Schools Forum

5th December 2013

Mental Health Interventions for School Children (MHISC)

This report relates to both maintained and academy schools

Recommendation

The Schools Forum is recommended to:

1.0 Note outcomes achieved to date through the Dedicated Schools Grant (DSG) funded MHISC framework to provide mental health interventions to school children with an open Common Assessment Framework (CAF)

2.0 Agree to a continuation of the DSG funding for the MHISC framework for two further years until March 2016, at £150,000 per financial year.

1.0 Introduction

1.1 In 2011 the Schools Forum raised concerns about the level of unmet emotional well-being and mental health needs within the school setting. The Forum subsequently approved a total of £420,000 (at £210,000 per year) until March 2014 to deliver 'Emotional Well-being and Mental Health Services for Schools'. This work has become known as the MHISC framework (Mental Health Interventions for School Children).

1.2 A competitive tender exercise in 2012 identified 12 providers that could deliver evidence based, timely, and cost effective mental health interventions to Warwickshire school children. These providers were placed on a framework contract that enables specific interventions from the providers to be purchased as required.

1.3 The MHISC framework is open to children or young people with a CAF who have been assessed as having an emotional well-being or mental health need. A CAF Officer selects, from the 12 providers, the most appropriate and cost effective intervention for that young person and a referral is made for an intervention of (usually) six sessions to be delivered.

1.4 Interventions provided through the framework include: counselling, mentoring, group work, family therapy and bereavement support. Crucially, however, the framework meets the following quality criteria:

- *Targeted* at those in greatest need by working through the CAF process.
- *Timely* as providers must deliver an initial session within three weeks of receiving a referral.
- *Cost effective* as CAF Officers must select the most competitively priced provider (who can meet the assessed needs of the child or young person).
- *Evidence based* as providers were required to demonstrate the national evidence base as part of their submissions during the tender process.
- *Outcomes focused* as outcomes are recorded for all interventions using the Goodman Strengths and Difficulties Questionnaire (SDQ).
- *Systemic* as all interventions are delivered as part of a wider CAF process which requires involvement of the whole family.

1.5 A total of 424 children and young people have accessed the MHISC framework to date (as at the end of September 2013). An analysis of the SDQ scores following interventions shows that MHISC has been successful in reducing mental health concerns from clinically significant levels to average levels on a par with the wider population of young people. This analysis was conducted on 25% of the most recently closed 114 referrals since April 2013, with average scores presented in Table 1, below.

1.6 The MHISC contract is underspent against the annual budget of £210k. This is due to low demand in the initial states of the scheme (as shown in table 3). A total of £114k was allocated at the end of September, with a total forecast spend of £190k by March 2014.

1.7 Funding for the MHISC framework ends on the 31st March. There is provision within the framework agreement for the contract to continue until the 31st March 2016, if funding is continued. A total of £300k is sought to continue the contract for the two year extension at £150k per year.

2.0 **Main Issues and findings**

National context

2.1 There is a growing body of national research that reinforces the need to address the mental ill health of school age children as summarised below:

- The prevalence of mental health disorders in children and young people is increasing as demonstrated by an increase in referral rates to Child and Adolescent Mental Health Services (CAMHS) of more than 40% between 2003 and 2010. (Durham University Mapping Unit)

- There is a strong link between mental distress and poor educational outcomes and early drop out. (Cornaglia et al, 2012, for the Centre for the Economics of Education)

- Mental health disorders in childhood can have high levels of persistence:
  - 25% of children with a diagnosable emotional disorder and 43% with a diagnosable conduct disorder still had the problem three years later
  - Young people experiencing anxiety in childhood are 3.5 times more likely than others to suffer depression or anxiety disorders in adulthood.

  (CAMHS Review, 2008)

- One in ten children aged 5 to 16 has a clinically significant mental health problem. (Meltzer et al, 2003, for the Office for National Statistics).

- Conduct disorder is the most common mental disorder in childhood. By the time they are 28 years old, individuals with persistent antisocial behaviour at age ten have cost society ten times as much as those without the condition. (Scott et al, 2001)

Local context

2.2 This national trend is echoed in Warwickshire by the Education of Children Out of School service (ECOS) that reports an increase in the number of children being educated out of school due to mental ill health (Warwickshire CAMHS Needs Analysis). In addition, local mental health organisations in Warwickshire are reporting increases in both the number and complexity of clients.

2.3 Pupils across Warwickshire report, through the 2013 Annual Pupil Survey, significant levels of negative feelings:

- **46%** secondary school children feel angry all of the time, most of the time or some of the time.
- **9%** of primary and secondary pupils combined said they ''felt lonely all of the time or most of the time''
- **41%** of primary and secondary pupils said they did not feel confident all of the time or most of the time.

MHISC outcomes and reach

2.4 The MHISC framework has had a significant impact on the mental well-being of children and young people accessing the CAF process. Below are summaries of three case studies which show some of the individual outcomes of MHISC interventions:

- Pupil aged 7 who, after witnessing domestic abuse and moving schools, had low self-esteem and was at risk of deteriorating behaviour,

poor attainment and further reduction in self-esteem. Following twelve MHISC counselling sessions the school and parents were confident that the child was doing far better. Had a MHISC intervention not taken place the likely outcome would have been a more specialist intervention at a later age when the issues were more entrenched and effects on attainment more pronounced.

- Pupil aged 13 suffered a traumatic experience of the sudden death of a close family member leading to panic attacks and poor behaviour at school (leading to a fixed term exclusion). Specialist CAMHS input was refused, while support through the school did not prevent further deterioration in behaviour. MHISC intervention was able to provide a specialist youth worker and then a counsellor that has led to a markedly different presentation: less teary and more expressive and lively, with an improvement in school attendance and behaviour. It is 'extremely likely' that this young person would have needed intensive intervention in the future and was at risk of permanent exclusion.

- A young man, aged 16, had not attended school since a false allegation of rape towards him from a fellow pupil when he was 14. Medication was provided by CAMHS, but with no therapeutic input. He would not wash, get dressed or clean his teeth. He had very low self-confidence and did not want to meet anyone out and about from school. CAF support included a Family Support Worker and then a Targeted Youth Worker. A MHISC referral was made once CAMHS had agreed that counselling was appropriate. This intervention has (combined with the work of the other professionals) had a significant impact: he now attends college; has made friends, including female friends; and is able to walk into the village and go on outings. His mother reports that he isn't frightened or suffering from anxiety attacks since MHISC counselling. This referral has enabled him to build his emotional resilience, and both his family and professionals feel that the counselling underpinned all of their other work.

2.5 Outcomes from MHISC interventions are recorded through the SDQ (Strengths and Difficulties Questionnaire), a nationally recognised tool for measuring levels of mental ill-health against five scales: emotional symptoms, conduct problems, hyperactivity/inattention, peer relationship problems and pro-social behaviour.

2.6 This questionnaire can be completed by the pupil, parent and teacher, giving a fuller view of progress. Scores are placed within three bands: average (no clinical problems), raised (emerging clinical problems), and high (substantial

clinical problems). Table 1 presents the average scores from a 25% sample of MHISC interventions delivered since April 2013.

Table 1: Average SDQ scores for MHISC interventions

	At start of intervention	**At end of intervention**
Child / young person	17.06 (Raised)	9.74 (Average)
Parent/carer	20.42 (High)	12.89 (Average)
School	13.90 (Raised)	9.56 (Average)

2.7 These average SDQ results show two key points:

I. That MHISC interventions are reaching children and young people with clinically significant mental health issues, i.e. the appropriate client group.

II. The MHISC interventions are succeeding in reducing mental health issues to average levels, i.e. levels that are not clinically significant.

2.8 In addition to the SDQ scores, clients reported an average customer satisfaction score of 9.7 out of 10.

2.9 The three quality measures above: case studies, SDQ outcomes, and customer satisfaction show that the MHISC framework is delivering good outcomes for the children and young people accessing the interventions.

2.10 Although no formal survey of teachers' views has been conducted, anecdotal evidence from CAF Officers suggests that the MHISC framework is well supported by Schools; there is a suggestion that schools that previously did not open a CAF are starting to do so because MHISC funding is available.

2.11 MHISC interventions have been delivered across Warwickshire, with a total of 424 children and young people receiving an intervention since April 2012. Table 2 shows the proportionate spread of interventions across Warwickshire. It shows that referrals reflect the socio-economic balance of the County, with the highest number of referrals in Nuneaton and Bedworth and North Warwickshire and the lowest in Stratford and Warwick Districts.

2.12 Table 3 shows the age / type of school of MHISC referrals. It can be seen that approximately two thirds of referrals are for primary school age children and one third for those of secondary school age. This suggests that MHISC referrals are being made as early interventions.

Table 2: MHISC reach across Warwickshire

District	**Percentage of MHISC referrals**

North Warwickshire	23%
Nuneaton and Bedworth	32%
Rugby	20%
Warwick	12%
Stratford Upon Avon	13%

Table 3: MHISC interventions per school age

School type / Sector	**Percentage of MHISC referrals**
Early Years	0.2%
Primary	63%
Secondary	35%
Post-Secondary	1%

MHISC cost analysis

2.13 The MHISC framework was awarded £420,000 (£210,000 per year) of DSG funding up until March 2014. However, it is anticipated that the total spend for the MHISC funding will be approximately £190,000 with an underspend of £230,000. This reflects a lower number of referrals made in the initial months of the scheme. Table 2, below, profiles spend in each quarter of the framework and shows a steady increase in the number of MHISC referrals made over the course of the funding.

Table 3: MHISC spend per quarter (from April 2012-Sept 2013)

Actual 2012/13				Actual 2013/14		Expected 2013/14		**Forecast Total**
Q1	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**	
£5,468	£11,548	£17,965	£20,780	£30,943	£27,656	£35,000	£40,000	£190,000

2.14 The actual spend of £114,360 to the end of Q2 leads to a unit cost, for the 424 children receiving a MHISC intervention, of £270 per person.

2.15 Benchmarking CAMHS services across the country in 2012 showed that counselling services cost an average of £50 per hour. This equates to £300 per child. Against this comparison, MHISC can be seen to be good value.

2.16 An analysis using a Social Return of Investment model (SROI) has been undertaken on the 19 most recent CAF closures where a MHISC intervention was accessed. This model uses a peer reviewed methodology endorsed by Coventry University (as part of a Masters Programme completed by a WCC member of staff) and LARC (Local Authority Research Consortium).

2.17 This analysis suggests that up to £678,000 of spend has potentially been saved across these 19 cases in total by preventing a range of anticipated

outcomes including: referrals to CAMHS; exclusions; truancy / school refuser court cases; evictions; and special education provision. This sample of 19 cases represents a potential saving of £35,700 per young person accessing MHISC as part of a CAF.

Continuation funding

2.18 The MHISC framework was established with a two year contract, ending on the 31st March 2014, with an option to extend for a further two years. Approval is sought from the Schools Forum to continue funding the MHISC framework for these two available years up to the 31st March 2016.

2.19 £300,000 is sought to continue the MHISC framework for two more years, at £150,000 per annum. This represents a £120,000 reduction in the budget over the two years and reflects an analysis of the demand while recognising the need to make savings.

2.20 This level of funding will enable approximately 550 interventions to be delivered per annum and is based on the increasing level of demand over the previous six quarters. Monthly monitoring of spend will assess the level of demand, and if it emerges that more interventions are being made, then MHISC referrals will need to be triaged by CAF Officers. This will be undertaken in two ways:

- CAF Officers will assess the initial CAF assessment to identify priority cases that have greater need for a MHISC referral
- SDQ assessments will be used to identify which cases require a second block of interventions, and which can cease after the first block.

2.21 In the event that the level of demand is less than forecast, leading to a significant underspend in 2014/15, then a follow up report will be submitted to the Schools Forum identifying the revised budget required.

2.22 Emotional well-being and mental health issues are the second most common reason for a CAF being opened for children and young people. If funding for the MHISC Framework is not continued then the service will cease. This will result in an estimated 550 children and young people unable to get the right intervention for their assessed needs, which will impact on the success of their CAF and the wider anticipated outcomes.

3.0 Conclusion

3.1 Schools Forum funding for the MHISC framework has enabled the CAF process to make significant and quantifiable improvements to the mental health of Warwickshire children and young people as evidenced by case studies, SDQ scores, customer satisfaction sores and an analysis of the social return on investment.

3.2 Benchmarking shows that MHISC interventions represent good value for money, with providers selected who can meet the identified needs of the child or young person at the lowest cost. The value of the MHISC framework is particularly striking if compared against the predicted savings anticipated by an SROI analysis.

3.3 Continuation funding for two years of £150,000 per annum will enable the MHISC framework to continue while realising a £60,000 per annum reduction in budget.

	Name	**Contact Details**
Report Author(s)	Andrew Sjurseth CAMHS Commissioner	andrewsjurseth@warwickshire.gov.uk
Head of Service	Sarah Callaghan and John Betts	sarahcallaghan@warwickshire.gov.uk johnbetts@warwickshire.gov.uk
Strategic Director	Wendy Fabbro	wendyfabbro@warwickshire.gov.uk
Portfolio Holder	Cllr Heather Timms	cllrtimms@warwickshire.gov.uk