar question was posed in the key informants survey, to which 71% of respondents reported that there was no risk their area would reduce existing services and sources of support once the MHSTs were in place.

6. Progress and early impacts

Key points

- Before the Covid-19 pandemic started, Trailblazers were making good progress in implementing mental health support teams (MHSTs). Sites were learning and improving over time, and some of the initial challenges faced had been worked on and were being resolved.
- 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 generally, there was a substantial decrease in referrals to MHSTs in the early months of the pandemic. At the same time, many educational settings were seeing an increase in mental health problems: among children and young people, parents and carers, and their own staff.
- MHSTs rapidly adapted in order to overcome some of the barriers that lockdown presented and continue to provide a service, and this was widely praised. There were three main responses to Covid-19: using strategies to increase referrals; switching to remote delivery; and changing or expanding the type of support provided. Trailblazers expected to continue with remote delivery for some elements of their work, although in a blended model with face-to-face approaches.
- Early reported impacts of the programme included better partnership working and, for educational settings, improved support for children and young people with mild to moderate mental health problems; reduced waiting times to access support; staff feeling more knowledgeable and comfortable talking to pupils about mental health issues; and more positive and proactive cultures around mental health and wellbeing.
- A very small number of educational settings had disinvested in in-house mental health support either some time before the programme or once their MHST was in place. In these cases, the MHST had simply substituted for existing support, rather than being additional to it.

Progress made by the Trailblazers in the early phase of the programme

When the first phase of fieldwork started in November 2020, it was almost two years after the 25 Trailblazer sites had been announced, and almost a year since the first cohort of education mental health practitioners (EMHPs) had completed their training

and mental health support teams (MHSTs) were becoming fully operational. For much of the preceding year, however, England had been in full or partial lockdown due to the Covid-19 pandemic, and the teams – like all services – were working in exceptional, challenging and unanticipated circumstances. We were, therefore, mindful of the importance of exploring the early progress that Trailblazers had made in light of the pandemic. Of further interest was the learning from and potential legacy of any changes made to services and ways of working in response to Covid-19. This issue was explored with interviewees, but the lasting impact of the pandemic on the Trailblazer programme will only become apparent over time, and more so once lockdown conditions have been fully lifted. It will continue to be a focus in the next phase of fieldwork.

Overall, the picture in terms of progress was a positive one. While it was clear that there was variation between areas in the pace of progress and the nature and extent of challenges encountered, the general view was the Trailblazers had achieved a great deal in a relatively short space of time:

“I think it’s a massive thing what people have achieved in very short time frames...they’ve achieved an incredible amount really.” (Regional leads, 006)

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 (before the pandemic), all teams were operational in some form by this time. As noted in Chapter 5, at the outset of the programme, some sites had not fully grasped the scale and complexity of the implementation challenge:

“Obviously health and education coming together is a massive challenge and I don’t think anybody underestimated that, but I think what sites did underestimate was how big this project was and I don’t know whether everyone took on board that you are implementing a brand new service.” (Regional leads, 007)

That said, 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.

An important area where Trailblazers had made progress was in establishing an infrastructure which would facilitate and underpin joint working across the various partners involved. Central to this had been building relationships and establishing governance arrangements across diverse organisations and sectors that, in several areas, had had relatively little (if any) prior experience of working together. The need for further development of these relationships and arrangements was acknowledged, in particular to strengthen the involvement of schools and colleges in shaping service

design and delivery. Notwithstanding, interviewees were keen to emphasise that strengthening of partnership working for children and young people's mental health should be seen as an important outcome of the programme in itself.

Many schools and colleges responding to our survey reported positive early experiences of the MHST working with their setting, and our early findings indicate that the support offered by the teams was broadly welcomed (even where there were concerns about the kind of support that MHSTs were able to provide – see Chapter 7 for further discussion). A number of factors were described by schools and colleges as having contributed to these positive early experiences, summarised in Box 9. These suggest that where MHSTs were working well, this was due to a combination of flexible and collaborative approaches to working with educational settings, and the provision of advice and support that helped educational settings to better address mental health – both at the 'whole school' level and for individual children and young people. Details of the ways in which MHSTs were felt to be working less well are shared in the following chapter, where we discuss issues and challenges.

Box 9. School and colleges' positive early experience of mental health support teams: what specifically had worked well?

- Good two-way communication between educational setting and MHST
- Having a dedicated team member working with the school to ensure continuity
- Team members being flexible and keen to learn
- Support to develop whole school approach
- School able to work collaboratively with the team to plan and deliver staff training on mental health issues
- Provision of a tiered response of support
- Team signposting to wider resources and services
- Team providing information and advice about a specific child/young person, helping the school to decide how best to provide support
- Support to develop peer mentoring programmes.

Impact of Covid-19 on implementation

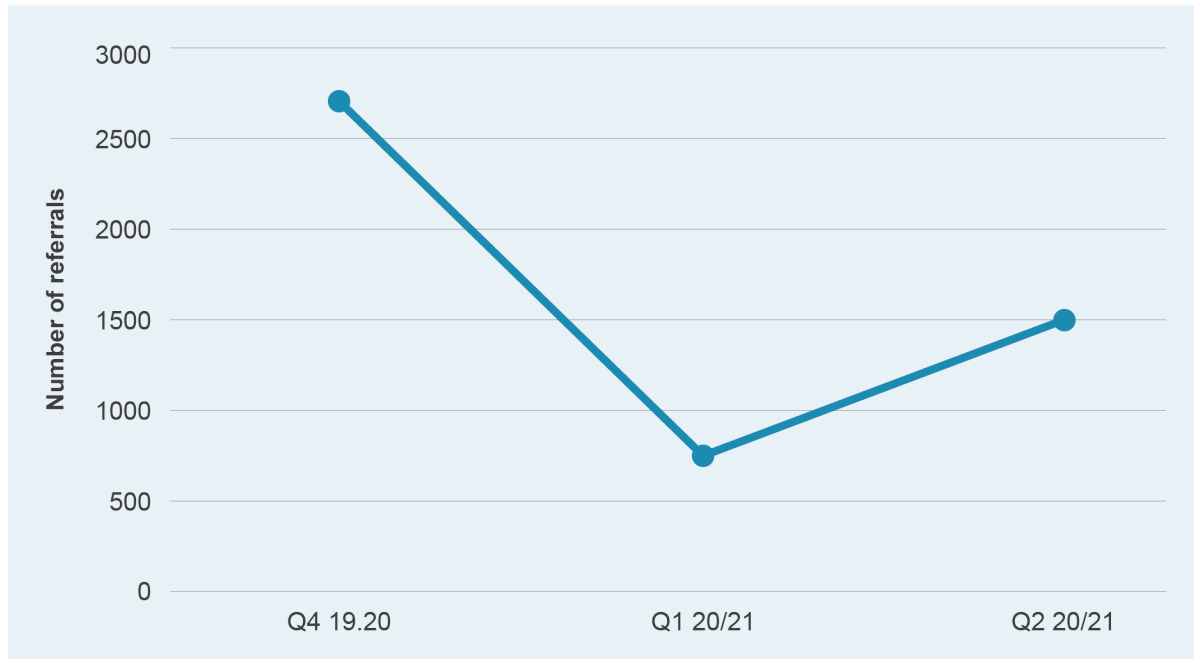
Challenges

By the time of the first national lockdown in response to Covid-19, MHSTs had been operating for a matter of weeks in most sites. EMHPs were transitioning from their training year into practice, in many areas senior staff therapists were still being recruited, teams were starting to establish themselves and build relationships with educational settings, and referral processes were being implemented for the first time. In the initial weeks after lockdown started, there was a great deal of uncertainty and confusion about what implications Covid-19 would have for MHSTs and for the Trailblazer programme more generally:

“In terms of the impact of Covid, when it first hit everybody then quite a lot of the teams were going through it, it was such an extraordinary time, something none of us has been through before. New challenges, not knowing whether or not the programme was going to stay, not knowing if the trainees were going to stay, not knowing if those that were, so the team leaders etcetera that had permanent positions, would they be pulled off the programme and pulled into other services? So initially when Covid hit there was huge wobbles everywhere.” (Regional leads, 001)

Consistent with the pattern across children and young people's mental health services generally (Thomas 2020), there was a substantial fall in referrals to MHSTs in the initial months of the pandemic. Eighteen Trailblazers reported activity data to NHS England and Improvement in the first half of 2020; collectively the MHSTs in these sites accepted 2,722 referrals between January and March, with this falling to 758 referrals between April and June 2020 (Figure 13). Several explanations were offered for this, above all that it was much harder for staff to spot mental health problems and less likely that these would be disclosed by a child or young person given that the majority of pupils were not attending school in person. Also, as we discuss in more detail below, it was unclear in the initial weeks of the pandemic if and how MHSTs could continue to provide support in lockdown conditions. All MHSTs eventually switched to delivering elements of support remotely, but it took some time to prepare for and make this switch.

Figure 13. Referrals accepted by MHSTs in 18 Trailblazer sites between January and September 2020²⁴



[Source: Aggregated programme data, January 2021; n=18 Trailblazer sites]

While the impact of Covid-19 on educational settings had been variable, negative impacts were widely reported and included increased staff workloads, stress and fatigue; coping with constant uncertainty and disruption; concerns about the safety and wellbeing of pupils, and an increase in safeguarding issues; dealing with angry and frustrated parents; and the challenges of designing and engaging children and young people in remote learning. Many schools and colleges were also seeing an increase in mental health problems, among staff, pupils and parents:

“We have noticed an increase in needs of the children and parents. Lots of parents have come for mental health support. Lots of this need has also linked to safeguarding issues. These issues weren’t immediate, but after a couple of weeks my staff felt a bit swamped.” (Educational setting survey response)

“Since returning to school we have had increased need and...so at times we have been very stretched. We have had a lot of cases which have

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Some caution should be exercised in interpreting these figures, as the way in which the quarterly monitoring data are reported (for example, data are inputted manually and are reported in aggregate rather than as individual data points) means there is a higher risk of error. That said, all the evidence from Trailblazer sites confirms a decrease in referrals in the early months of the pandemic.

overlapped with safeguarding and so capacity has reduced further.” (Educational setting survey response)

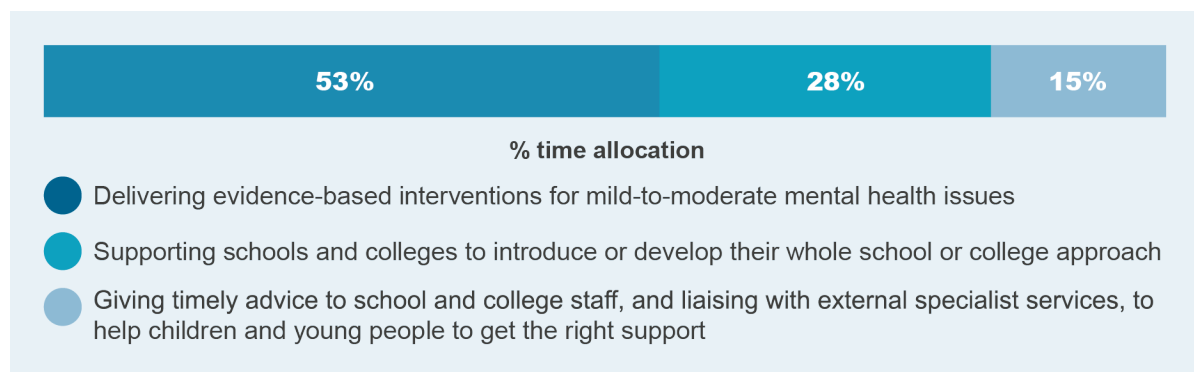
“Children whose parents couldn’t work were facing extreme deprivation and we provided daily food packages to them. These families were under an extreme amount of stress and this will inevitably have affected the wellbeing of all involved.” (Educational setting survey response)

There was a strong sense that some educational settings were firefighting and, as a result, they lacked the time and headspace to engage with their MHST:

“Early on in Covid school engagement was a definite concern...schools were just, I think it was just the pressure, they were just overwhelmed and, even though they were very much concerned about the health and wellbeing of the children and young people, they had so much other things that they needed to prioritise.” (Regional leads, 008)

The shift to remote working had made it harder for MHSTs to get to know the educational settings they were working with and build relationships with staff. Combined with the pressures on educational settings, some felt this had particularly impacted on the work to develop whole school approaches. In the words of one interviewee, this element of the programme had *“slipped down the priority list”* (Project lead, 003). The most recent activity data reported by MHSTs (July-September 2020) indicates that teams were delivering all three of their key functions, albeit that a little more of their time was spent delivering direct interventions (53%), than working with educational settings to introduce or develop whole school approaches (28%) and providing advice, signposting and liaising with external specialist services (15%) (Figure 14).

Figure 14. Mental health support teams average time allocation (%) across their key functions²⁵



[Source: Aggregated programme data, January 2021; n=15 Trailblazer sites]

When lockdown conditions started to ease in the summer of 2020, the option for teams to return to work in school and college buildings opened up. In many cases, negotiations about teams returning to work on site were not straightforward. A notable area of tension was around the use of personal protective equipment (PPE) – most commonly, that MHST staff were required by their employer (in most cases, an NHS mental health trust) to wear PPE for all face-to-face contacts, whereas there were different rules and expectations for school staff:

“So I think the difficulty is caused by the fact that the schools have their own risk assessments and approach to the use of PPE in their schools and then the teams that are employed by large mental health trusts in particular, they have their own rules around the use of PPE and I think it’s where those two rules are not the same that it’s difficult to maintain a blended offer...So you might have the school saying “actually, for our children we don’t want our visitors to wear a mask, you can sit at the end of a table in a room and you can be two metres apart” and then the provider is saying “actually, but our mental health support team staff, they need to be wearing face coverings and gloves because they’re moving about the schools.” (Regional leads, 003)

These findings highlight some of the practical difficulties of working across the education and health sectors, underpinned by the different ways in which ‘risk’ is understood and assessed in these sectors.

Opportunities

A clear picture emerged from our findings that teams very quickly adapted how they were working and what they could provide, in response to the limitations and challenges presented by lockdown. In effect, the pandemic necessitated creativity and innovation. Many teams seized the opportunity to do things differently and this was widely praised:

“I think there will be nobody on this call that won’t say it was absolutely amazing how quickly people just got their heads down and just made sure that the service could be delivered in some form or fashion, especially [in] the Trailblazers...Whereas other services have backed off, the [mental health support teams] completely sprung into action.” (Regional leads, 007)

Broadly, this adaption in response to Covid-19 took three main forms: i) developing strategies to increase referrals; ii) switching from face-to-face to remote working and support; and iii) changing or expanding the type of support provided (see Box 10 for more details). All these responses were supported and encouraged by national guidance issued by NHS England and Improvement.

Box 10. How mental health support teams adapted their services and approach in response to Covid-19

1. Strategies to increase referrals

MHSTs sought to increase referrals to their services in two main ways. First, by using a range of communication channels to increase awareness of their service and let educational settings know that they were still accepting referrals:

“Teams have undertaken co-ordinated communications through social media and websites to raise the profile of the services and to ensure that families are aware that mental health services are open for business.” (Key informants survey respondent)

Second, teams worked with other local mental health services and/or non-Trailblazer schools, so as to offer support to a wider group of children and young people locally:

“We also saw, where referrals dipped because the schools had closed, we saw them working with other services so that if there were any referrals going into CAMHS, even the ones that might have been just borderline that they might not have taken before, they were putting extra support in so that they could be picked up.” (Regional leads, 007)

“The team has been flexible in adapting [the] programme online and opening these resources up to other schools outside of the Trailblazer clusters.” (Key informant survey respondent)

2. Switching to remote delivery

In all 25 Trailblazer sites, teams started to offer remote support, using telephone and/or digital platforms. The adoption of digital technology was especially challenging, involving practical issues (e.g. team members needing computer and internet access, having a private space to work from in the home etc.) and concerns about issues including lack of team training and skills for digitally delivered support, safeguarding and confidentiality, information security, barriers to access, and the suitability of providing emotional and wellbeing support to children and young people remotely:

“...the challenges of starting to use software if you don't really know how to use it, your Wi-Fi's not working, the families that you're working with don't have access to software or they don't have kit or whatever, they don't have any privacy, you know, all of those kind of things were really challenging earlier on.” (Regional leads, 006)

The impossibility of providing support face-to-face for substantial periods of time during 2020 and into 2021 had driven efforts to address some of these challenges, enabling teams to offer online consultations, digital interventions, virtual group sessions and other technology-based approaches:

“...the virus is an awful thing but it has sort of accelerated the use of digital somehow and maybe some sites that were reticent or slow to adopt in the past are now really – it’s more that you have to now, to do anything, you have to become confident and competent. And I think in schools as well as amongst services, there’s a skills gap that really was addressed quite quickly....there was a bit of a leap forward in confidence.” (Regional leads, 007)

In periods when lockdown restrictions had eased, and where teams were able to negotiate access to school and college premises, they moved towards a blended model, with a mixture of virtual and face-to-face support.

Some Trailblazers reported that the switch to remote working had improved partnership working at the strategic level, as it had become easier for people from different organisations to meet together using platforms such as Zoom and Microsoft Teams.

3. Changing or expanding the type of support provided

Some sites reported that MHSTs, in response to particular needs arising from the pandemic and/or to fill the gap created by the drop-off in referrals, had developed new resources and offers of support. Several respondents mentioned that teams had expanded their focus to include providing support to parents and teaching staff. Some examples of this work included:

“...they [MHSTs] are also working with schools to support the teaching staff around their own emotional health and wellbeing whilst supporting the [children and young people].” (Key informants survey respondent)

“The team has developed pre-recorded workshops to support staff and students with their wellbeing. We have also been delivering monthly webinars to support parents.” (Key informants survey respondent)

“...the one thing that I was really impressed with over Covid was the innovation of those sites in terms of looking at different ways in which they could get support out to children and families, either by a kind of virtual parent group or the amount of resources that have been developed and produced and put onto local websites for children or parents to access over that lockdown period were just amazing.” (Regional leads, 007)

In some cases, this extension of support to staff and parents had helped to build relationships:

“We’ve seen the mental health support teams provide staff guidance, parent guidance. We’ve seen them support the teachers, the actual professionals within those settings. So as much as I would never have wished a pandemic on anyone, I think what that’s done for those relationships with some of those sites and some of the schools, has probably been massively positive.” (Regional leads, 007)

More than half (57%) of respondents to the key informants survey reported that at least some of the changes made by MHSTs in response to Covid-19 were likely to endure after the pandemic. Most commonly, respondents reported that the teams in their site were likely to continue delivering aspects of mental health support using online platforms, in a blended model that combines digital and face-to-face approaches. Some commented that such a blended model would be beneficial inasmuch as it would give children and young people more choice about how they are supported; could increase the number of individuals supported at any one time (because less travelling would free up time); and make it easier for teams to provide a continuous service throughout the year, including during school holidays. The importance of continuing to offer face-to-face interventions was also emphasised, given that some children and young people are not able or do not feel comfortable accessing support online. Relatedly, a concern was raised by one interviewee that decisions about the balance between face-to-face and digital delivery should be based on what is most appropriate and effective for children and young people, and not by financial considerations (e.g. potential pressures to make efficiency savings or do 'more with less' in the post Covid-19 environment):

“The face to face stuff. My worry is, as I say, we won’t actually get back to the business as usual even as it was before. I hope we do to some extent, but my worry is that we might not but I don’t know.” (Regional leads, 002)

Early impacts

While it is not a goal of the early evaluation to formally assess whether the Trailblazer programme is achieving its desired outcomes, many people who participated in our first phase of fieldwork shared examples of early impacts that they had observed. Examples shared by schools and colleges through the survey of educational settings included:

- Being able to support more children with mild to moderate mental health problems
- Reduced waiting times for children/young people to access help
- Being able to provide more support within the school environment, thereby preventing mental health problems from worsening and the need for referrals to specialist services
- Positive feedback on the support received from children and young people and/or families
- Having improved access to advice about mental health problems and how best to support them

- Improved signposting to external mental health services and sources of support
- Staff feeling more knowledgeable and comfortable talking to and supporting children and young people with their mental health
- Senior mental health leads, and those in other key roles, feeling more supported
- Development of a more proactive and positive culture around mental health and wellbeing – for example, mental health issues being more openly discussed (within school and with parents).

Specifically, respondents told us:

“Having worked with the local MHST now for over a year, I feel that I have easy access to specialist support for identified pupils, not only for referrals but also advice. I also feel I can signpost pupils and their parents to specialist support in a timely manner now. The feedback from parents whose child/children have used the MHST to date has been very positive which impacts on making my role easier!” (Educational settings survey respondent)

“Knowing that the support is there has helped me to develop a more proactive culture in school. Both other staff and parents have been coming forward and asking for support when a problem is mild to moderate. This has made mental health a more acceptable topic of conversation for people who may not have been comfortable talking about it before.” (Educational settings survey respondent)

“It has stopped some children’s needs escalating to a full CAMHS referral. We have been running the programme for over a year now and it has given me somewhere to go for advice and support. Having a person to join my team has made this a seamless operation and has allowed my school to extend our offer and hopefully reduce the burden at higher tiers.” (Educational settings survey respondent)

Among other participants (i.e. those not based in educational settings), the main early impact reported was better partnership working and collaboration across the organisations that had been involved in designing and/or implementing the MHST service:

“The MHSTs pilots have enabled us to have more joined up conversations and planning across health, social care and education. We are moving towards systems thinking rather than service thinking and how we can work together more effectively and make best use of resources and having ‘no wrong front door’.” (Key informants survey respondent)

Opportunities for skills and career development were also described:

“I have had the opportunity to develop and expand my skills and knowledge through setting up and running the MHST, including launching the service, publicising services to [children, young people, parents and families] and working with a range of partners to seek feedback on and develop the services that we offer...I have achieved a post graduate certificate in Supervision and we continue to offer a high level of supervision to the members of the MHST.” (Key informants survey respondent)

Less promisingly, we heard of one example where a school had stopped funding a counsellor post because they felt this support was no longer needed once the MHST was in place. The MHST had, therefore, simply substituted for existing support, rather than being additional to it:

“One of the principles is that the mental health support teams are additional and complementary to other support, it's not meant to replace it. But you can say that as many times as you like but we have heard examples of a school with a separately funded counsellor by the school leaves and they don't replace them – this was [name of area] – there was a knock-on impact and almost immediately referrals that were unsuitable that were going into the mental health support team.” (Regional leads, 006)

A small number of other educational settings reported that, due to financial pressures, they had taken the decision to stop funding in-house support for mental health problems before the programme started:

“We used to employ our own child psychologist 2 days per week but it was too expensive and we couldn't justify allocating budget to it. We do all we can with the resources we have.” (Educational settings survey respondent)

Where this is the case, it raises questions about whether MHSTs truly represent additional capacity, as the programme intends, or whether they just bring educational settings back to a previous level of provision. We must note that the extent of disinvestment in mental health support so far reported – either prior to or as a result of the programme – appeared to be very small, but we will investigate this issue further in our next phase of fieldwork given that a core principle for MHSTs is that they *“should be additional to and integrated with existing support.”*

7. Challenges and enablers

Key points

- Aside from the impact of Covid-19, several issues and challenges were reported by Trailblazers. Some participants felt that the nature and remit of the support which mental health support teams (MHSTs) could provide had not been adequately explained to educational settings. Other raised concerns about the scope of the MHSTs service, in particular that it did not include the most urgent unmet needs. Relatedly, the standard MHST intervention which education mental health practitioners (EMHPs) had been trained to deliver (time limited, CBT-informed therapy) was considered less suitable and effective for some groups of children and young people.
- 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 soon after training.
- Engagement of educational settings was a recurring theme. Covid-19 had intensified pressures and demands on educational settings and some, as a consequence, lacked the time and headspace to fully engage with their MHST. Some educational settings reported that mental health problems among parents, carers and staff had increased as a result of the pandemic, and were keen to offer more support to these groups. There is a question about whether this can be provided by MHSTs, especially in light of observations from some sites that demand is already exceeding 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.
- Several enablers and success factors for the programme were described including a receptive local context; co-production of the MHST service and approach with children and young people, parents and carers; a stable and consistent workforce; collaboration between MHSTs and other local services; MHSTs being flexible and adaptive; networking and sharing the learning; and taking a system-wide approach to implementation.

Challenges and issues

A key focus of our early fieldwork was to explore any challenges and issues that Trailblazer sites had faced as they developed and established mental health support teams (MHSTs), and as these teams moved from set up into becoming fully operational. Several themes emerged, some of which echo common findings in the literature on service innovation and improvement (e.g. da Silva 2015) and evaluations of other programmes seeking to improve prevention and intervention for children's mental health (Burn et al 2020; Day 2017; Stewart 2008).

Remaining gaps in support

A common theme in the early experiences shared concerned the fit between what MHSTs were able to provide, and educational settings' expectations and priorities for support. In some cases, what was described was an apparent lack of understanding or confusion about what teams could (and could not) offer, most often with the suggestion that the service had not been sufficiently explained to educational settings. Developing and clearly communicating referral pathways and criteria was often the proposed solution, to guide educational setting staff to make appropriate referrals. Linked to this, some felt that their site needed to do more work to define 'mild to moderate' mental health problems, a task which national guidance from NHS England (2019) acknowledged is "challenging but important":

"So I think this is where for me, the programme could have supported schools to understand the distinction between what is mild to moderate and what is CAMHS [child and adolescent mental health services] and we all loosely say 'CAMHS'...it's just a word. If you're not 'in' mental health services, it's just what do those five letters mean?" (Regional leads, 003)

But many respondents, in particular those from schools and colleges, took a different view. Investment in mental health support for children and young people, and the programme's focus on prevention and early intervention, was welcomed. However, what many educational settings reported they needed most was help for children and young people whose mental health problems were more serious than 'mild to moderate', but either were not deemed 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 NHS services:

"Support for children with more serious or complex needs. Trailblazer programme offers very similar support to the support we are able to offer in school – need support for children at the next level." (Educational settings survey respondent)

“We’ve got kids who are between CAMHS and between Early Intervention who are like Tier 2 equivalent who are not reaching thresholds, or are on waiting lists and we need this thing. So what schools and colleges thought might be the most helpful thing was not necessarily the thing that the MHSTs could offer.” (Educational settings survey respondent)

We were told that this group of children and young people, who are falling between the gaps in mental health provision, is increasing as the demand for specialist mental health services in many areas grows, compounded by the mental health impacts of Covid-19. Relatedly, some shared frustration about assessment processes for NHS mental health services being too narrowly focused on clinical symptoms, such that children with complex lives and problems were unable to access support because they did not neatly fit referral criteria.

One respondent noted that MHSTs could potentially provide support to this group of children and young people, as teams included more senior and experienced therapists:

“I worried early doors that there were going to be cases that wouldn’t meet the threshold of specialist CAMHS but were too high for EMHPs...and that’s still a concern although I think they’re working on that in terms of how to escalate – and that’s the idea of those senior posts within the team, that there is some flex on that, so while the EMHPs can’t pick up those cases, those Band 6 roles should be able to at least hold them and signpost on.” (Regional leads, 001)

It is noteworthy, then, that the MHST manual notes that, *“The responsibilities and functions of this role [i.e. senior mental health clinicians] will be further informed by the Trailblazers”* (NHS England 2019).

Team training and skills

Another strong theme emerging from our early fieldwork was about the extent to which MHSTs had the breadth of skills and experience to provide support to all children and young people with mild to moderate mental health problems, and tailor that support to individual needs and circumstances. Several issues were raised. First, some felt that the training provided to education mental health practitioners (EMHPs) had not sufficiently prepared and equipped them for working in educational settings:

“I was so enthusiastic about this project and delighted to be taking part, as mental health support is something we have done a lot in my school over the past few years. I have been completely disillusioned about the MHST worker aspect of the project as the new recruits had little experience of working with children of the age group they were eventually deployed with. The fact they

were supporting in schools while training was muddled and didn't give them the skills and confidence to be effective in school." (Educational settings survey respondent)

Second, several respondents commented that the 'standard' MHST intervention which EMHPs had been trained to deliver (time limited, CBT-informed therapy) was less suitable and effective for particular groups. The need for MHSTs to offer more specialist and tailored forms of support was emphasised, for groups including younger age children, children who are self-harming, children with special educational needs (SEN), and vulnerable and disadvantaged children (i.e. where mental health problems are related to or unpinned by factors such as poverty, family instability or domestic violence):

"My school is an SEN school and it has been difficult to fit Trailblazers into my school as it is not set up for it. SEN is always a second thought as well and we find that rarely are programmes of support ever constructed with our type of pupils in mind." (Educational settings survey respondent)

"Deprivation in our area. Many children have ACE's [adverse childhood experiences] and other complexities/social factors that are impacting on their mental health and may make the CBT evidence based approach not appropriate as their level of need is too high, or there is systemic work to be done." (Key informants survey respondent)

"There needs to be more provision or training for the Trailblazer team on working with children individually in primary schools...In some areas, parental engagement is low and therefore relying on an intervention that a parent engages with for an hour every week for 6 weeks is not realistic. We need to be creative with a different way of engaging parents and upskilling, informing and promoting mental health with them." (Educational settings survey respondent)

"...there have been issues around schools asking, understandably, for EMHPs to work with children and young people with things like self-harm, but the [training] curriculum doesn't cover that and the whole what's mild to moderate?" (Regional leads, 001)

Relatedly, one respondent explained that more specific or complex needs would sometimes only become apparent over time, so a child or young person initially supported by an EMHP may need to be referred to a more senior therapist with the skills to provide appropriate support:

"The EMHPs are finding that with a number of cases they will reveal a lot of clinical risk in session 2/3 and require more senior input because the EMHPs are too inexperienced. Often this is linked to discovering ASD [autistic

spectrum disorder] type traits/behaviours and the risk is escalated.” (Key informants survey respondent)

Some called for teams to be skilled in and offer a wider range of support and interventions including, for example, play therapy, family psychotherapy and trauma-informed therapy.

Staff retention and turnover

Our survey of local stakeholders asked respondents to describe the three main implementation challenges they had experienced so far. The most widely mentioned was staff retention, particularly in relation to EMHPs. As the workforce is being built alongside the roll-out of the programme, when an EMHP left, teams had to wait for another round of recruitment and training before they could be replaced, leaving them under-staffed in the intervening period:

“...and it just is this reoccurring picture that EMHPs drop off and that’s one of my huge worries in the programme, is just this revolving door. People come, people go and we just find ourselves training and training people again and again and again, there is no pool to draw on to get qualified people in, it’s quite a challenge.” (Regional leads, 004)

Several reasons were proffered for why EMHPs had left their post so soon after training, including differences between expectations of the role and the reality once in post; the amount of travel required because they were recruited to a team based some distance away from their home; lack of senior staff to provide supervisory support; and changes in personal circumstances (e.g. re-locating or having a baby). In addition, some suggested that the EMHP role was seen as a stepping stone into other careers, such as clinical psychology, and felt that more attention needed to be given to creating opportunities for career progression within the role to reduce staff turnover. We heard that one Trailblazer site had *“designed a kind of pathway through the teams so that people can progress within the team and try and aid retention there”* (Regional leads, 006).

This challenge of staff retention is not unexpected, and mirrors what was previously reported for children’s wellbeing practitioners (CWPs), on which the EMHP role is based. A 2020 report commissioned by Health Education England noted the similarities between the trainee profile, training and competencies of CWPs and EMHPs (Lang 2020). The report found that, for both roles, there were *“Question marks around career progression both vertically and horizontally [that] are likely to impact retention.”* It set out a series of recommendations including fast-track routes

into supervisory roles, top-up training (to enable people to move between equivalent roles in children's to adult's services), opportunities to develop specialist skills, and the creation of new titles and roles within existing teams such as 'CBT therapist'.

Demand exceeding capacity

Given the diversity of areas and educational settings involved in the Trailblazer programme, it is not surprising that MHSTs' early experiences of working with schools and colleges varied. Some respondents reported that there were educational settings in their site where teams felt they were not being fully utilised, where the priority was to work with school or college staff to raise awareness of the support on offer and encourage referrals to be made. More commonly, the opposite challenge was described: that the amount of MHST time allocated to educational settings was not sufficient to meet existing and, as a result of Covid-19, growing demand for mental health and wellbeing support.

Alongside improving access to specialist and external services, further funding for 'in-house' support within educational settings, which was felt to be critical for enabling early intervention, was identified by several respondents as a priority. More support for parents was another common theme, described as being important in itself and for prevention, given the strong links between parental and child mental health:

"Also, I would like to have support for parents which we can access. A large number of our parents are under the care of a local centre and this is saturated with need and so the need of our parents is not being met, this in turn impacts on the wellbeing of our children." (Educational settings survey respondent)

An issue raised by one respondent was whether the paperwork which MHST staff have to complete might be limiting the amount of time they can spend providing direct support:

"The [mental health support team does] a fantastic job with the students they see. They are very restricted by the paperwork they are expected to complete, and this has a huge impact on the amount of pupils they are able to see. Our counsellors see 6 pupils per day, 1 each lesson, and then complete any paperwork after 3pm. This structure does not seem possible with the Trailblazers and my question is should their paperwork take away from time they could be spending with students. On average they are only able to see 3 pupils each which is half compared to our counsellors." (Educational settings survey respondent)

This is an issue that merits further investigation, and one which the evaluation will be able to explore in our second phase of fieldwork, when we will be speaking directly to MHST staff.

Communication with and engagement of educational settings

A thread running through many of the themes we describe in this chapter is about how programme stakeholders and MHST staff were working with educational settings to implement the new service. Many recognised that relationship building was a long-term process that would take time to achieve, and the overall impression was that progress was being made. However, some of our interviewees remarked that communication with schools and colleges about the programme had not always been good, although sometimes this reflected problems in the flow of information at a higher level (i.e. between the national team and local areas):

“...some schools were saying ‘I’m not going to send anything out to parents because we’re not 100% sure what’s happening.’” (Regional leads, 007)

Engagement of educational settings had been a challenge prior to the pandemic, but Covid-19 had created something of an engagement paradox: it had increased the need to get MHSTs established and operational, but at the same time had decreased the time and resources that educational settings could devote to this. We heard from several respondents that it had become more difficult to access external services during the pandemic, especially in the early months, and this had meant that staff in schools and colleges were spending more of their time supporting pupils with mental health problems. The strain this was placing on key staff (e.g. mental health, pastoral, SEN and safeguarding leads) was highlighted as a particular concern.

Of the senior mental health leads who responded to our educational settings survey, two-thirds (64%) felt they had sufficient protected time to perform their role. Capacity to engage appeared to be more of an issue where the senior mental health lead and/or main contact person within the setting was covering several roles:

“Key staff in schools not having the time for the programme e.g. Deputy head is the main contact so too many responsibilities.” (Key informants survey respondent)

Delays to the roll-out of the senior mental health leads training

There was evident disappointment and frustration among some interviewees about the delays to the senior mental health leads training. This training represents the major investment from the Trailblazer programme directly into schools and colleges, and is intended to support and equip senior mental health leads to fulfil their leadership role effectively. There were concerns about the impact of the delays, both on how the training is eventually received, and on the implementation of the programme as a whole. On the first of these, we were told:

**“Some areas think that it’s long overdue and it should have been in place sooner...it’s going to make what should be a great offer land a bit flat really.”
(Regional leads, 008)**

One Trailblazer site had developed its own local training programme for senior mental health leads; the possibility that others might do the same was suggested.

In terms of the impact on implementation of the programme, a key purpose of the training was to support educational settings to develop cultures and ways of working that promote mental health. This, in turn, would provide a solid foundation on which the programme could build. Therefore, educational settings that had – prior to the Trailblazer programme – already 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:

“Where they’ve got a really well-established structure within the school with a clear lead and a real focus on whole school approach, the MHSTs and the EMHPs are able to slot really well within that structure...So I think that’s why, you know, the ordering has almost, it’s the wrong way round really to introduce the MHSTs without doing that awareness building within the school through the senior mental health lead training...When we’ve been out to visit the schools they’ve all said, haven’t they, that those that have that kind of champion for mental health and have that whole school approach sort of embedded to some extent have really been able to take on the MHSTs properly and really get the most out of it.” (Regional leads, 008)

The provision of other training to educational settings – principally through the *Wellbeing for Education Return* programme – was acknowledged and welcomed, but the need for swift progress to confirm the timescales and process for rolling out the senior mental health leads training was nonetheless emphasised.

Limitations of digital delivery

A topic that many participants commented on was the learning from the rapid switch to remote and digital delivery, as a result of Covid-19. This switch had enabled teams to continue to work with educational settings and provide some direct support, even during lockdown conditions. It had also presented an opportunity to explore the possibilities, as well as the limits, of digital technologies. Some positive examples were shared. For example, one site had offered online group support sessions, which brought together children from across several schools. They had found this to be more effective than face-to-face groups because children seemed to be more comfortable talking about mental health issues when others in the group were from different schools.

Problems were also described, above all that some children and young people were unable to access mental health support online, and that these were often the same groups whose lives had been most negatively affected by Covid-19 (e.g. children living in poverty and/or in unstable home environments). Experience had shown that not everybody wanted to engage with digitally delivered support, and while technical challenges were being addressed they had not been entirely overcome:

“It has reduced the uptake of workshops. Parents are reluctant or unable to access workshops via Teams/Zoom. Yesterday a planned workshop could not go ahead as internet access failed.” (Educational settings survey respondent)

Children and young people may not feel comfortable discussing their mental health problems in the home environment, especially where family or home-related factors are involved. Some other examples were given where digital interactions were unsuitable, including for younger children, where it was important that a child be seen in person (e.g. if they had an eating disorder or there were safeguarding concerns), and for initial assessments where it was important to pick up on body language and other non-verbal behaviours.

Data and reporting challenges

MHSTs are required to routinely capture and report a range of data on service activity and performance. This includes outcomes data for direct interventions which, the MHST manual states, should be collected on a session-by-session basis, to support the therapeutic process and track progress over time (NHS England 2019). The manual also identifies three levels at which data should be gathered (Box 11). All of the individual-level and some service level (e.g. waiting times, interventions delivered) data are reported nationally through the Mental Health Services Data Set (MHSDS).

Box 11. Outcomes data MHSTs are expected to routinely collect and report

- **Individual level:** person-centred, goal-based outcomes, as well as symptom and impact measures, to determine the progress of a child or young person, their level of functioning, as well as their experience of care
- **Service level:** to evaluate the team's delivery of the core functions; this includes the number of interventions delivered, onward referrals to specialist services, average waiting times and feedback from children, young people, families, parents and carers
- **Education setting level:** to demonstrate how well the MHST has integrated with the whole school/college approach to mental health, and the impact it has had on issues such as academic performance, exclusions, attendance and Ofsted ratings.

Several challenges were described. Reporting processes were felt by some to be excessively time-consuming and burdensome. IT-related barriers appeared to be particularly affecting teams based within voluntary sector organisations:

“We’ve got two mental health support team providers [in our region] that are voluntary sector and they did not have the infrastructure needed to be able to respond to that kind of data, the sort of data requests that are essential to track the programme.” (Regional leads, 006)

There were also issues with the metrics, most commonly that the information being used to track progress was heavily oriented towards MHSTs’ direct support function, with very little focus on capturing information about the development of whole school approaches. More specific issues were also reported by individual Trailblazers:

- Some MHST activities and interventions did not easily map onto the predefined codes in data systems, meaning some work could not be reflected in the collected data
- Difficulties in having to state ‘reason for referral’ which requires a diagnosis, despite MHSTs not necessarily offering diagnoses
- The data manual was still being drafted so there was a risk that sites might be investing in reporting systems that were eventually shown not to be suitable
- A lack of clarity on how to report time allocation across MHST functions in MHSDS.

Uncertainty about future funding

A final challenge mentioned concerned the uncertainty about ongoing funding for MHSTs. At the point of our fieldwork, funding had been confirmed only to the end of March 2021, and some sites reported that this was affecting their ability to re-fill posts where staff had moved on. This issue was most apparent where MHSTs were provided by a voluntary sector organisation, although we may expect that all Trailblazer sites will be keen for clarification as to whether and how funding will continue beyond 2022/23.²⁶

26 Soon after the fieldwork period, NHS England and Improvement confirmed funding arrangements beyond March 2021 for the Trailblazer sites.

Enablers and success factors

As well as describing the challenges encountered, Trailblazers also described a range of factors that were considered critical to successful implementation. Despite there being differences between Trailblazer sites and how implementation work had been set up locally, it is interesting to note that there was a high degree of consensus about these factors.

Local context

A range of factors, which we have broadly grouped into the category of 'local context', relate to the organisational landscape in Trailblazer sites. There was a widespread view that, to be successful, implementation must be grounded in strong partnership working arrangements, underpinned by governance models that were transparent and inclusive. As noted in Chapter 5, the funding for MHSTs was allocated from NHS England and Improvement to Clinical Commissioning Groups (CCGs), which were expected to "*provide strategic governance and oversight of MHSTs*" (NHS England, 2019). Moreover, in most Trailblazers, the MHST service was being provided by the NHS trust providing specialist children and young people's mental health services in the area. Some felt that this tilted the balance of power towards health. Ensuring that all key organisations and sectors – including local authorities, schools and colleges – were able to meaningfully influence the design and delivery of MHSTs was frequently emphasised.

In a number of areas, prior work to foster integration between health and education meant that some relationships and structures were already in place. This had provided a foundation for programme implementation, and these areas had often been able to progress more quickly as a result:

"...there were some areas that are really well established or seem to already have a big set-up with CAMHS clinicians in schools and all that kind of stuff like [name of area] for example and if you've already got that kind of infrastructure it's more straightforward." (Regional leads, 006)

It was also acknowledged that building and maintaining relationships was an ongoing process, not a one-off. This process had been harder and demanded more time and effort in sites where there had been a lot of turnover of staff in key programme roles, again affecting the speed at which progress could be made. Respondents from educational settings also highlighted the importance of leadership within their own organisations, and in particular the role of the senior leadership team in identifying mental health and wellbeing as a priority, in championing the programme (e.g. with staff, parents and governors), and supporting staff in key implementation roles.

Co-production with children, young people, parents and carers

Several participants remarked on the importance of children, young people, parents and carers being able to shape what MHSTs could provide and how they worked. Indeed, it is one of the programme's operating principles that *"MHSTs should co-produce their approach and service offer with users"*. On this issue, one regional lead reflected that:

"...what myself and [name of colleague] saw very much from the onset was those who were not strong in co-production struggled. Those who were really strong in co-production, i.e. the ones who were listening and working with, struggled less." (Regional leads, 005)

We do not yet fully understand how specifically the involvement of children and young people, and parents and carers has enabled or contributed to effective implementation. Our in-depth research will provide an opportunity to explore this important issue further.

A stable and consistent workforce

Many respondents to our surveys commented that success would crucially depend on the programme being able to recruit and retain an adequately sized and suitably qualified workforce. Issues of staff retention and training have been discussed in some detail in the 'Challenges and issues' section above. We would add that several respondents commented on the importance of having consistent staffing arrangements; as one person described it: *"Linking named mental health workers to schools to build relationships and get to know schools and staff"* (Key informants survey respondent). This arrangement would also promote continuity of care for the children and young people being supported by MHSTs.

Collaboration between mental health support teams and other local services

The importance of MHSTs being complementary to, and integrating with, existing sources of support in their local areas was frequently highlighted. The general view was that MHSTs must work in collaboration with other services, teams and professionals – both those based within educational settings (such as school and college counsellors and educational psychologists) and those in the wider community (including specialist NHS mental health services, voluntary sector and local authority services, as well as general practice). This would help to foster a coordinated approach to children and young people's mental health across local areas, support smooth transitions between services, avoid duplication, and promote sharing of learning and resources.

Mental health support teams being flexible and adaptive

A common view among participants was that MHSTs must be willing and able to work flexibly, in order that ways of working can be appropriately tailored to each child/young person and setting. The MHST manual emphasises flexibility in when and where sessions take place. To this, respondents added the need for flexibility in the types of support being offered, and in how MHSTs work with educational settings to develop their whole school approach. It was recognised that teams could only be responsive within the boundaries of their training and skills. Given this, some suggested that Trailblazer sites might work more closely with Health Education England and the universities involved to shape the training for EMHPs.

Networking and sharing learning

A factor that emerged particularly strongly from our interviews with regional leads was the value of networking between and across Trailblazer sites, to support the sharing of experiences, learning and good practice. Local and regional networks were a means by which those in key implementation roles could seek advice to understand and address emerging challenges, or access practical tools and resources developed in other areas to support their own work:

“So for example our colleagues in [another area], they’ve got a lot more 18/19 [i.e. Trailblazer] teams so we’ve been sharing learning across providers and that’s one way of getting information and learning. We set up a network between the NHS England Green Paper leads, so we meet informally regularly and kind of built up our own network.” (Regional leads, 003)

A small number of respondents to our educational settings survey called for networking opportunities between senior mental health leads in participating schools and colleges, to share resources and ideas, and also help them explore the best way of utilising the support offered by MHSTs.

Taking a system-wide approach to implementation

As described in Chapter 5, our initial fieldwork identified different approaches to setting up and implementing the programme in the Trailblazer sites. One early observation was that some areas had taken a more systemic approach to implementation, embedding the Trailblazer programme into existing work, strategies and partnership arrangements. This contrasted with areas that had taken a more narrow focus, where MHSTs were designed and implemented as a ‘project’ in itself. Some regional leads commented that the system-wide approach, while potentially more complicated to set up and manage, had made it easier for service models and learning to be scaled up across regions as additional MHSTs were established in later waves of the programme.

8. Discussion and next steps

Summary of main findings

This report presents data collected from Trailblazer sites between November 2020 and mid-March 2021. These initial findings point to areas where substantial and important progress has been made, and suggest that – at least among those we have heard from so far – there is a fairly high degree of optimism about what the programme has the potential to achieve. Nonetheless, there are also several issues and challenges which will need to be considered and addressed as the roll-out of the programme continues. Box 12 provides a summary of our main findings to date.

Box 12. Summary of main findings to date

- Overall, there was consensus that the Trailblazers had achieved a great deal in a relatively short space of time. Setting up the programme locally was a substantial and complex task, and some areas had not fully grasped the scale of the implementation challenge. Despite this, all 58 mental health support teams (MHSTs) were operational in some form by January 2020, and this was considered a major achievement.
- By the time of our fieldwork, governance arrangements were established in the Trailblazers, with representation (in almost all sites) across health, education and the voluntary sector. That said, there was also a view that local governance and leadership was not yet truly shared across these groups and, in particular, that the way in which the programme had been set up created a health/NHS dominance.
- MHSTs are expected to “*co-produce their approach and service offer with users*” (NHS England 2019). This does not appear to be routinely happening. Our findings suggest that the extent to which children, young people and families have been involved in shaping the design and approach of their local MHSTs is highly variable, and that some areas have made more progress in creating opportunities for influence than others.
- Teams had been in operation for a matter of weeks when the Covid-19 pandemic started. Mirroring a broader trend in children and young people's mental health services, there was a considerable fall in referrals to MHSTs in the early months of the pandemic. Referrals rates started to pick up again in summer 2020.

- Many MHSTs responded to the pandemic, and the many challenges this presented, by quickly adapting the support they were offering and their ways of working. This included switching to delivering direct support remotely, and many Trailblazers anticipated that they will continue with remote delivery for some elements of their work, although in a blended model with face-to-face approaches.
- Engagement of schools and colleges was felt to be critical to the success of the programme, but also challenging to achieve (especially post March 2020, once educational settings were dealing with the impacts of Covid-19 and successive periods of lockdown). It was also suggested that some educational settings needed more help to prepare for the programme and make the most of the support on offer from their MHST. In light of this, there was some disappointment about the delayed roll-out of the senior mental health leads training.
- Views on the MHST service were mixed. Schools and colleges universally welcomed the funding of additional capacity for in-house mental health support. At the same time, there were concerns that MHSTs were not able to meet some of the most urgent unmet needs, and that the training for education mental health practitioners (EMHPs) placed limits on the extent to which services could be appropriately tailored to individual settings, and children and young people.
- One of the most widely reported challenges concerned staffing, and in particular retaining EMHPs once appointed. Difficulties recruiting senior staff were also reported and, in some Trailblazer sites, senior team members had been recruited from local NHS mental health services (which potentially created a staffing problem for those services).
- Evidence of programme impact is emerging. Several local stakeholders reported that the programme was strengthening local partnership working. Some schools and colleges reported positive early effects including staff feeling more confident talking to children and young people about mental health issues; being able to access advice about mental health issues more easily; and quicker access to direct support for children and young people with some mental health problems.

Discussion

Before we discuss the substantive themes emerging from the first phase of data collection, it is interesting to note the apparent divergence in views and opinions between the quantitative and qualitative findings. Responses to the fixed choice (i.e. quantitative) survey questions – which largely probed people's intentions and expectations for the programme – were overwhelmingly positive. The experiences shared through the interviews and free text survey questions focused on the

day-to-day reality of delivering mental health support team (MHST) services. These were more critical and point to difficult challenges for the programme. Some of these challenges were being tackled at a local level, but others will require action from the programme's national partners. In the following section we discuss our plans for the next phase of fieldwork. This next phase provides an opportunity to explore more fully these divergent findings and, in particular, to develop our understanding of the day-to-day working of MHSTs.

Returning to the overall design and objectives of the Trailblazer programme, as described in Chapter 1, there is an explicit intention that Trailblazer sites will test out "*different models of delivering the teams*" (Department of Health and Department for Education 2017). Our findings show that there is variation between Trailblazers – which we discuss further below – but it is not clear what is meant by "different models" and the extent to which such differences are fully reflected in the Trailblazer sites. Is the intention, for example, to test out models led by different sectors or agencies (e.g. NHS versus local authority versus voluntary sector); MHSTs with different team compositions and skill mix; or how the MHST service works in different educational settings (e.g. primary versus secondary versus special schools)? Moreover, there is a question about the extent to which this intention to test out different models has driven the selection of sites (in the Trailblazer and later waves of the programme). In short, have sites been selected to enable direct comparisons to be made and, if they have, what precisely is being compared?

Notwithstanding these questions about programme design, we have observed variation between Trailblazers, and this is helpful from an evaluation point of view. It provides an opportunity to explore different ways of setting up and operating MHSTs, and examine the influence of contextual and other localised factors on this. On the basis of the information we have so far, it is difficult to categorise and compare Trailblazers according to these differences, although we have tried where possible to draw out some of the ways in which approaches appear to vary. We have also observed where there seems to be less variation; for example, in the majority of Trailblazer sites, the MHST service is being delivered by the local NHS children and young people's mental health service provider (in a small number of cases, in collaboration with other – e.g. voluntary sector – organisations). In the next stage of our fieldwork, 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.

Aside from the issue of whether such a typology can be constructed, it is important to bear in mind that the Trailblazers were not chosen to be statistically representative of the country as a whole (either demographically, or in terms of their mental health or education systems). Therefore, while the Trailblazers will undoubtedly yield valuable

insights for areas involved in later waves of the programme, the generalisability of their experiences will need to be carefully considered. It is not uncommon in programmes of this complexity and scale for the first wave of 'implementers' to be chosen for particular characteristics that are thought likely to drive rapid progress and learning, and this is also true of the Trailblazer programme.²⁷ There was also a strong view from those who participated in our initial research that, for the programme to have maximum impact, it must enhance mental health provision for children and young people where this is needed most. Addressing longstanding inequalities in access to mental health support is becoming even more important, given what is becoming clear about the impact of Covid-19 on children and young people's mental health. The pandemic has disproportionately affected children and families from disadvantaged and vulnerable groups, who were already at higher risk of developing mental health problems and less likely to access appropriate support (Allwood and Bell 2020; Crenna-Jennings and Hutchinson 2020). As wider roll-out of the programme progresses, a strong focus on addressing such inequalities is imperative. It is positive that, following the Trailblazer wave, the national team amended the criteria for selecting successful sites, and these now include the requirement that applicants submit expressions of interest that "[prioritise] addressing need and health inequality". The case study research provides an opportunity for us to explore how this requirement has been interpreted and applied in practice.

Much of what we heard about in the early fieldwork concerned the work that Trailblazers had done to build a local partnership to design and implement MHSTs. This is to be expected. While the programme is funding the creation of a new service, for the local areas putting this into practice it is the infrastructure that they build to enable and underpin this which is all-important. As numerous previous initiatives have shown, relationship building is the glue that holds service innovation and integration efforts together (e.g. Erens et al 2015; Social Care Institute for Excellence 2017). Our research suggests that Trailblazers have made good progress in establishing partnerships and an infrastructure to set up and deliver MHSTs. That said, it also seems to be the case that – at least in some sites – NHS partners are dominant in leadership and governance arrangements. This might be another example of the tendency which has been observed for NHS organisations to play the dominant role in local partnership working arrangements (e.g. Alderwick et al 2016; National Audit Office 2018). Equally, it might reflect the way in which the programme has been set up: with funding flowing from NHS England and Improvement and held locally by Clinical Commissioning Groups (CCGs), which play a strategic governance

27 For example, in the Integrated Care Pioneers programme, part of the selection criteria for Pioneer status was "a 'proven track record' in successfully delivering 'public sector transformation at scale and pace'" (Erens et al 2015). Similarly, a key factor in the selection of Vanguard sites in the NHS New Care Models Programme was a "history of successful transformation" (Checkland et al 2019).

and oversight role. The experiences shared so far suggest that this has made it more difficult to achieve a balance between health and 'other' stakeholders (including education) in local planning and decision-making processes.

Our findings also raise questions about the extent to which children and young people, parents and carers have been able to influence the design and set up of MHSTs in their area. The expectation on Trailblazers is that local approaches are 'co-produced' with these groups, but is this achievable within the constraints of a nationally directed programme of this kind? This clearly depends on what is meant by co-production. One widely used definition describes co-production as *"delivering public services in an equal and reciprocal relationship between professionals, people using services, their families and their neighbours"* (Boyle and Harris 2009). The goal to *involve* children, young people and families, and ensure that their views are meaningfully considered in key decisions may be more realistic. Evidence has long shown that involvement is most likely to be successful where it is carefully planned and appropriately resourced (Bombard et al 2018). Given the demands of set up and implementation, this may be one area where Trailblazers would benefit from bringing in specialist expertise (as they had done in one region, which was felt to have worked well). There is also a role for the national partners, who could usefully assess whether the overall approach in the Trailblazer programme is one that facilitates or impedes involvement, and what changes could be made to create a more enabling environment. They might also consider how they can demonstrate leadership by example, by creating opportunities for children and young people to influence the design and delivery of the programme at the national level.

There is a clear and strong rationale for the Trailblazer programme's investment in mental health prevention and support within educational settings. Children spend more time in schools and colleges than any other setting outside their home and – as noted by the Children's Commissioner in her most recent report on mental health – *"Consistently, children have been particularly positive when they can access the treatment in and around their school"* (Children's Commissioner 2021). The data we have drawn on in this report shows that a great many educational settings already offer various activities and forms of support for mental health and wellbeing, much of it funded through their own budgets. But there was also a strong message about increasing the availability of in-house support, particularly – but not only – because of the significant impact of Covid-19 on mental health, among children and young people, their parents and carers, and school and college staff. It is unsurprising, then, that the additional capacity offered through MHSTs was widely welcomed.

The design of the national Trailblazer programme has been strongly influenced by the approach and learning from the Children and Young People's Improving Access to Psychological Therapies (IAPT) programme. Both programmes are funding the

creation of a new workforce – education mental health practitioners (EMHPs) in the Trailblazer programme, children's wellbeing practitioners (CWP) in IAPT – trained to deliver brief and low-intensity psychological interventions, with an orientation towards cognitive behavioural therapy-informed approaches. This is driving a significant, and much needed, expansion in the children's mental health workforce. However, a common theme in our findings was that the 'standard' interventions EMHPs are trained in are less suitable and effective for some groups. These include, for example, children with special educational needs, children who are self-harming, and children whose mental health problems are linked to their family or social circumstances (for example, financial hardship, domestic or other forms of abuse, or living in care). It is not the purpose of this evaluation to interrogate the evidence-base underpinning the design of the programme, or the EMHP training programme specifically. That said, it is relevant to note that the evidence-base for the interventions EMHPs are trained to deliver is still emerging, and there is much still to be learned about their effectiveness and which children they are best suited to help (Ludlow et al 2020). In the next phase of fieldwork, we are keen to explore with MHST staff the extent to which they feel equipped and able to tailor support to different needs, and what the limits of this tailoring might be.

A related issue that emerged strongly in our initial fieldwork concerned the gap in mental health support for children and young people whose needs go beyond the 'mild to moderate' level which EMHPs have been trained for, but are not severe enough to meet the eligibility criteria for specialist help. Many educational settings – and some wider stakeholders – articulated concern and frustration about the ongoing difficulties children in this situation faced trying to access support, and the pressures this could place on key staff (including mental health and pastoral leads) to help those children manage their distress and stay in school. This may be where the third of the MHSTs' key functions comes into play: giving timely advice to educational setting staff, and liaising with external specialist services, to help children and young people to get the right support and stay in education. But for teams to fulfil this bridging role, there have to be services available to which they can signpost or refer children, and our findings suggest that this is not necessarily the case. On this issue, Mind (2020), commented that *"In some areas, community support services are not available so if a young person is not accepted into specialist services there may be nowhere else for them to go, leading to many young people falling through the gaps in the system."*

While we expect that MHSTs will want to operate with clear eligibility and referral criteria, it is 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. They may also be asked to provide interim support for children and young people with serious mental health problems who are waiting to be seen by specialist

services. The average waiting time for specialist mental health treatment is currently around two months, but this varies substantially between areas. Similar issues have been reported for other 'low-intensity' roles in the mental health workforce. For example, a study of primary care mental health workers reported that:

"A more central issue relates to the difficulty of applying academic and skills training to the messy world of real-life clinical practice. PCMHWs [primary care mental health workers] highlighted issues of risk management, and the difficulties in dealing with complex cases that stretched beyond the intended remit of their role." (Rizq et al 2009)

The British Psychological Society has proposed that further training is needed for EMHPs, to work with children and young people who have more complex needs:

"It is important there is a clear pathway for children and young people who present with more complex or severe mental health and wellbeing needs. EMHPs should refer young people with more severe needs to specialist provision, but they also need to be appropriately trained to identify and manage more complex needs within the school environment on a day-to-day basis." (British Psychological Society, 2019)

One MHST told us that support for this group of children and young people is already being provided by senior and experienced therapists within the team.

These findings point to a tension for MHSTs, between managing their capacity and responding to needs for support. Another area where this tension might play out is around parental mental health, something which several educational settings identified as a critical issue. Many respondents observed that mental health problems among parents had increased since the start of Covid-19. This is borne out by the most recent findings from England's Mental Health of Children and Young People survey:

"Children with a parent in psychological distress were more likely to have a probable mental health problem. This is particularly concerning because parents, compared with working age adults without young children, have experienced larger than average increases in mental distress during the pandemic, which suggests that support for parents at this time matters for child mental health." (Newlove-Delgado et al 2021)

Educational settings wanted to do more to help parents access support for their own mental health problems, and welcomed the support and/or resources that some MHSTs had developed for parents during the pandemic. Whether and how MHSTs could continue to play a role in helping parents with mental health problems remains to be seen and, again, comes back to what is possible within limited capacity.

A further workforce-related issue is that of staff retention. A great deal has been achieved in a relatively short space of time to design a national training programme, and recruit, train and place the first cohort of EMHPs (with subsequent cohorts also progressing through their training, although with some delays due to Covid-19). The challenge for the programme is to retain these staff once trained, with reduced team capacity due to vacant posts being one of the biggest challenges reported by Trailblazers. Programme monitoring data from summer 2020 reports vacancy rates of 9%, which is lower than for equivalent roles in the IAPT programme (10%) but higher than the current NHS vacancy rate (7%). Staff turnover problems have been reported for similar para-professional roles, including those developed for the adult and children and young people's IAPT programmes (NHS England 2016). Studies point to some possible reasons: that 'low intensity' therapist roles are seen as a stepping stone into other careers (Rizq et al 2009), and are associated with relatively high levels of emotional exhaustion, stress and burnout (Westwood et al 2017). At least one Trailblazer site has already developed a local career pathway for EMHPs to reduce staff turnover. In light of concerns raised by regional interviewees 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 in the first phase of fieldwork 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 whole school approaches to promoting mental health and wellbeing. This is a topic that clearly illustrates the point we make above about differences between the quantitative and qualitative data. Our survey findings suggested that educational settings were strongly committed to and making good progress in implementing the key elements of a whole school approach. But we learned from interviewees that there was considerable variation between educational settings, with some only just starting to develop their approach. This has important implications for MHSTs, who will need to tailor the advice and support they provide so it fits with and complements what is already being delivered in each setting. It might also help to explain the disappointment some shared about the delayed roll-out of the training for senior mental health leads. This was seen to be a foundational element of the programme, equipping mental health leads with skills and knowledge to develop and embed a whole school approach. While we would caution against too much expectation being invested in a single training programme, there is still a question about how educational settings – particularly those where cultures and practices that support mental health and wellbeing are not widely established – can be prepared to take full advantage of the opportunities that the programme offers.

Finally, we should note that assessing how well Trailblazer sites have progressed in setting up and delivering MHST services is complicated. A matter of weeks after

MHSTs were becoming fully operational, the Covid-19 pandemic started, and since then teams have been operating in challenging and exceptional circumstances. What we do know is that many teams responded to the pandemic, and the many challenges this presented, by quickly adapting their ways of working. A major change, and one which is likely to endure in some form beyond the pandemic, was the switch to delivering some types of support remotely, most often via online or digital platforms. This switch was rapid and challenging, but many welcomed the opportunity created by Covid-19 to overcome barriers and try out online and digital approaches. It is not clear whether MHST staff received any training to develop their digital competencies, or what type of knowledge and skills might be most needed. This is reflective of wider experiences during the pandemic, with both teaching and NHS staff rapidly adapting to remote working for which many have had little or no formal training (e.g. Ofsted 2021; Topol 2019)

More is becoming known about digitally delivered support in children's mental health (e.g. Liverpool et al 2020). But there is also much still to be learned, above all which children and young people these interventions are most suitable for and the conditions under which they work best. The limitations of digital support are widely acknowledged, linked to a range of factors including inequalities in technology and internet access (Mind 2020a). There is also the question of whether children and young people want to be supported in this way. Research undertaken before the pandemic found that children would prefer a combination of face-to-face and digital support (Place2Be 2019). This suggests that the blended model which Trailblazers anticipate adopting post-Covid is the right one. The possibility that digital approaches will be encouraged (or even pushed) for financial reasons was identified by a small number of respondents, and this mirrors concerns raised more widely:

“But there is a risk that, as charities and funders come around to the need to engage with and invest in digital services, opinion swings too far and other services start to be seen as too expensive, low in reach or unnecessarily intensive. The sector needs to continue advocating for approaches such as blended care and some of the more expensive kinds of support (such as one-to-one counselling), to ensure that quality and depth is not lost in a quest for reach.” (Wilkins and Anderson 2021)

Given this potential risk, it is critical that children and young people are directly involved in decisions about the ways that MHSTs will provide support in the future.

Next steps for the evaluation

As has been summarised above, we have already learned a great deal about the Trailblazer programme. We also acknowledge that our findings present a snapshot of the programme: data were collected over a relatively short period of time, and for almost all of that 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 were pleased to have had responses from all 25 Trailblazers. 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. We also recognise that there are some important groups that we have yet to hear from, including children and young people, and frontline MHST staff. In our next phase of fieldwork, we will be speaking to a wider range of stakeholders in six Trailblazer sites and undertaking focus groups with children and young people, to ensure that our assessment of the programme is a rounded and inclusive one. Alongside this, we will undertake a second round of surveys with educational settings and key informants.

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:

- What the day-to-day work of MHSTs looks like. For example, how they are spending their time, including the balance of time across their three core functions; the degree and nature of collaborative working within and across MHSTs, and with other professionals and services that support children and young people who have mental health problems; how they are working with staff in educational settings, and what are their experiences of working across different types of setting.
- How MHSTs are addressing equality and diversity considerations, and the extent to which services have been designed to specifically address under-served groups and unmet needs. This will include exploring what forms of direct support MHSTs are offering, whether they feel equipped and able to tailor this support to different needs, and what the limits of such tailoring might be. Relatedly we are keen to understand if and how Trailblazers have defined 'mild to moderate' mental health needs.
- Have, and how have, Trailblazers listened to children and young people, and parents and carers, in the development and running of their MHST service? Who have they heard from, what approaches to involvement (or co-production) have been used and what has been the learning from these?

- How local governance arrangements and relationships are evolving as the programme progresses. For example, to what extent is the ongoing development and implementation of MHSTs guided jointly by education and health, and which other stakeholder groups are involved? Relatedly, do Trailblazer sites have mechanisms in place for service review and improvement, and how well are these working?
- The experiences of EMHPs, which seems important to understand given their centrality to MHSTs and as a new role in the mental health workforce. For example, how have EMHPs found the transition from training into practice, and how well do they feel their training has equipped them for the role? How much supervision and support are they receiving and how effective is this; what additional training or development might they benefit from? What has been their experience of working therapeutically with children and young people?
- Have, and how have, Trailblazers used the flexibility they have been given around team composition, and has this resulted in distinctive MHST approaches and ways of working in different areas?
- What educational settings understand by a 'whole school approach', how they are developing their approach, and what contribution the programme, and MHSTs specifically, are making to this. Also, what do children and young people think about whether their school or college promotes mental health and wellbeing, and how this might be improved?
- How many of the changes to service delivery models made in response to Covid-19 will be retained as we come out of the pandemic? In particular, how are Trailblazers making decisions about the balance between face-to-face and remote approaches when planning their post-Covid service models, and what groups, evidence and factors are informing these decisions? Are MHST staff being trained in digital practice and, if they are not, what training would they like to receive?
- MHSTs' experiences of data collection and reporting, and how much of their time is spent on this. More specifically, does outcomes measurement support the therapeutic process and are the data which teams are collecting being used to monitor and improve their service?

The research to explore these themes and issues is already underway, and our findings will be shared in a second report to be published in summer 2022. Alongside this, plans are being developed for a longer-term evaluation of the Trailblazer programme's outcomes and impact, building on this early study and assessing whether the programme has succeeded in its goal to improve children and young people's access to support, and their mental health and wellbeing.

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Appendices

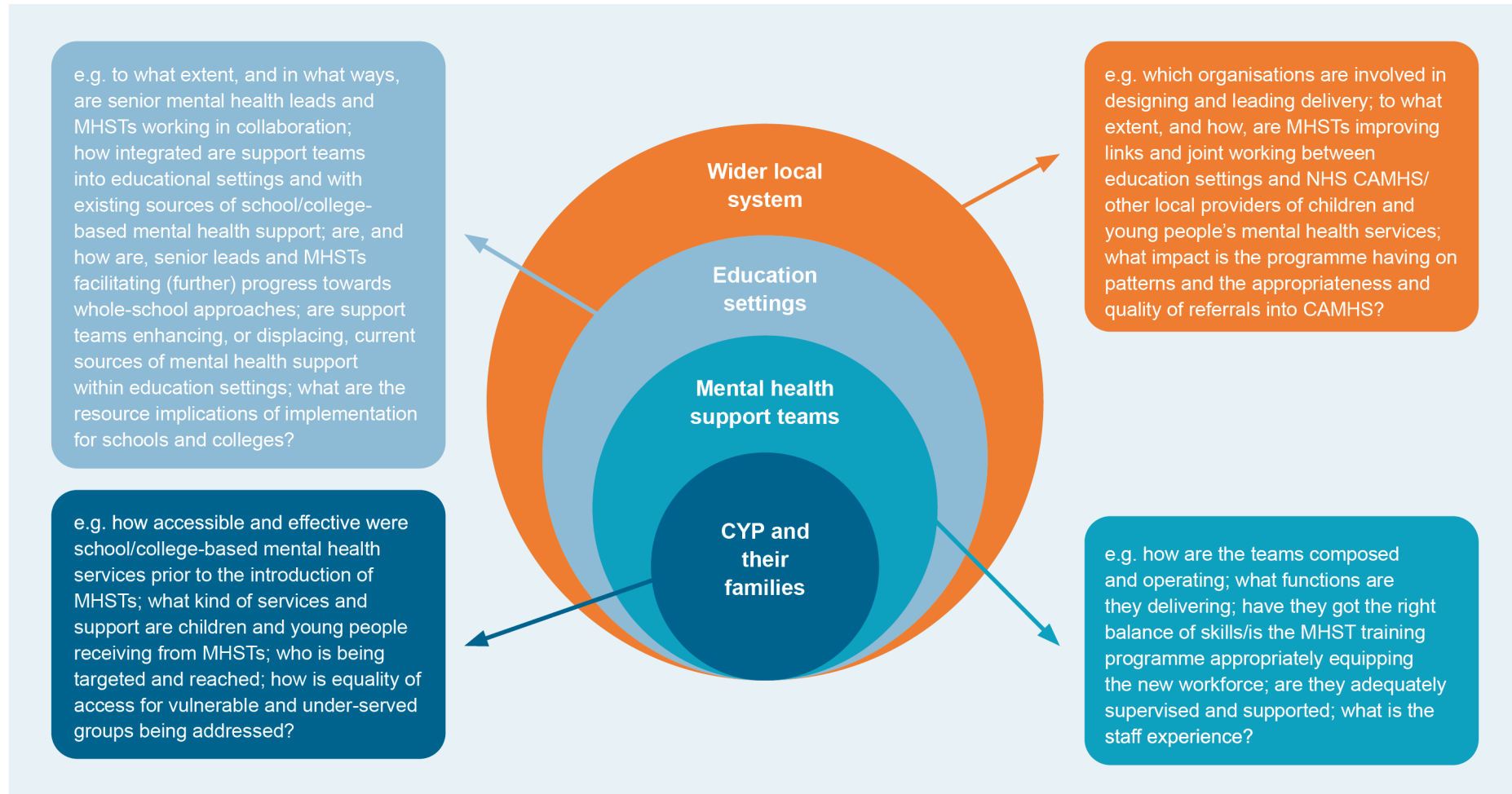
Appendix 1. Children and Young People's Mental Health Trailblazer programme timeline

Date	Milestone
December 2018	59 MHSTs across 25 Trailblazer sites announced (including 12 sites also running four-week waiting time pilots). ²⁸
January 2019	220 Education Mental Health Practitioner (EMHP) trainees commenced training programmes across seven Higher Education Institutions. EMHP supervisors receive specific training to equip them in their role.
January 2019	Publication of the NHS Long Term Plan. It commits to continued investment in children and young people's mental health (CYPMH) including the funds to roll-out MHSTs up to 2023/24. The MHSTs will contribute to the ambition of at least an additional 345,000 children and young people aged 0-25 being able to access support via NHS-funded mental health services.
February 2019	Just over 1,000 schools and colleges confirmed as participating in 18/19 trailblazer sites.
July 2019	123 more MHSTs announced in 57 areas across the country; 48 of which are new areas announced for 2019/20, the remaining nine of which are Trailblazer areas expanding their MHSTs (Waves 1 and 2).
September/October 2019	Training begins for Wave 1 MHST EMHPs.
December 2019 – April 2020	MHSTs within the first Trailblazer cohort (those announced in December 2018) start to become operational.
January 2020	Training begins for Wave 2 MHST EMHPs, now across 13 Higher Education Institutions.

Date	Milestone
Spring 2020	Covid-19 pandemic. Where in place, the majority of Mental Health Support Teams adapted – and in some cases expanded – services so they could continue to support schools and colleges, and children and young people during the pandemic. In many cases they are also working closely with other local services and professionals, including the voluntary sector, educational psychologists, school nurses and Early Help providers.
May 2020	<p>NHS England and Improvement published the areas selected to develop a further 104 MHSTs during 2020/21 (Waves 3 and 4). This will bring the total number of MHSTs to over 280. Recruitment and training of these teams began in November 2020.</p> <p>Over 180 Mental Health Support Teams are either operational or in development in schools and colleges, with further cohorts on the way.</p>
August - December 2020	<p>Wave 1 MHSTs to become operational.</p> <p>Most Wave 1 EMHPs had delays to training due to impact of Covid 19 pandemic. However, the majority of Wave 1 EMHPs will qualify by December 2020.</p>
August 2020	Wellbeing for Education Return announced – a new £8m package of training and resources intended to support education staff to respond to the impact of COVID-19 and lockdown.
September 2020	Review of training needs for senior mental leads in schools and colleges commissioned (completed early 2021).
November 2020	Wave 3 EMHP trainees expected to begin their training at university, delayed 2 months due to Covid19 pandemic.
January - March 2021	Wave 2 MHSTs expected to become operational.
January – Feb 2021	Wave 4 MHP trainees expected to begin their training at university, the start dates will vary due to Covid 19 pandemic.
March 2021	The Government announces an additional £79 million for mental health support for children and young people.
March 2021	Work is underway with key stakeholders, including training providers, to establish whether it is possible to offer training to senior leads in the next academic year (2021-22).
June 2021	Department for Education announces that – from September 2021 – schools and colleges can apply for a grant for a member of staff to attend training to develop a whole school approach to mental health and wellbeing.

Date	Expected Milestone
Spring 2021	End date for Wellbeing for Education Return consultation support.
September 2021	2021/22 sites expected to be announced (Waves 5 and 6). Wave 5 EMHPs expected to begin their training at university (TBC, depending on impact of Covid-19).
January 2022	Wave 6 EMHPs expected to begin their training at university.
September 2022	2022/23 sites expected to be announced (Waves 7 and 8). Wave 7 EMHPs expected to begin their training at university.
January 2023	Wave 8 EMHPs expected to begin their training at university.
September 2023	2023/24 sites expected to be announced (Waves 9 and 10). Wave 9 EMHPs expected to begin their training at university.
January 2024	Wave 10 EMHPs expected to begin their training at university.

Appendix 2. Evaluation levels of investigation



Reproduced from the study protocol. The full protocol is available at <https://fundingawards.nihr.ac.uk/award/NIHR130818>

Appendix 3. Research tools

a. Key informant survey

Thank you for your help with this important survey. This survey is part of the early, national and independent evaluation of the trailblazer programme being conducted by a team of researchers from the BRACE Rapid Evaluation Centre (a collaboration between the University of Birmingham, RAND Europe and the University of Cambridge) in partnership with the Policy Innovation & Evaluation Research Unit (PIRU), based at the London School of Hygiene & Tropical Medicine (LSHTM).

You have been invited to participate as a project lead for one of the 2018/2019 Trailblazer sites. The questions will cover the local mental health context for children and young people, the Mental Health Support Teams for your Trailblazer site, your expectations for the programme, support and readiness for the programme, governance and stakeholder involvement, the delivery model, resource availability and the anticipated programme outcomes.

The survey should take about 30 minutes to complete. If you cannot complete it in one sitting, your answers will be saved so you can return to it at another time.

Completing the survey is entirely voluntary. Your responses will be kept completely confidential and used anonymously in reporting. Data will be stored securely and managed in accordance with the UK Data Protection Act (2018) and General Data Protection Regulation (GDPR) 2018.

You may withdraw at any stage prior to submitting your responses. You can also withdraw up to five days after you have participated in the survey, and there are no consequences for withdrawing. If you do decide to withdraw, your data will be destroyed. Please contact a member of the team using the contact details below if you do want to withdraw.

If you have any questions or comments about the survey, please contact lhocking@randeurope.org (survey lead)

1. To continue with the survey, please click 'I agree to take part in the survey' below.

- I agree to take part in the survey

Background information

2. Which Trailblazer area are you currently working in?

- Berkshire West
- Bromley

- Buckinghamshire
- Camden
- Doncaster and Rotherham
- Gloucestershire
- Haringey
- Hertfordshire
- Hounslow
- Liverpool
- Greater Manchester
- North Staffordshire
- Stoke on Trent
- Newcastle
- North Kent
- Kirklees
- Northumberland
- Nottinghamshire
- Oxfordshire
- South Tyneside
- South Warwickshire
- South West London HCP
- Swindon
- Tower Hamlets
- West London

3. *Non-project lead respondents only:* Are you a partner/stakeholder from the education sector?

- Yes/no

4. *Non-project lead respondents only:* Are you a mental health support team (MHST) manager

- Yes/no

5. *Non-project lead respondents only:* Which of the below best fits your role in the Trailblazer programme? Select all those that apply

- CCG lead for the Trailblazer programme
- Senior responsible officer for the Trailblazer programme
- Mental health support team (MHST) manager
- Partner/stakeholder from the education sector
- Partner/stakeholder from NHS children and young people's mental health services

- Local authority (commissioner) partner/stakeholder
- Local authority (children's services) partner/stakeholder
- Partner/stakeholder from public health
- Partner/stakeholder from a voluntary sector organisation
- Other (please specify)

6. Please provide the name(s) of the organisation(s) you work for.

- [free text box]

7. *Non-project lead respondents only:* Could you briefly describe your role in relation to the Trailblazer programme?

- [free text box]

Local context

8. Please list up to 3 of the main programmes/initiatives/approaches for supporting mental and emotional health in educational settings in your area (excluding the Trailblazer programme).

- [Three free text boxes]

9. *Project lead respondents only:* What are the main priorities for children and young people's mental and emotional health within your area?

- [Free text box]

10. *Project lead respondents only:* How does the Trailblazer programme fit with existing priorities, approaches and sources of support for children and young people's mental and emotional health in your area?

- [Free text box]

11. Please respond to each of the following statements:

[Scale from strongly agree – strongly disagree]

- Before the Trailblazer programme, the education and health sectors worked well together to deliver mental and emotional health support for children and young people
- There has been prior work in my area to develop whole school approaches to emotional and mental health
- Children and young people's emotional and mental health is seen as 'everybody's business'

- The Trailblazer programme aligns with existing emotional and mental health support programmes for children and young people in my area.
- Children and young people with emotional or mental health needs can access help from local NHS Children and Young People's Mental Health Services within an acceptable length of time.
- The local specialist NHS Children and Young People's Mental Health Services respond well to children and young people in mental health crisis.
- My area has good systems in place for the identification of children and young people with emotional and mental health needs.
- My area's approach to children's mental and emotional health ensures there is an appropriate balance between prevention and intervention
- I know how to get advice from my local NHS Children and Young People's Mental Health Services on emotional and mental health needs.
- *Project lead respondents only:* There is good awareness of the Trailblazer programme among all key organisations and stakeholder groups in my area

12. *Project lead respondents only:* Are you aware of a local evaluation of the Trailblazer programme taking place in your area?

- Yes/no/unsure

13. *Project lead respondents only (if yes to Q12):* Could you provide any details about it, for example the project lead or organisation carrying out the evaluation?

- [Free text box]

14. *Project lead respondents only (if yes to Q12):* Do you think the involvement with a local evaluation will mean stakeholders may be less willing or able to engage with this (national) evaluation?

- Yes/no/unsure

Understanding of the mental health support teams (MHSTs) in your area

15. *Project lead respondents only:* Which organisation(s) holds the contract to deliver mental health support teams in your area?

- [Free text box]

16. *Project lead respondents only:* How were educational settings selected and recruited to be a part of the Trailblazer programme? Please briefly outline here.

- [Free text box]

17. How has the COVID-19 pandemic affected the timescales for implementation of the Trailblazer programme in your area?

- Significantly affected/somewhat affected/not affected/don't know

18. *Project lead respondents only:* To what extent, if at all, has the engagement of educational settings in the programme been affected by the COVID-19 pandemic?

- Significantly affected/somewhat affected/not affected/don't know

19. How has your area adapted the Trailblazer programme and the work of the MHSTs in response to the COVID-19 pandemic?

- [Free text box]

20. Do you think the changes that have been made to the Trailblazer programme as a result of COVID-19 will be permanent?

- Yes/no/unsure

21. *If yes to previous question:* Which of the changes do you think will endure after the pandemic?

- [Free text box]

Expectations for the Trailblazer Programme

22. I expect that the Trailblazer programme will...

[Scale from strongly agree – strongly disagree]

- Improve how we support children and young people with mild to moderate emotional and mental health needs.
- Help to support the emotional and mental health needs of disadvantaged children and young people
- Help to meet the demand for mental health services for children and young people.
- Help to address the inequalities in access to mental health services for children and young people.
- Help to prevent children and young people developing more severe emotional and mental health needs.
- Improve the appropriateness of referrals to specialist NHS Children and Young People's Mental Health Services

- Result in a more joined up approach to emotional and mental health across education and the NHS in my area.
- Strengthen local partnership working for children and young people's emotional and mental health
- Increase understanding of children and young people's emotional and mental health needs.
- Help children and young people to better understand their own emotional and mental health
- Help children and young people to feel more confident about seeking help when they have concerns about their emotional and mental health
- Have a positive impact on my role
- *Project lead respondents only:* Help to prevent children and young people developing emotional and mental health problems

23. *If strongly agree/agree selected in Q22 relating to impact on role:* Please use the box below to describe the impact you expect the programme to have on your role

- [Free text box]

24. What would success look like for you in terms of the Trailblazer programme? List your main 3 points.

- [Three free text boxes]

25. What factors will be most critical to the success of the programme? List your main 3 points.

- [Three free text boxes]

26. *Project lead respondents only:* What local factors may help the implementation and success of the Trailblazer programme?

- [Free text box]

27. *Project lead respondents only:* Are there any local factors that could hinder the implementation and success of the Trailblazer programme?

- [Free text box]

Support and readiness for the MHSTs

28. Please say whether you agree or disagree with each of the following statements in relation to the support for and awareness of the trailblazer programme in your

local area

[Scale from strongly agree – strongly disagree]

- There is support for the programme locally from key organisations
- The roles and responsibilities of those involved in implementing the Trailblazer programme within my area are clear
- I am confident that I can effectively fulfil my role within the Trailblazer programme
- I have sufficient protected time to perform my role within the Trailblazer programme
- I know where to go for information and advice to help me effectively fulfil my role within the Trailblazer programme

29. *Project lead respondents only:* Please say whether you agree or disagree with each of the following statements in relation to yours and other individual team members readiness to be involved in the Trailblazer

[Scale from strongly agree – strongly disagree]

- The training received by Educational Mental Health Practitioners (EMHPs) was sufficient for them to undertake their role effectively
- EMHPs are receiving sufficient supervision to support them to undertake their role effectively
- Other MHST team members have sufficient skills to fulfil their role effectively

30. *MHST managers only:* Please say whether you agree or disagree with each of the following statements in relation to yours and other individual team members readiness to be involved in the Trailblazer programme

[Scale from strongly agree – strongly disagree]

- I have received sufficient training to perform my role
- Educational Mental Health Practitioners (EMHPs) in my team(s) feel the training they received was sufficient for them to undertake their role effectively
- EMHPs are receiving an appropriate level of clinical supervision to support them to undertake their role effectively
- The MHST(s) I manage have the right balance of skills and experience to undertake its work effectively
- The MHST(s) I manage have sufficient capacity to deliver their core roles and responsibilities effectively
- MHSTs are well integrated into existing care pathways for children and young people with mental health problems

- I am confident that the MHST(s) I manage will integrate and work with other local services to support children's emotional and mental health effectively
- MHSTs are working effectively with educational settings to assess their existing provision and gaps in mental and emotional support for children and young people

31. *Education stakeholders only:* Please say whether you agree or disagree with each of the following statements

[Scale from strongly agree – strongly disagree]

- There has been effective communication with educational settings locally about the Trailblazer programme
- Educational settings are supportive of the Trailblazer programme
- Educational settings understand what will be delivered by the MHSTs/ EMHPs in their setting
- Educational settings have been sufficiently involved in the design of the Trailblazer programme locally
- Educational settings have been sufficiently involved in decisions about how MHSTs will work in their setting
- The allocation of MHST time and resources to educational settings are transparent
- The allocation of MHST time and resources to educational settings have been agreed by the local governance board
- MHSTs/EMHPs will complement and enhance existing approaches and sources of support for children's emotional and mental health within education settings

32. When delivering the Trailblazer programme, what so far has gone well? List the 3 main positives

- [Three free text boxes]

33. When delivering the Trailblazer programme, what so far has gone less well? List the 3 main challenges

- [Three free text boxes]

Governance and stakeholder involvement

34. Project lead respondents only: Please rate the level of local involvement of NHS CAMHS in the following stages of the Trailblazer Programme

[Strongly involved/somewhat involved/slightly involved/not involved/don't know]

- The application process
- Design of the local model/approach
- Preparation/set-up for implementation
- Governance of the Trailblazer Programme
- Implementation of the Trailblazer programme (including training)

35. *Project lead respondents only:* Please rate the level of local involvement of local Clinical Commissioning Groups (CCGs) in the following stages of the Trailblazer Programme

[Strongly involved/somewhat involved/slightly involved/not involved/don't know]

- The application process
- Design of the local model/approach
- Preparation/set-up for implementation
- Governance of the Trailblazer Programme
- Implementation of the Trailblazer programme (including training)

36. *Project lead respondents only:* Please rate the level of local involvement of the local authority children's services in the following stages of the Trailblazer Programme

[Strongly involved/somewhat involved/slightly involved/not involved/don't know]

- The application process
- Design of the local model/approach
- Preparation/set-up for implementation
- Governance of the Trailblazer Programme
- Implementation of the Trailblazer programme (including training)

37. *Project lead respondents only:* Please rate the level of local involvement of public health services in the following stages of the Trailblazer Programme

[Strongly involved/somewhat involved/slightly involved/not involved/don't know]

- The application process
- Design of the local model/approach
- Preparation/set-up for implementation
- Governance of the Trailblazer Programme
- Implementation of the Trailblazer programme (including training)

38. *Project lead respondents only:* Please rate the level of local involvement of educational settings in the following stages of the Trailblazer Programme

[Strongly involved/somewhat involved/slightly involved/not involved/don't know]

- The application process
- Design of the local model/approach

- Preparation/set-up for implementation
- Governance of the Trailblazer Programme
- Implementation of the Trailblazer programme (including training)

39. *Project lead respondents only:* Please rate the level of local involvement of the voluntary sector in the following stages of the Trailblazer Programme
[Strongly involved/somewhat involved/slightly involved/not involved/don't know]

- The application process
- Design of the local model/approach
- Preparation/set-up for implementation
- Governance of the Trailblazer Programme
- Implementation of the Trailblazer programme (including training)

40. *Project lead respondents only:* Please rate the level of local involvement of children and young people in the following stages of the Trailblazer Programme
[Strongly involved/somewhat involved/slightly involved/not involved/don't know]

- The application process
- Design of the local model/approach
- Preparation/set-up for implementation
- Governance of the Trailblazer Programme
- Implementation of the Trailblazer programme (including training)

41. *Project lead respondents only:* Please rate the level of local involvement of parents and carers in the following stages of the Trailblazer Programme
[Strongly involved/somewhat involved/slightly involved/not involved/don't know]

- The application process
- Design of the local model/approach
- Preparation/set-up for implementation
- Governance of the Trailblazer Programme
- Implementation of the Trailblazer programme (including training)

42. *Project lead respondents only:* Are there any stakeholders who you think should be involved in local governance arrangements but currently aren't?

- Yes/no/unsure

43. *If yes to previous question:* Please comment on who is missing and what role they could play

- Free text box

44. *Project lead respondents only:* If children, young people, parents and/or carers have been involved in the design and delivery of the Trailblazer programme in your area, please describe how

- Free text box

45. *Project lead respondents only:* Has the local approach to the Trailblazer programme been designed to take into account all groups of children and young people, including those who are disadvantaged and under-served by existing mental health services?

- Yes/no/unsure

46. *Project lead respondents only:* Please explain how the programme has been designed to take children and young people who are disadvantaged and under-served by existing mental health services into account.

- Free text box

47. Please say whether you agree or disagree with the following statements in relation to the governance of the Trailblazer programme in your area
[Scale strongly agree – strongly disagree]

- There is clear and effective leadership for the Trailblazer programme locally
- My area has a clear strategy to deliver the Trailblazer programme
- There is there a shared understanding of what a 'whole school approach' means across key stakeholders
- There is sufficient support for the programme from NHS England
- There is sufficient support for the programme from the Department for Education
- Project lead respondents only: Health and education partners are working together effectively
- Local partners are working together effectively to implement the programme

48. Please use the box below to provide any further details on the extent and effectiveness of local partnership working to implement the Trailblazer programme

- Free text box

The delivery model

49. The delivery model for the Trailblazer programme in your area as designed is...

[Scale strongly agree – strongly disagree]

- Built on a good understanding of local needs and gaps in children and young people's emotional and mental health support
- Sufficiently flexible to be tailored to individual educational settings
- Integrated with existing support for children and young people's emotional and mental health outside of educational settings
- Integrated with existing support for children and young people's emotional and mental health within educational settings
- Using co-production to develop approaches and service offers with children, young people and parents/carers
- Supporting the introduction/development of a whole school approach to emotional and mental health
- Allowing children and young people to access emotional and mental health support throughout the whole year (including outside term time)
- Guided by a clear and shared understanding of what mild-moderate emotional and mental health needs are in my locality

Resources

50. Please say whether you agree or disagree with each of the following statements in relation to the resourcing of the Trailblazer programme

[Scale strongly agree – strongly disagree]

- MHSTs have sufficient financial resources to perform their core roles and responsibilities
- MHSTs have sufficient staffing capacity to meet the mild-moderate needs of the children and young people in my area
- MHSTs have sufficient physical space available to deliver the Trailblazer programme
- Educational settings have sufficient resources, including staff, to take full advantage of the opportunities that the new MHSTs or EMHPs offer
- There is no risk that my area will reduce its existing services and support to children and young people with emotional and mental health needs now the MHSTs or EMHPs are in place

51. *Project lead respondents only:* Briefly describe any recruitment or training issues the MHSTs in your area are facing at the moment.

- [Free text box]

52. *Project lead respondents only:* Have any organisations in your local area provided additional financial resources for the programme on top of what is provided through the Trailblazer programme?

- Yes/no/unsure

53. *Project lead respondents only (if yes to previous question):* Please state how much additional funding was provided and from which organisation(s).

- [Free text box]

54. *Project lead respondents only:* Has the Trailblazer programme in your area received any in-kind contributions?

- Yes/no/unsure

55. *Project lead respondents only (if yes to Q54):* Could you estimate how much in-kind contributions were received?

- [Free text box]

56. *Project lead respondents only (if yes to Q54):* Which organisation(s) provided this in-kind contribution?

- [Free text box]

57. *Project lead respondents only (if yes to Q54):* What has this contribution be used for? Please select all those that apply

- Staffing
- Office space
- Equipment
- Other (please specify)

Outcomes of the Trailblazer programme

58. *Project lead respondents only:* Please say whether you agree or disagree with each of the following statements in relation to the intended outcomes of the Trailblazer programme

[Scale strongly agree – strongly disagree]

- The Trailblazer programme outcomes have been clearly defined by the national programme team
- The Trailblazer programme outcomes have been clearly communicated by the national programme team
- The planned programme outcomes are the most appropriate to aim for
- The programme has the correct elements in place to deliver the planned outcomes

Conclusion

59. Is there anything else about the implementation of the trailblazer programme in your specific setting or locally that you would like to tell us?

- [Free text box]

60. *Project lead respondents only:* We may contact you again to ask whether you would be willing to participate in a follow-up phone interview for the evaluation. Would this be OK with you?

- Yes/no/unsure

b. Educational setting survey

What is the survey for?

The Department for Education and Department of Health and Social Care have selected areas across England to implement and test out new models of early intervention for children with mental health problems and promote good mental health and wellbeing in education settings. These approaches include having a senior mental health lead (SMHL) in each educational setting and deploying education mental health practitioners (EMHP), operating within mental health support teams (MHST) to work with schools and colleges, and to form a link between NHS Children and Young People's mental health (CYPMH) services and educational settings. The MHST coordinator will act as the main staff member for liaising with MHSTs (You may have different names for these teams and roles in your area, for example, MHSTs may be known as Emotional Wellbeing Teams). This national programme started in 2018 and will run until 2023, and the first wave of the programme has involved the creation of 59 mental health support teams in 25 'trailblazer' areas. According to the information we have been given, your educational setting is in a trailblazer area.

The current survey is the first of two surveys that will gather essential information that is not collected routinely. It is designed to complement the Department for Education's provision survey which was undertaken in trailblazer areas from mid-March to mid-June 2019. It focuses on your expectations for the programme, details about the local context, including other local programmes of work to improve emotional and mental health in your education setting, preparation for implementation, governance and stakeholder involvement, and how the MHST concept is being implemented locally. We are also interested in learning about the impact of restricted opening of educational settings during the Coronavirus (COVID-19) pandemic on the programme and the provision of mental health services. This information will be used to help develop the trailblazer programme.

We will provide all educational settings with a summary of the findings of this survey but, because in reporting, information will be anonymised, we will not provide detailed results at the regional or educational setting level.

Who has been selected for the survey?

We are interested in the views of the senior mental health leads or MHST coordinators at all of the educational settings across the 25 trailblazer areas, or staff members with a different title who may be playing a similar role. We are expecting one reply per educational setting.

Who is conducting and funding the project?

This evaluation is being conducted by a team of independent researchers who are part of the BRACE Rapid Evaluation Centre (a collaboration between the University of Birmingham, RAND Europe and the University of Cambridge) in partnership with the Policy Innovation and Evaluation Research Unit (PIRU), which is based at the London School of Hygiene and Tropical Medicine (LSHTM). The project is funded by the National Institute for Health Research (NIHR). More information on the BRACE Centre can be found [here](#), and on PIRU can be found [here](#).

Is the survey confidential?

Your responses will be kept completely confidential and will be reported anonymously. Data will be stored securely and managed in accordance with the UK Data Protection Act (2018) and General Data Protection Regulation (GDPR) 2018 and in accordance with the University of Birmingham's and LSHTM's policies for data storage and management. All data will be stored on password-protected computers and servers, and will only be accessible to members of the research

team. Data will be stored for a period of 10 years in line with the University of Birmingham's and LSHTM's Research Data Management Policy, after which it will be destroyed. Identifiable data (your name and contact details) may be stored at either the University of Birmingham, RAND Europe or LSHTM. If you would like more information about how your personal data will be processed, used and stored, you can find it by [clicking on this link](#). We will ask at the end of the survey for your contact details as we may want to contact you for a follow-up interview. If you give us your details, they will be deleted as soon as data collection has been completed at the end of the study.

Who has reviewed the study?

This study has been approved by the Research Ethics Committees at the University of Birmingham (ERN_19-1400 - RG_19-190) and London School of Hygiene and Tropical Medicine (Ref: 18040) and by the NHS Health Research Authority (IRAS 270760).

Who do I contact if I want to make a complaint?

If you would like to talk to someone from the University of Birmingham outside of the immediate evaluation team, you can contact: Professor Catherine Needham: C.Needham.1@bham.ac.uk (Director of Research for the School of Social Policy, University of Birmingham).

Completing the survey

The survey should take about 15 minutes to complete. If you cannot complete it in one sitting, your answers will be saved so you can return to it at another time.

Completing the survey is entirely voluntary. You may withdraw at any stage prior to submitting your responses. You can also withdraw up to five days after you have participated in the survey, and there are no consequences for withdrawing. If you do decide to withdraw, your data will be destroyed. Please contact a member of the team using the contact details below if you do want to withdraw.

If you have any questions or comments about the survey, please contact mustafa.al-haboubi@lshtm.ac.uk (educational settings survey lead).

Thank you for your help with this important survey.

1. To continue with the survey, please click 'I agree to take part in the survey' below.

- I agree to take part in the survey

Information on the survey respondent

2. Is the mental health support team in your setting now receiving referrals?

- Yes/no/unsure

3. Are you, within your educational setting (please select **all roles** that apply)

- Senior mental health lead for the children and young people's mental health trailblazer programme?
- Lead for mental health, not specifically in relation to the trailblazer programme?
- Deputy head teacher/ Vice Principal or equivalent?
- MHST coordinator?
- Head teacher/ Principal or equivalent?
- Other member of Senior Leadership Team?
- SENCO or equivalent?
- Other teaching staff?
- Pastoral Lead?
- Support staff (e.g. inclusion, safeguarding)?
- Year Head?
- Other (please specify)?

4. *Respondents who did not select senior mental health lead in previous question:*

You indicated that you are not the senior mental health lead for the children and young people's mental health trailblazer programme. Does your educational setting have a senior mental health lead for the children and young people's mental health trailblazer programme?

- Yes, and the position is filled
- Yes, but the position is currently vacant
- No, we decided not to have a senior mental health lead specifically for the programme
- No, but we plan to appoint a senior mental health lead for the programme in the future
- No, because we have a lead for emotional and mental health, not specifically in relation to the trailblazer programme
- Other (please specify)

5. *Respondents who selected senior mental health lead in Q3:* How did you come into the senior mental health lead role in your educational setting?

- I was already the mental health lead and volunteered to take on the role

- I volunteered to take this as a new role
- I was asked to do it
- Other (please specify)

Mental health programmes and resources in place and views on existing services

6. Did your educational setting have a 'mental health lead' before the trailblazer programme? This could have been either be a stand-alone role or part of a wider role

- Yes/no/don't know

7. *If yes to Q6:* How long has your setting had a mental health lead?

- Less than 1 year
- 1-2 years
- 3-4 years
- 5 years or more
- Don't know

8. Please say whether you agree or disagree with each of the following statements in relation to your educational setting. In my educational setting...

[Scale strongly agree – strongly disagree]

- Children and young people's emotional and mental health is seen as 'everybody's business'.
- Children and young people with emotional and/ or mental health needs can access help from local NHS Children and Young People's Mental Health Services within an acceptable length of time.
- The local specialist NHS Children and Young People's Mental Health Services respond well to children and young people in mental health crisis.
- We have good systems in place for the identification of children and young people with emotional and mental health needs.
- I know how to get advice from my local NHS Children and Young People's Mental Health Services on emotional and mental health needs.

9. Do you agree that your educational setting is pursuing a '**whole school approach**' in relation to Public Health England's eight principles to promote emotional health and wellbeing in schools and colleges?

[Scale strongly agree – strongly disagree]

- Leadership and management: In this setting there is senior leadership support for promoting emotional health and wellbeing

- School ethos and environment: The culture in this setting promotes respect and values diversity
- Curriculum, teaching and learning: There is a focus within the curriculum on social and emotional learning and promoting personal resilience
- Student voice: This setting ensures all students have the opportunity to express their views and influence decisions
- Staff development, health and wellbeing: Staff in this setting are supported in relation to their own health and wellbeing so that they can support student wellbeing
- Identifying need and monitoring impact: This setting assesses the needs of students and the impact of interventions to improve wellbeing
- Working with parents/carers: This setting works in partnership with parents and carers to promote emotional health and wellbeing
- Targeted support: This setting ensures timely and effective identification of students who would benefit from targeted support and ensures appropriate referral to services

10. What does your setting most need in order to further improve how it supports the emotional and mental health of its children and young people?

- [Free text box]

Expectations of the trailblazer programme

11. Please say whether you agree or disagree with each of the following statements in relation to the implementation of the trailblazer programme in your educational setting:

[Scale strongly agree – strongly disagree]

- The programme will help my colleagues better support children and young people's emotional and mental health.
- The programme will increase understanding of children and young people's emotional and mental health needs in this setting.
- The programme will improve how we support children and young people with "mild to moderate" emotional and mental health needs.
- The programme will help to prevent children and young people developing more severe emotional and mental health needs.
- The programme will improve the appropriateness of referrals to specialist NHS Children and Young People's Mental Health Services.
- The programme will result in a more joined up approach to emotional and mental health across education and the NHS.
- The programme will have a positive impact on my role.

12. *If strongly agree/somewhat agree selected for positive impact on role in Q11:*

Please use the box below to describe the impact you expect the programme to have on your role:

- [Free text box]

Governance and involvement in the trailblazer design

13. Please say whether you agree or disagree with each of the following statements in relation to your educational setting (**please think about the period before restricted opening of educational settings as a result of the Coronavirus [COVID-19] pandemic when responding to these statements**):

[Scale strongly agree – strongly disagree]

- The trailblazer programme reports its activities regularly to the Senior Leadership Team
- This educational setting has been involved in the overall design of the programme locally.
- This educational setting is able to shape the day-to-day working of its mental health support team or education mental health practitioners.
- I understand what will be delivered by the mental health support team or education mental health practitioners
- The mental health support team or education mental health practitioners will be responsive to the specific needs of students in my setting

14. Is your educational setting making plans to ensure that its mental health support team or education mental health practitioners will be well integrated with the existing services and professionals supporting the emotional and mental health of pupils/ students?

- Yes/no/don't know

15. Have you told your pupils/ students about the new mental health support team or education mental health practitioners?

- Yes/no/don't know

16. Has your educational setting told parents or carers about the new mental health support team or education mental health practitioners?

- Yes/no/don't know

17. Have you or your Senior Leadership Team told teaching and ancillary staff about the new mental health support team or education mental health practitioners?

- Yes/no/don't know

Readiness to implement the programme

18. Please say whether you agree or disagree with each of the following statements in relation to your educational setting:

[Scale strongly agree – strongly disagree]

- The Senior Leadership Team is supportive of the programme.
- The Governors are supportive of the programme.

19. What proportion of staff in your educational setting know that the setting is part of the trailblazer programme?

- All/Most/About half/Less than half/Very few/None/Don't know

20. *MHST coordinator respondents only:* Has your educational setting...

[Yes/no/unsure]

- Appointed a named mental health support team coordinator to work with both your local NHS Clinical Commissioning Group (CCG) and the incoming mental health support team or education mental health practitioners?
- Completed its own assessment of current provision and gaps in services/support?
- Involved (or plans to involve) children and young people or their families in decisions about what the mental health support team or education mental health practitioners will provide?
- Identified physical space within your educational setting for mental health practitioners to work with children and young people, and their families?
- Signed up to the FutureNHS Collaboration platform?

21. *If respondent selected yes to being signed up to FutureNHS Collaboration platform in Q20:* Did you find the FutureNHS Collaboration platform useful?

- Yes/no/don't know

22. *Senior Mental Health Lead respondents only:* Please say whether you agree or disagree with each of the following statements:

[Scale strongly agree – strongly disagree]

- I have considerable experience of working with students with emotional and mental health needs.

- I am confident that I can fulfil the senior mental health lead role.
- I have sufficient protected time to perform the senior mental health lead role.
- I know who to contact in the local NHS to help me effectively fulfil my senior mental health lead role.
- I know who to contact in the local authority children and young people's mental health services to help me effectively fulfil my senior mental health lead role.
- I know who to contact in the voluntary sector to help me effectively fulfil my senior mental health lead role.

Resources

23. Please say whether you agree or disagree with each of the following statements in relation to your educational setting:

[Scale strongly agree – strongly disagree]

- My educational setting has sufficient resources, including staff, to take full advantage of the opportunities that the new mental health support team or education mental health practitioners offer
- There is no risk that my setting will reduce its existing services and support to children and young people with emotional and mental health needs once the mental health support team or education mental health practitioners are in place

Impact of COVID-19

24. What impact has the restricted opening of educational settings during the Coronavirus (COVID-19) pandemic had on your educational setting's ability to provide mental health support for your pupils/ students?

- [Free text box]

25. What impact has the restricted opening of education settings during the Coronavirus (COVID-19) pandemic had on your educational setting's ability to access wider mental health services and support for your pupils/ students?

- [Free text box]

26. What other impacts has the Coronavirus (COVID-19) pandemic had on mental health and wellbeing in your educational setting?

- [Free text box]

Other issues not previously covered

27. Is there anything else about the implementation of the trailblazer programme in your specific setting or locally that you would like to tell us?

- [Free text box]

Details of the setting

28. What is the name of your educational setting?

- [Free text box]

29. What is the postcode of your educational setting?

- [Free text box]

30. Do you know your educational setting's LAESTB code?

- Yes, please write it in the box below
- Don't know (2)

31. *If don't know selected for Q30:* Do you know your educational setting's URN?

- Yes, please write it in the box below
- Don't know

Request for follow-up interview

32. At some point in the next few months, we may contact you again to ask whether we could conduct a follow-up interview with you. Would this be OK with you?

- Yes
- No

33. *If yes selected for Q32:* Please write down your telephone number and confirm your e-mail address to make it easier for us to contact you:

- Telephone number [free text box]
- E-mail address [free text box]

c. Regional lead interviews topic guide

1. Can I ask you what your current role is in relation to the trailblazer programme?
 - a. How long you have been in post?
 - b. Can you tell me what sorts of things you do day to day in your role in relation to the trailblazers (TB) programme?
2. Thinking about how the programme has developed - prior to the national lockdown in March (as a result of covid-19) how was the TB programme progressing in your area?
 - a. E.g. recruitment, training, engagement with schools, TB set-up, involvement of CYP, parents and carers, relationships between stakeholders, interventions
3. Obviously covid-19 has been a significant factor in the last 6 months, how have things been going since the national lockdown?
4. How has covid-19 specifically affected the programme?
 - a. Any pauses in delivery, delays?
 - b. How have the MHSTs adapted?
 - c. Use of digital services to deliver support and interventions during lockdown – any experiences of this? Will the use of digital platforms continue after the pandemic?
 - d. Has there been a shift in the balance of activities of MHSTs? Have MHSTs had to adjust content/focus (e.g. covid, balance between interventions, WSA etc.)
 - e. If there has been a shift in the balance of activities, is this expected to be temporary? How do they plan to re-balance activities post Covid-19?
 - i. [If delivery of interventions has become main focus] Is there a plan for how to re-establish activities post covid-19 to focus more on the whole school approach, activities to support prevention etc.?
 - f. Will any changes made to the programme during COVID-19 be maintained after the pandemic, or will you return to your original programme plan?
5. Looking back on everything so far, what has gone well? What are the early achievements and successes in your region?
 - a. E.g. different TB models, different ways of delivering support, engagement and working with schools, joint working between health and education,

involvement of CYP/parents/carers, recruitment, referrals, resource availability, digital working

6. Have you got any good practice examples/learning you would be willing to share with us?
7. What challenges have TBs in your area been facing? What has gone less well? (Covid and non-covid related)
 - a. E.g. different TB models, different ways of delivering support, engagement and working with schools, joint working between health and education, involvement of CYP/parents/carers, recruitment, referrals, resource availability, digital working
8. Are there any key differences between Trailblazer sites in your region?
 - a. Any differences between wave one and two
9. Do you think progress in your area is on track?
10. How and how well does the TB programme fit with other initiatives to support mental health and wellbeing in educational settings in your region?
 - a. Does TB build on previous pilots, programmes e.g. Schools link, CYP IAPT
11. We know that local context can play a big role in programmes and their success. Which contextual features in your area do you think are most likely to be influential in the TB programme?
12. One of the things we're interested in is how areas are defining the group MHSTs are supporting? How has this group been identified or defined locally?
 - a. Are you aware of differences between how local areas/TB sites are doing this?
13. Do you think that the governance of the programme is jointly owned/shared across health and education in the TB sites in your region?
 - a. Do you think there are any stakeholders missing from this?
 - b. To what extent are CYP and parents and carers involved?
 - c. Any early learning from the TBs in your region about the factors that support effective joint working across health and education?
14. Our understanding is that the programme is trying to strike a balance between providing central direction and the ability to flex the programme to suit local

circumstances. What is your view on the flexibility to 'tweak' the TB programme to reflect regional needs?

- a. Is the balance right?
- b. Is there enough local flexibility?
- c. Are there areas or issues for which more central direction would be helpful?

15. How do you work together as regional leads?

- a. How do you share intelligence?
- b. Has your role had to adapt due to covid-19?
- c. Have you provided opportunities for TBs to come together in your regions?

16. Are you aware of similarities or differences in the way in which regions have implemented the programme?

17. Are you aware of any local evaluations of the TB programme?

- a. If yes – do you know who has is leading the evaluation? Do you know who has funded this?

18. Is there anything else about the TB programme or your area which we have not asked you about today which you would like to add?