Department for Education

Evaluation of the Mental Health Assessment Pilots for looked after children

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Sarah Brown, Graham Thom, Rhona Murray, Kate Davies, Sheetal Mistry and Isabel Hampton. SQW

Government Social Research

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Summary

Under the regulations set out in the Care Planning, Placement and Case Review (England) Regulations 2010, local authorities (LAs) are responsible for ensuring that an assessment of physical, emotional and mental health needs is carried out for all looked after children within twenty working days of their first entry into care.

In 2016 the Education Select Committee identified that the emotional and mental health elements of the initial health assessment of looked after children were often inadequate and ineffective, and required improvement. The report of an Expert Working Group (EWG) recommended that the mental health assessment needed to become more timely, holistic, needs-based, and person-centred.

In response, the Department for Education (DfE) appointed a consortium led by the Anna Freud Centre (AFC) to pilot a new approach to mental health assessments for looked after children in nine local authority areas over two years to develop and test changes to the assessment system for looked after children on entry into care. The programme began in January 2019. All pilots were grant-funded to September 2020. Due to the Covid-related disruption, DfE offered sites the opportunity to extend their delivery period until March 2021, which was taken up by five sites.

The key elements of the pilot included:

- the application of mentalisation to the assessment process, which means operating to a set of principles including being empathetic and validating, attentive and curious, and taking a wider perspective beyond any individual interaction with someone
- inclusion of the child's network in the assessment process
- introduction of a virtual mental health lead (VMHL) to support frontline assessors
- a package of different tools to supplement the Strengths and Difficulties Questionnaire (SDQ)
- the addition of a child-centred, written output that reflected the perspective of the child on their mental health and wellbeing and incorporated views from their network.

The programme was established with considerable ambition, albeit in a limited number of places and on a fairly limited timetable. However, fewer children eventually completed assessments than originally anticipated: 116 children across seven sites completed their assessments by the end of March 2021, against early estimates of 350 children.

The evaluation, which covered the same time period, was a largely qualitative study due to the scale of the programme. It involved consultations with site stakeholders, interviews with carers and/or children and young people (covering the experience of 20

children), expert review of interview transcripts with children and parent/carers and written outputs from their relevant assessments, and review of monitoring and cost data. The nature and scale of the evaluation evidence means findings should be taken as being indicative of the potential impact of the programme and the pilot approach.

The programme has generated considerable learning, particularly on perceptions of how the various elements of the approach have operated. The sites reported that the mentalisation stance was an important concept to inform their assessment, albeit challenging to define and operationalise. The VMHL, new assessment tools and the written output were reported as functioning as practical ways to operationalise the approach. The tools seemed to be the least challenging element of the new approach. It took time for assessors to get comfortable with using the tools but there was acknowledgement that the right tool for the child can be a useful aid to mental health assessment.

The written output and the VMHL were both widely welcomed by sites. However, the written outputs were not always particularly informative, and in some cases struggled to be child centred. It also needs to be clearer how the document from the child's perspective fits with other professional formulations, and what it is intended to lead to.

The VMHL was reported to play a significant role in supporting frontline practitioners to undertake assessments and was perceived as fundamental by the sites. Yet the evaluation found limited evidence of this then leading to positive outcomes from children and their carers. While, according to sites and some carers and children, the process was mostly done well, there were only a handful of examples of tangible results in terms of referrals or other concrete supportive action. This, in combination with the lower than hoped for quality of the written outputs, means a note of caution should be sounded about the value added by the VMHL. The principles of the role are entirely sensible but how the VMHL meets the strategic aspect of the role in enabling a site to deliver consistently good quality assessments needs to be further developed. This is especially important given the role is an additional cost for the assessment process and thus clearly has to demonstrate on-going value for money.

Most sites were positive about their own learning from the pilot. However, only one site was planning to continue with the pilot largely in its current form. Six other sites wanted to retain aspects of the pilot approach but, for various reasons, are unable to do so, apart from allowing participating staff to continuing using the skills and experience they have gained.

Overall, evidence from the children themselves, or their carer, did suggest that some good practice exists in terms of the new assessment process meeting the EWG criteria of thoroughness, quality, accuracy, timeliness and extent to which they are person centered. However, elements of the approach piloted appear to require further refinement and further evidence is required, at scale, to demonstrate effectiveness.

Chapter 1: Introduction

Children in care are amongst the most vulnerable in our society and are significantly more likely than their peers to have a mental health difficulty[1]. Under the regulations set out in the Care Planning, Placement and Case Review (England) Regulations 2010, local authorities (LAs) are responsible for ensuring that an assessment of physical, emotional and mental health needs is carried out for all looked after children within twenty working days of their first entry into care. This assessment must be conducted by a registered medical practitioner. Information derived from this assessment informs a health plan which sets out the support that should be provided to meet a child's needs.

In 2016 the Education Select Committee identified that the emotional and mental health elements of the initial health assessment of looked after children were often inadequate and ineffective, and required improvement[2]. The report of an Expert Working Group[3] (EWG) tasked with understanding how to improve mental health and wellbeing support for looked after children, and those who were previously looked after, recommended that the mental health assessment needed to become more timely, holistic, needs-based, and person-centred.

In response, the Department for Education (DfE) appointed a consortium led by the Anna Freud Centre (AFC) to pilot a new approach to mental health assessments for looked after children in nine local authority areas over two years (with delivery of assessments running from July 2019 to March 2021) to develop and test changes to the assessment system for looked after children on entry into care. The key elements of the pilot included the application of mentalisation to the assessment process, inclusion of the child's network in the assessment process, introduction of a virtual mental health lead (VMHL) to support frontline assessors, a package of different tools to supplement the Strengths and Difficulties Questionnaire (SDQ), and the addition of a child-centred written output that reflected the perspective of the child on their mental health and wellbeing and incorporated views from their network.

The nine pilot sites were local authority areas of Brighton & Hove, Devon, Doncaster, Merton, North Tyneside, North Yorkshire, Salford, Staffordshire and West Berkshire. In January 2019 the pilot sites embarked on a design and preparation phase, with support from AFC. In July 2019 the first sites began implementing their new mental health assessment process. By October 2019 the last site had begun implementation. In September 2020, four of the sites completed delivery. Five sites continued delivery to March 2021, after disruption caused by the Covid-19 pandemic.

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[1] Outcomes for children looked after by local authorities in England, 31 March 2019, Department for Education, p6 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/884758/CLA_Outcomes_Main_Text_2019.pdf

[2] https://publications.parliament.uk/pa/cm201516/cmselect/cmeduc/481/481.pdf

[3] https://www.scie.org.uk/children/care/mental-health/report

Evaluation brief and objectives

In July 2018 SQW Ltd, in partnership with Qa Research, Colin Waterman and Nic Crosby, was commissioned to evaluate the effectiveness and impact of the pilots. The evaluation ran to August 2021.

The key objectives for the evaluation were to:

- Assess the success and effectiveness of the pilots in delivering the project aims and objectives including specific consideration of whether the piloted assessments meet the required criteria (thoroughness, quality, accuracy, timeliness and extent to which they are person-centred), and the appropriateness of the professionals involved in carrying out the assessment
- Understand the impact the assessment approaches have on children and families, the LA and its stakeholders, and the wider system
- Review the extent to which changes to the statutory framework that underpins the assessment process requires change
- Assess the nature of support provided as a result of the pilot and whether the relevant interventions were already available or commissioned by the pilots
- Consider the cost implications of the changes to assessment.

Report structure

This report is the final report of the evaluation and is structured as follows:

- Chapter 2 – evaluation approach and method
- Chapter 3 – programme model and delivery
- Chapter 4 – pilot implementation
- Chapter 5 – costs of the new approach
- Chapter 6 – outcomes for children and young people
- Chapter 7 – reflections and learning.

Note on site identification

The identity of the nine participating pilot sites is publicly known. However, the report aims to provide an assessment of the overall learning from the programme rather than evaluating each site. As such, the report avoids attributing specific details to named sites.

Chapter 2: Evaluation approach and method

This section of the report describes the evaluation approach and methods, outlines some of the key stages in the evolution of the evaluation and reflects on evaluation challenges.

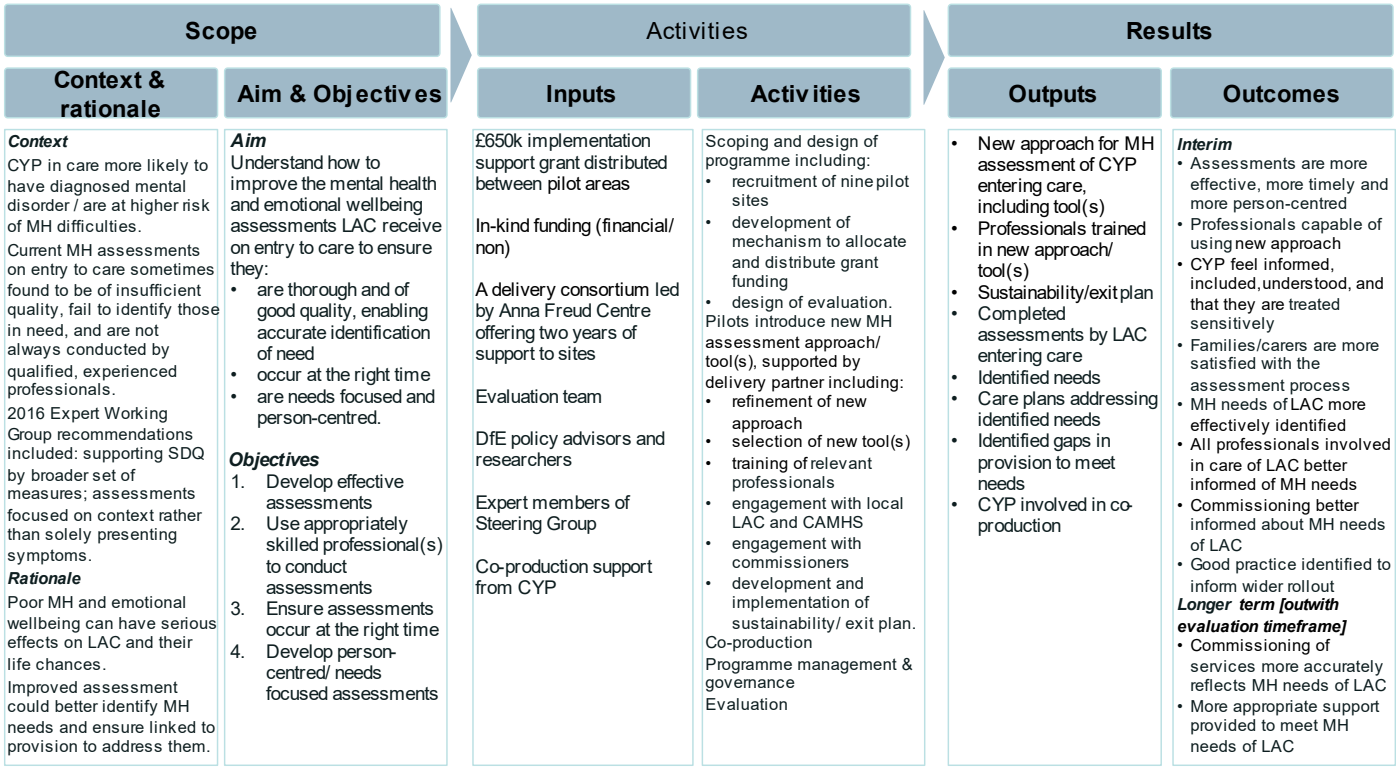
Evaluation approach

The evaluation followed a theory-based approach to provide evidence on *what* happened during the pilot programme and offer explanations as to *why* it happened. Theories of change are an evaluation tool used in theory-based approaches. A theory of change makes explicit the logic behind how a programme is supposed to generate change, including relevant assumptions about what needs to be in place for change to occur. As programmes do not exist in isolation, a theory of change also highlights key aspects of the context that may influence the success of the programme.

While a theory of change necessarily simplifies a complex reality, it aims to capture the main elements of how a programme creates change in a particular context. This informs how resources should be deployed to measure the effectiveness and impact of a programme.

A theory of change (see Figure 1) was developed to map out the logic of the programme. Progress through the steps in the programme theory of change was observed through methods as described below. This report assesses the evidence collected to determine the extent to which the programme theory was realised and what influenced any divergence from each step in the causal chain.

Figure 1: Theory of Change for the Mental Health Assessment Pilots



Evaluation research questions

The evaluation was also designed to address the key research questions as set by DfE.

- How successful are the pilots in delivering the project aims and objectives?
  a) What, if any, improvements have there been in the timeliness and appropriateness of assessments and referrals?
  b) What has been the impact of the pilots?
- How effective are the assessment approaches in delivering the specified objectives and project aim, namely mental health assessments that are: thorough, good quality, accurate, timely, needs focused and child centred?
  c) What has the impact been on children and families?
  d) What can we learn to help inform the delivery of health assessments in other areas?
  e) What impact, if any, have the pilots had on the practice of local authorities or provider, or the wider range of stakeholders?
- What are the strengths and weaknesses of their approaches, and what are the enablers/ barriers to successful outcomes and to wider roll out?
- What are the key lessons and best practice for assessments of looked after children?
- Have there been any changes in awareness and knowledge of mental health and well-being assessments and/or changes in processes and systems, particularly regarding inter-agency working and the strategic commissioning of services?
- What are the cost implications of the changes to assessment?
- Were appropriate interventions (already available or newly established) available to meet the complex needs of looked-after children following assessments?
  f) What has been the impact on commissioning of services in local areas?
  g) Have the pilots informed development of practice, and if so, how?
  h) Are the pilots changing how local areas behave, in terms of services commissioned or other types of support?
- Are there any unintended consequences caused by the pilots, and how can we resolve them?

Methods

The research methods to collect evidence for the evaluation are shown in Table 1.

Table 1: Research methods

Method	Detail	Coverage
Interviews with pilot site stakeholders	Face to face, telephone and video calls with Virtual Mental Health Leads (VMHL), frontline assessors, project managers, commissioners of children's services and other stakeholders as relevant/available. Covering design, implementation, governance, outputs and outcomes.	Spring 2018 - telephone calls with 9 sites Autumn 2019 - face to face visits with 9 sites September 2020 - telephone/ video calls with four sites November 2020 - video calls with five sites February 2021 – video calls with five sites Informal telephone calls throughout.
Review of monitoring data	Monitoring data submitted monthly by sites in a template designed by SQW. Covering demographics of pilot participants, and progress through the assessment stages to capture activity and outputs.	All nine sites to during their participation up to September 2020 or March 2021.
Interviews with carers and children	Telephone or video calls with carers and/or children and young that have completed the pilot assessment and had a finalised written output. Young people 16+ were allowed to be interviewed without a carer present. Covering experience and outcomes from participation in the pilot.	20 children/young people's experience covered through: • 13 interviews with carers • 6 interviews with children/young people – 1 of these interviews did not involve a carer • 5/9 sites covered.
Expert panel review of assessment write-ups	Review of written outputs from assessments and corresponding interview transcripts via video call with experts. Examining experience, outcomes and delivery against EWG criteria.	Two sessions held: February 2021 and June 2021.
Collection of cost data	Collection of cost data through a Word document designed by SQW. Covering cost of pilot compared to business-as-usual assessment process.	Five sites that completed March 2021.

Risks, issues and changes to the evaluation

The evaluation began with a scoping phase that ran until April 2019. During this phase, a number of risks to the evaluation were identified, in particular the number of children expected to go through the assessment process and the challenges of obtaining consent from participating children and their carers. It was noted that low throughput would affect the analysis that could be undertaken and robustness of findings. During the course of 2019 it became clear that throughput was significantly below original expectations and, as such, the following main changes were made to the evaluation:

- The planned online survey of carers and children was cancelled. The resource was transferred to additional qualitative research with three sites not originally included in the planned research activities.
- Planned research with a comparison group of children going through the business-as-usual assessment was discontinued. The resource was set aside for additional interviews with children participating in the pilot.

These changes meant that the evaluation no longer had a quantitative strand and became a mainly qualitative study. The evaluation was subsequently affected by the temporary pause on research fieldwork instituted by DfE in response to the Covid-19 pandemic and national lockdown. From March 2020 to August 2020 evaluation activity was limited to receipt of monitoring data from sites able to submit and observation at AFC-led video-calls. Fieldwork resumed in August 2020 with four sites that chose to exit the programme in September 2020 at the end of their original grant agreement. Fieldwork with the five sites that extended pilot delivery to March 2021 was postponed from autumn 2020 to the first quarter of 2021.

Reflections on challenges

The challenges posed by the evaluation, and subsequent adaptations of the evaluation approach and methods, have important **consequences for understanding the strength of the evaluation evidence and the robustness of the findings**.

First, the scale of the programme reduced over time, from an initial expectation that each pilot site might apply the new assessment process to a majority of children entering care (with the range of children entering care varying from 150 per year to nearly 1,000), to site estimates of delivering 30 to 50 assessments each during the programme, to actual completion of assessments for 116 children in total across all sites. This reduction meant the evaluation plan required revision, as described above, to remove the comparator group and cancel the collection of quantitative longitudinal outcome data. Further, only a small percentage of those with a completed assessment also consented to participate in the evaluation interviews. **The consequence of this scaled back programme and evaluation activity means that the evidence base is much more limited and less robust than anticipated.** The findings are based on self-reported data and feedback from pilot sites and a small amount of evidence directly from carers and children (20

children in total across five sites) who self-selected to participate in the evaluation research. As such, **findings should be taken as being indicative of the potential impact of the programme.**

Second, the programme was designed as a limited pilot, with nine sites in England selected to participate. These sites were diverse in many respects including their geography, demography, population, rate of children entering care and population of children in care. The ways in which they chose to implement and deliver the pilot were also diverse in terms of the particular cohort they targeted, the staffing structure (for example using social workers or children and adolescent mental health service (CAMHS) practitioners to undertake the mental health assessments), and the governance of their project. This meant **there were multiple variables to consider that might influence the progress and outcomes for each pilot site**. Dealing with multiple variables would have been easier if there had been a greater number of children completing assessments in each site per site or more sites, as there would have been more evidence for each particular combination of variables. Alternatively, if there had been fewer differences in how the sites implemented their pilots, it would have reduced the number of variables.

Third, it was difficult to clearly distinguish between the new ways of delivering mental health assessments implemented by pilot sites and what they were previously doing. In general, sites claimed some experience of elements of the new assessment process, particularly the use of mentalisation. This is explored in more detail later in the report. Findings must therefore be understood in this context and **extrapolation of learning to sites less familiar or unfamiliar with the key elements of the approach should be undertaken with considerable care**.

Fourth, while not a challenge, per se, it is worth noting that it was agreed with DfE during the scoping phase that the nature of support provided as a result of the pilot and any further long-term outcomes for children in case were beyond the scope of the evaluation. This is made clear in the theory of change (above, Figure 1) and reflected that the pilot could not influence the availability or quality of wider services. The evaluation therefore only considers outcomes in terms of the quality of the assessment process and experience of children and carers of the pilot, rather than whether it led to ‘better’ (more appropriate) support or later the effects on children in other aspects of their lives such as stability of placements, improved educational outcomes or improved health and wellbeing outcomes.

Finally, while the Covid-19 pandemic did present some challenges to both delivery of the programme and the evaluation, it had less impact than might be expected. Although there was a pause in the number of children receiving and progressing through assessments, during the first few months of the pandemic, slow throughput was already identified as a problem in February 2020. Eventually, both the pilots and the evaluation

were able to resume, having transferred some activity to virtual modes of working, as described later in the report.

Chapter 3: Programme model and delivery

This section describes the key elements of the pilot mental health assessment and the nine participating sites. It discusses the effects of Covid on implementation and details the scale of pilot delivery.

Key elements of the pilot assessments

The key elements of the pilot assessment approach are detailed in Table 2.

Table 2: Key elements of the pilot assessments

Element of assessment	Detail
Mentalisation	Mentalisation was the guiding approach underpinning all engagements within the assessment. Mentalisation means operating according to a set of principles including: being empathetic and validating towards the child (or other person, for example a member of the child's network), being attentive and curious, and taking a wider perspective beyond the specific engagement e.g. considering how information or behaviour within one engagement can be considered against other information or circumstances.
Measures/ tools	One of the EWG recommendations was to expand the range of measures / tools (validated questionnaires) used to support the collection of information about mental health and wellbeing from the child and their network beyond the nationally mandated SDQ. AFC identified a core set of measures for sites to use although it was recognised that sites might already be using and continue to use other tools. The SDQ was included in the package. Specific tools were also expected to be use for specific cohorts e.g. Devon's under-5s.
Virtual Mental Health Lead (VMHL)	The VMHL acted as a supervisor/ coordinator of the assessment and written output, supporting the assessor to reflect on the process and information collected through providing a safe space to gain perspective. This was intended to support the capability of the assessor to mentalise.
Child's network	Inclusion of the child's network, in particular their foster carer/parent/residential care worker and teacher etc. was integral to the mentalisation approach, which required multiple perspectives on the child's mental health to be considered in the assessment.

Element of assessment	Detail
Written output (wellbeing passport, journal)	A written document that presented the assessment from the perspective of the child but included perspectives of others in their network. Guidance stated that it should contain information on feelings, behaviour and relationships, a shared understanding of the child's needs and indicate what needs to happen. It was expected to be regularly updated rather than be a one-off output.

Source: SQW

Although the sites differed in what they had in place prior to the pilot, compared to the business-as-usual approach the pilot approaches generally had more assessment meetings, greater involvement from the network, use of more measures, more supervision from a senior mental health practitioner, and written outputs were from the child's perspective rather than professional formulations.

Structure and duration

The structure of each assessment was as follows: an initial contact with the carer or child to explain about the assessment followed by one or more assessment meetings with the child. Some of the assessment meetings involved using the prescribed measures, as considered appropriate by the assessor. Subsequently or in parallel, assessment meetings and completion of measures would be undertaken with relevant members of the child's network. During the assessment process, the assessor would have meetings with the VMHL to reflect on the process and information collected in order to develop a written output that presented the child's perspective of their mental health and wellbeing along with other relevant perspectives. The final written output was intended to be jointly agreed with the child and shared with other professionals according to the child's preference.

Despite the obligation to undertake an assessment of children entering care within 20 working days of entry into care, in practice, sites conducted the mental health assessment at an appropriate time for the child according to their placement stability and emotional state. Initially the number of assessment meetings and duration of assessment was not dictated although later more guidance was given to sites (see below).

Evolution of model

The majority of programme elements were largely accepted by the pilot sites. This included the mentalisation approach, the role of the VMHL, and inclusion of the network. However, there were some aspects of the programme that were refined based on feedback from the pilot sites to AFC. For instance, the long list of tools provided at the

outset was initially perceived as challenging by some sites and consequently reduced to a shorter list of prescribed tools that all children should be offered although mandatory completion was not required.

The most contested aspect of the model was the written output, as the majority of sites did not consider the template provided by AFC at the outset of the pilot to be sufficiently child centred. After discussion between AFC and sites, it was confirmed that written outputs could be tailored by site and by cohort/child as long as the document contained the core information, namely information relating to the child's emotions, behaviours and relationships. Rather than including all the child's responses to any measures, it was advised that these could be detailed or summarised/reflected on as appropriate. There was no clear instruction on whether to include goals, actions or identified sources of support.

The period of the time an assessment might take place over was another area which created a lot of feedback from sites. After sites provided their own estimation of how long the assessment process might take, with some indicating that to be wholly child-centred the process might last a year, AFC and DfE clarified that the expectation that an assessment might take three to four meetings and the first iteration of the written output should typically be available after no more than four months. This was caveated with an acknowledgement that each child would be different, and some might take significantly more or less time.

Pilot sites

Nine sites were chosen for the pilot programme from over fifty applications. The sites were selected to reflect a range of contextual characteristics such as rural/urban, poverty, and percentage of BAME among population, as well as factors relating to the pilot such as rate of child inpatient admission for mental health, rate of children entering care and most recent Ofsted judgement for children's services. Each site's relevant experience was also taken into consideration. All the selected sites had some evidence of having used an approach similar to mentalising or reflective practice, although during the application process it was difficult to compare this to AFC's conception of mentalising. Importantly, none of the pilot sites were wholly unfamiliar with mentalising and its related principles and practice.

In terms of key aspects of delivery, there was some variation between sites in terms of cohort and staffing:

- Cohort: five sites worked with the over 6s, three sites limited it to 6 to 12s (although one site extended the age bracket to 18 to increase the number of eligible children partway through the programme), and one site worked with under

5s. Only one site narrowed their cohort beyond age, choosing to focus on unaccompanied asylum-seeking children (UASC).

- VMHL: all sites employed a professional with a mental health background to fulfil the role. Four used a clinical psychologist and five used CAMHS professionals. One site used a social worker Independent Reviewing Office (IRO) in addition to their CAMHS professional. Three of the nine sites split the role between two people.
- Frontline assessors: overall more sites (six) used social workers to deliver assessments although two of these sites also used CAMHS staff. Two sites only used CAMHS staff, and two sites opted for an external practitioner to deliver their assessments (although one of these sites planned to train social workers as assessors later in their pilot). The decision to bring in an external practitioner was done in response to work pressures on existing staff.

In terms of the process of delivery, the degree of difference between sites decreased over time as the model evolved (as described above) with aspects such as duration of assessment becoming more standardised based on guidance from AFC (informed through discussion with DfE).

Effects on Covid on delivery

The Covid pandemic affected all sites in terms of immediate pressures on staff and restrictions in access to children and young people due to lockdown and social distancing regulations. Over time, sites responded differently according to local circumstances and capacity. Three sites effectively halted their pilot by stopping all assessments although they continued to offer support to their young people and use the VMHL to support those working directly with young people. Six sites scaled back activity, focusing only on supporting those children already undergoing the new assessment process. The sites that continued to deliver assessments modified their approach, for example using telephone and/or video consultations with children and their network instead of relying on face-to-face meetings.

All pilots were originally grant-funded to complete the programme in August or September 2020. Due to the Covid-related disruption, DfE offered sites the opportunity to extend their delivery period until March 2021. Five sites took up this offer and four sites chose to complete their pilot as planned. Sites chose to complete as planned mainly due to capacity issues, with the relevant personnel unable to continue to support the pilot for the additional time.

Scale of delivery

As referenced in section 2, the anticipated scale of delivery was reduced during the programme's lifetime. Sites' early estimates suggested 350 completed assessments could be achieved during the lifetime of the programme, that is 350 children would have a written output with which they agreed from the assessment. Ultimately, 116 children across seven sites completed their assessments by the end of March 2021. Two sites had no completions because they experienced delays in the launch and mobilisation of their pilot, found it challenging to identify eligible children given their selected cohort, and their frontline assessors faced significant pressures, both before and during Covid (reasons for low completions are explored further in the section on Barriers and Challenges below). These children represented the full range of ages from under one year old to eighteen, with an average age of ten years. Overall, more assessments were completed for boys than girls (59% vs. 41%)[4].

[4] This is broadly similar to the national profile: in England 56% of looked after children are male and 44% are female.

Chapter 4: Pilot implementation

This section describes implementation of the programme in the nine pilot sites and presents findings for key elements of the pilot approach, including enablers and barriers, and learning.

Key elements of the new approach

Summary

- Mentalisation was the underpinning approach for the new assessment process.
- The measures, the written output and VMHL operationalised the mentalisation principles.
- The measures helped prompt practitioners to explore a wide range of issues in relation to a child's mental health and wellbeing.
- The written output helped to guide the assessment process and can yield a tangible outcome for the child, but the content and form of documents has room for improvement.
- The VMHL is valued for their support to frontline assessors but the extent to which they have raised the standard of assessment and output is uncertain.

Mentalisation

A majority of sites reported that the mentalisation approach was the most important element of the pilot. From the perspective of VMHLs and frontline assessors, the mentalisation stance informed decisions about how everything else was done, for example administering tools in person (or by video) instead of sending them by post, engaging more substantively with the child's network, and supervision of frontline assessors by the VMHL. Both VMHLs and frontline practitioners reported that mentalisation can be challenging to practise, requiring a high degree of sensitivity and attention from the practitioner, and thus proper training and supervision is needed to enable staff to use the stance correctly and with confidence. Positive results of adopting a mentalising approach were reported as:

- giving the child space, permission and an invitation to articulate their own perspective, leading to better conversations about them and their mental health issues, and so yielding new and more valuable information about the child
- facilitating better conversations with the child's network
- supporting delivery of a more child-centred assessment process

- enabling more thoughtful and effective application of the measures such as the SDQ
- improving the confidence of social workers in having conversations about a child's mental health
- generating a representation of the child's perspective on their mental health that can inform other relevant professionals
- offering a therapeutic intervention in and of itself.

> "They [the child's network] have that feeling that it's really connected them to the child. It's an emotive experience. They are in touch with something about the child that most assessments do not provide you with." (VMHL)

All sites stated that elements of mentalisation, such as child-centred conversations, were already practised as part of the standard assessment process, even if mentalisation was not recognised as a term. However, it was reported that by providing training, time and support (through the VMHL), the pilot provided an opportunity to apply mentalisation more fully and more widely. Feedback on the use of mentalisation in the pilot indicates that, while aspects of mentalisation might have been understood by pilots, its application was fairly restricted, reportedly due to capacity constraints and lack of guidance on how to do so. The pilot programme has therefore been responsible for deepening, expanding and refining both the understanding and practice of mentalisation as part of the mental health assessment process.

While the wider adoption of mentalisation and its beneficial effects are to be welcomed, a number of issues were identified. First, the use of new terminology to describe principles of existing practice was seen as confusing and unhelpful by a minority of interviewees. Second, it was widely felt that a wholehearted application of the approach could be exceptionally time-consuming and that, in practice, some boundaries needed to be set, for example the number of interviews with a child as part of the new assessment process. Third, application of the approach to certain cohorts was seen to be trickier, for example children under five and those with learning disabilities, where direct communication with the child was different. Fourth, as the programme progressed, some stakeholders reported that they began to query how the quality of mentalisation practice could be assessed and maintained over time, both within existing and new staff.

Measures/tools

Sites recognised the drawbacks of the SDQ as the single way of assessing a child's mental health. In particular, the way the SDQ focuses on a score rather than the narrative

of child's circumstances was seen to be simplistic and unhelpful. As a single point of data, it was also considered to be potentially misleading about a child's mental state, depending on their mood at the time of completion. One site consultee stated that the SDQ is only useful in aggregate, for assessing a population rather than an individual.

Nearly all sites already had measures in place to enhance the SDQ but recognised that, prior to the pilot, assessments were still falling short of the EWG standards. For example, some sites undertook consultation with the child's network, but it tended to be patchy rather than systematic and was not always clearly focused on mental health issues. Consequently, issues were missed and there was a focus on symptoms rather than the circumstances of the child.

The pilot programme developed a list of tools that could be offered to the child, carer or teacher but did not have to be completed if it was not appropriate (Table 3).

Table 3: Pilot programme recommended tools for mental health assessment

Parent/carer completed	CYP completed	Professional completed
Strengths and Difficulties Questionnaire (SDQ)	SDQ	Teacher SDQ
Brief Assessment Checklist for Children/ Adolescents (BACC/A)	Me and My Feelings	Children's Global Assessment Scale (CGAS)
Brief Parental Self-Efficacy tool (BPSES)	YORS/ ORS/ CORS	
	Student Resilience Survey	
	CRIES-8	

Source: SQW from AFC information

Evidence from the monitoring data indicates that, overall, the SDQ (carer) remained the most utilised tool, completed for 129 children. As this measure is legally mandated, this is unremarkable. The next most used tool was the BAC-C or BAC-A (for 117 children). There were another four tools that were used in 75 to 82 assessments: the Brief Parental Self-Efficacy tool (in respect of 82 children); the SDQ-Child (by 79 children); YORS/ ORS/ CORS (77 children); Children's Global Assessment Scale (75 children); and SDQ-teacher (for 72 children). There was a difference in how many tools sites used in each assessment. Of the sites that completed in March 2021[5] one site used almost all of the

[5] Data for the other sites was unavailable or are less comparable because the tools were less appropriate/accessible for their cohort: one site worked with under sixes and the other with UASC.

tools for most of their children, three sites used most of the tools for a lot of their children, and one site only consistently used the CGAS.

Some tools were already used by some sites. There were a range of experiences of the tools across sites. Advantages of the tools as reported by sites included:

- a structure and prompt to initiate conversations with children, sometimes allowing the practitioner to raise issues they would not have considered otherwise and eliciting new information (the Student Resilience Survey was mentioned as a tool that included questions about different topics)
- the introduction of additional tools for members of the child's network (see table above), yielding a wider set of perspectives on the child and thus a better assessment of their mental health and how to support them. An example was given of avoiding a CAMHS referral because the circumstances surrounding the child's poor SDQ score were better understood because of information provided through other tools
- the use of evidence-based tools, which gave them credibility among practitioners
- the inclusion of a range of tools that could be used as appropriate.

However, sites also reported concerns in relation to the tools:

- the package of tools was intimidating for practitioners without a clinical background, particularly in terms of interpreting responses and assigning scores
- some of the tools were seen as not child-friendly, for example in terms of language, the intrusiveness or irrelevance of questions, and length, thus practitioners had to be thoughtful in how they administered the tools e.g., using stickers to make the questionnaires more appealing
- not all tools were appropriate for all cohorts, for example very young children or children from a different cultural background e.g., UASC
- tools were not always available in different languages
- as a package, the tools take a lot of time to administer fully.

Overall, it was difficult to identify any pattern in use of the tools from the data or consensus on the value of specific tools from feedback because of the number of tools used compared to the small number of assessments and issues over the comprehensiveness of site monitoring data relating to tool use. While a small number of practitioners might have strong preferences, in general the view was that it is more important how a tool is used. Most sites agreed that the tools were a supporting mechanism for the mentalisation stance, offering specific routes to gaining relevant information from the child and their network. There was consensus among VMHLs and

practitioners that the tools themselves were insufficient on their own, as indeed use of the SDQ alone had showed, and it was important to use them with a mentalisation stance. Moreover, it was observed that the tools alone do not collect the full context from the child. Further evidence needs to be collected by professional to develop a full narrative.

> "The tools that we've got …. It gives you the statements to ask and the information to look at, but I think it does depend on the practitioner then and using your skills and knowledge in being able to deliver that effectively." - *Social worker*

Training and time were considered important to helping practitioners develop confidence and capability in using the tools effectively. One site reported that introducing the tools to assessors one at a time minimised difficulties.

Virtual Mental Health Lead (VMHL)

The role of the VMHL was essentially new. Most sites already had someone with clinical experience available to support or supervise frontline staff and, in some cases, this person simply assumed the mantle of the VMHL. Yet the role of the VMHL was wider than support to or supervision of frontline staff. The VMHL had a dual function: a strategic role in ensuring the quality of the pilot assessment process; and an operational role in supporting staff with each child going through the process. This strategic role did not exist prior to the pilot.

The role was highly valued by sites for a number of reasons. Frontline assessors report that they valued:

- the immediate access to mental health expertise and in some cases a more direct or improved connection to local CAMHS. This was particularly valued by practitioners without a mental health background: social workers in one site reported increased confidence in approaching young people about mental health with support from the VMHL
- being supported to reflect on both the detail of specific interviews and the overall narrative arising, and prepare for further engagement
- being given nurturing support through emotionally complex engagements
- reflective supervision from the VMHL during Covid, when they were under intense pressures.

> "If we didn't have the VMHL, would we have gotten this far? Probably not. It's definitely been the key to success." (Social work manager)

VMHLs and strategic leads valued the authority and profile of the role, raising the importance of mental health of children entering care and extending the scope of organisational responsibility for it. One site reported that the VHML was able to convene a range of stakeholders for the specific purpose of addressing the mental health of a looked after child, which had not happened previously.

There were some indications about factors that helped a VMHL to make the most of their role, as identified by VMHLs and project leads. Coming to the role with existing relationships and knowledge of local services was an advantage, although in at least one case the VMHL continued to deliver aspects of their previous role. The specific qualities of the VMHL were also considered to be important, particularly the ability to work effectively with multiple organisations and enthuse people with the possibilities of the pilot.

> [The VMHL] is absolutely passionate and is the golden thread through all of it. [They have] been there from the start and …believe in it and from that point of view the positive things has always been that if something has changed or the goalposts have shifted [they] will bring it back to 'but remember we were doing this to make things better'…. That has been a huge positive." (Commissioner)

All sites had a VMHL with a clinical background apart from one which opted for two VMHLs, one from health and one from social care. The addition of a VMHL firmly embedded in social care (rather than a clinical practitioner based in a social care team) was found to be advantageous in bringing an insider's knowledge of the social care system, for example the structures and processes, and access to social care.

> "It is quite difficult to straddle two services, but it needs to be done as the aim is to help children have a better experience of the service…and if we are serious about early intervention then it should happen." (CAMHS nurse)

Having two practitioners, one from health and one from social care, sharing the VMHL role would likely add costs in terms of coordination between two VMHLs but there is clearly some value of dual insight into health and social care at a strategic level.

In terms of programme support, the VMHLs themselves reported benefiting from peer support, particularly through informal channels that they set up themselves such as WhatsApp groups, in learning about how to operate in the new role.

Written output

One of the most fundamental critiques of existing practice, common to all sites and voiced by VMHLs and frontline practitioners, was the absence or weakness of the child's voice in the assessment process. Even in the sites that began with a good understanding of child-centred approaches, there was an acknowledgement from practitioners that there was limited or no consultation with the child (beyond the completion of the SDQ) and no agreement of a written output that presented the child's views and priorities. In all sites, prior to the pilot, assessment outputs focused on the concerns of professionals. This lack of the consideration of the child and production of an output that expressed their perspective rather than that of the professionals tended to result in children having to repeat their story.

Therefore, there was broad support for the concept of the 'Wellbeing Passport' or 'Wellbeing Journal'. Most sites were positive about the idea of bringing multiple sources of evidence about a child into one place and producing a systematic, structured narrative. It was anticipated that this child-centred, inclusive narrative would lead to a better understanding of the child's mental health needs and how to address them, including going beyond clinical referrals and interventions to more practical short and long-term strategies about how to make the child feel safe, happy and fulfilled. At best it was hoped that production of the written output, through articulating the experiences and perspectives of the child, and sharing sensitively with them views of others in their network, would be beneficial in and of itself. For example, it might help the child to identify their emotions, appreciate how others perceive them and consider what might be helpful to them. In essence, the written output was valued by VMHLs and assessors as being a route to practically implementing the mentalisation approach as it requires both the child's views and for the narrative to be told from their viewpoint.

Yet despite valuing the concept, sites experienced a range of challenges in producing the written outputs. First, completion of the written output was reportedly intellectually demanding in terms of interpreting the evidence and forming a view that respected the voice of the child while being useful for professionals. Second, completion was resource intensive, requiring review of the material, interpretation of tool(s) scores, and drafting of the document. Third, presentation of the document caused debate within sites and between sites and AFC, regarding the extent to which it was child centred. After discussions involving AFC and sites, all sites produced their own version, some informed by Children in Care Councils or similar. Broadly, sites simplified AFC's original template, increased the child friendliness by adding images, stickers and so on, and removed or downgraded the prominence of the scores for different measures. Some sites also removed the goals or plan section and the list of meetings that informed the assessment.

Feedback from sites on the completed written outputs came mainly from the five sites that continued delivery to March 2021, the other sites having only completed a handful of

assessments by September 2020. Overall sites were positive about the value of the documents, reporting that they were important as a way of structuring and guiding the assessment process, that they managed to convey the child's perspective and were useful as a way to share that perspective with other professionals. One IRO remarked on the additional information they were receiving about children through the written outputs. Some sites additionally reported that children had responded positively to the process of being listened to and having their perspective written down.

However, evidence from the interviews with the carers and children, and review of those documents, was more mixed. There was some positive feedback on the process and written output but for the majority of the children and carers interviewed the document was not memorable amid all the other interactions with services and paperwork generated as the child entered care. There was some evidence of good practice, including identification of children's likes, who is important to them, the meetings that had informed the assessment, and good use of graphics. There were a number of areas for improvement proposed by the expert panel, including:

- provision of a vivid portrait of the child to introduce the reader to the subject of the document and bring the child's aspirations and needs to life.
- inclusion of the purpose of the document in order to help professionals not involved in the assessment understand why the document contains the information it does, why it is presented in a particular way, how the document is intended to be used, and how it fits alongside other paperwork relevant to the child. For instance, if sites have a parallel formulation intended only for professionals with more detail about measures and scores, that provides important context for understanding the journal/passport
- clarity of scope – similar to the point above on purpose, it would help professionals coming to the documents cold to understand what is not in scope or not included as well as what is. This would allay queries about gaps. For example, if only one issue is identified as causing a child problems, it would be helpful to note this.
- inclusion of goals or a future pathway – the document is not a care plan, but it should indicate the child's aspirations and where intervention is required, even if the detail needs to be worked out at a later date by other practitioners. This is essential to accountability: it provides a set of things against which progress can be checked.
- detail on the process informing the document – as above on purpose and scope, for the professional reading the document, it is helpful to know what has informed the document, for example how many meetings, over what time period, with whom etc.

- a proper balance between detail and conciseness – while hard to strike, there were some examples of issues identified that did not seem to be followed up, for instance a child was recorded as having sleeping problems, but no action was indicated. The lack of detail or follow up in some of these examples may be simply the result of the practitioner's choice about what needed to be presented in the document or due to the practitioner's skillset and ability to identify or follow up on mental health issues.
- better content and presentation of documents for the under-fives, where the voice of the child was much weaker.
- review of the appropriateness of certain formats. For example, one version that was intended to be printed as a booklet was hard to read on a computer screen.

Overall, while the potential for the written outputs remains high, the final products do not match the good practice that the expert panel are aware of from elsewhere. A key concern of the evaluators, given the potential for improvement of the written outputs, is the extent of the supervision provided by the VMHL: as the individual with the strategic view of the pilot and tasked with supporting frontline assessors through the pilot, it might be expected that quality supervision would lead to quality written outputs. There are also questions that need exploring about how this document fits with other documents, for instance the extent to which different documents add value for the child and how the processes for different outputs might be streamlined.

Reflections on the pilot elements

While mentalisation was the underpinning approach for the pilots, the measures, written output and VMHL all played a role in helping to operationalise the mentalisation principles and give shape and substance to the pilot assessment process. The evaluation evidence continues to support the concept of the written output as a guiding factor in the process and a valuable output that should be able to translate the mentalisation process into more tangible outcomes for the child. However, it is clear that work needs to be done on improving the content and form of the documents. The measures are less essential to delivering an effective assessment but nevertheless extremely helpful in prompting consideration of a wide range of issues that may be important to the child's mental health and wellbeing.

On the basis of the evaluation evidence, it is less clear at this point how important the VMHL is to the package. Feedback from sites was universally positive, mainly in terms of their role as a support to frontline assessors. There was limited evidence of the VMHLs' positive impact on the quality of the outputs, which should be a key component of the process in guiding what comes next. It might have been expected that as part of raising quality the VMHL would have picked up and addressed the concerns raised by the expert panel. That this has not happened brings in to question some combination of the

importance placed on these documents by the VMHL; the competence of the VHMLs to support and review these documents; and the impact of VMHLs more generally in raising the standard of assessment and output.

Governance and staffing

Summary

- Local authorities are best placed to manage the pilot because of their role as corporate parent for looked after children.
- Senior stakeholder engagement was welcomed but did not necessarily lead to improved delivery progress due to competition from other priorities.
- In principle, training existing staff such as social workers to deliver the assessment process is more sustainable than bringing in external practitioners. However, high turnover of social workers means there are ongoing requirements to train new staff.
- Limited social worker capacity and high turnover militates against the building of trusted relationships that underpin the assessment process.

The majority of sites opted for a governance structure involving a steering group with a wide membership, encompassing health, social care, education, commissioners and providers, and in some cases care experienced young people and the voluntary sector. The broad membership was helpful: sites indicated it had facilitated improved joint-working between health and social care staff and made problem-solving easier because there was a broader set of experience, skills and contacts available.

There was a mix of senior engagement across the sites, with a couple reporting a high level of interest and at least two sites stating that senior managers were not involved at all. However, sites with a high level of senior buy-in have not made significantly more progress with the new assessment process in terms of throughput or sustainability due to competition with other priorities. For example, one site brought senior social work managers into their Steering Group to explore how social worker time could be protected for the pilot, but this did not noticeably affect engagement from social workers.

On balance, leadership from the local authority has been more valued than leadership from Trusts or CCGs because local authorities have more interaction with and responsibility for children entering care than health bodies. One stakeholder suggested it was more appropriate for a local authority to be managing a pilot for children entering care given their role as corporate parent. Two sites were set up by a health body, but the

local authority took over implementation, which was reported to be a sensible arrangement by site stakeholders. The health expertise could be delivered internally via the VMHL.

> "It was an advantage to be on the inside of the system rather than a health provider shouting from the outside." (Site stakeholder)

The one site that continued to be led by a health body reported struggling to gain profile for their work among senior stakeholders in the local authority and considered this to be a factor in the struggle to ensure sustainability of the pilot.

The majority of sites set aside dedicated project management resource and, in some cases, administrative resource. This resource was reported to be valuable at the set-up stage as pilots were managing multiple demands. The administrative resource was helpful in supporting project logistics and meeting the evaluation requirements to submit monitoring data, provide consents and written outputs.

There were two different approaches to delivery of assessments. A small number of sites brought in additional practitioners to undertake assessments, and this was clearly helpful in increasing capacity and getting assessments completed. Most sites trained existing staff, whether social workers, LAC nurses or similar, to undertake assessments. Sites training existing practitioners experienced a mixed reception to the training, with some practitioners querying the value of the mentalisation approach and measures, whether because of capacity or confidence, and some keen to undertake assessments.

Overall, evidence suggests that the in-house training appears to be the most sustainable option, as practitioners remain in post to continue using their skills and experience. However, with high levels of turnover, particularly among social workers, this should not be assumed. Additional training will be required on a regular basis. One site used their VMHL to continue delivering small, regular training to social workers, but this could not rapidly replace the practitioners that had moved roles as it took time to develop the skills and confidence within practitioners to deliver the mentalisation approach and the measures. It was also an additional responsibility for the VMHL, although one that most of them perceived as part of the role. The other model (bringing in an additional practitioner) had the advantage of being able to demonstrate proof-of-concept, that is what could be achieved with a dedicated practitioner. This site did not have the capacity problems among frontline assessors experienced by other sites, which is likely the reason this was the first site to both deliver completed assessments and complete the most assessments.

Across all sites, even those using CAMHS practitioners, there was an expectation or hope that social workers could be used to deliver this approach, either during the pilot or in the future. However, the monitoring data showed that, while more sites had social

workers in place to undertake the assessments than CAMHS practitioners, in practice more assessments were actually conducted by CAMHS practitioners than social workers. In one site, the explanation given was that social workers were under too much pressure to dedicate sufficient time to the pilot. The site has also reflected on the high levels of turnover among social work teams compared to CAMHS, which militates against the building of trusting relationships that are the foundation of the assessment process and has considered whether IROs might be better placed to deliver assessments.

Learning from implementation

Summary

- Enablers for the pilots included:
  - existing staff, processes and structures that were relevant to the pilot requirements, for example a process for social workers to flag mental health concerns about children
  - engagement from social workers
  - bringing in additional staff to increase delivery capacity
  - involving care experienced children and young people in the design of the template for the written output
  - sharing of learning across sites
  - video-technology where it increased access to or engagement with children and training for staff, and reduced time lost to travel
  - dedicated project management and admin resource that ensured logistical and administrative tasks were completed in a timely fashion.
- Challenges included:
  - longer than anticipated set up, for example due to delays in recruitment
  - problems identifying eligible children
  - adapting the approach to specific cohorts with different needs for example language requirements or abilities
  - uncertainty regarding pilot requirements that took time to work through with AFC
  - capability, confidence, and capacity of social workers, compounded by high turnover meaning continual loss of the knowledge, skills and relationships that underpin effective assessment
  - service level pressures such as Ofsted inspections.

- There was limited evidence of sustainability: while practitioners retained skills acquired during the pilot only one site committed funds to continuation of the pilot approach. This was despite interest in the approach at senior levels in other sites and may be a function of the limited evidence for improved outcomes and competition from other priorities.

This section explores a number of factors have both helped and hindered the introduction of the pilot assessments, which provides useful learning for addressing issues of sustainability and wider rollout.

Enablers

Aside from the pilot funding and support from the AFC-led delivery consortium, a number of factors supported introduction of the pilot changes. First, existing practice within sites typically facilitated the adoption of the new approach as there were **existing staff, processes and structures that were conducive to the pilot requirements**:

- Post-holders already working in sites brought local experience, knowledge and relationships to the pilot. In some cases, sites reported that this helped staff to understand local challenges, build on professional relationships with frontline practitioners and leverage support from other agencies. In one site, there was already a highly experienced and skilled frontline assessor to trial the new approach.
- Existing organisational structures or experience of joint working meant there were already strong links between social care and clinical mental health services, facilitating access to relevant expertise and support. For example, some sites co-located a mental health professional(s) within social work teams. One site reported that having a CAMHS team co-located with social work teams meant social workers were already comfortable with flagging concerns about a child's mental health.
- Existing processes to collect knowledge from the child's network and familiarity with measures other than the SDQ, including some of the tools forming part of the AFC package, reduced the number of new elements of the pilot for some sites, allowing them to focus resources elsewhere.

Evidence from sites indicates that **engagement from staff was probably one of the most critical factors** underpinning pilot implementation, and this was partly a function of their existing interest in and experience of mentalisation or similar practice. Where social workers were sufficiently inspired and committed, they found time to undertake and complete assessments. Senior support was necessary, although not always sufficient, in allowing time to undertake the additional tasks required by the pilot approach.

One evident advantage for delivery of the pilot was **bringing in additional staff to increase delivery capacity.** This was neatly demonstrated by the experience of one site that planned a parallel approach to delivery: one strand would use an external CAMHS practitioner brought in specifically to deliver assessments; a second strand would upskill existing social workers to deliver assessments. Ultimately, the external practitioner was able to complete a number of assessments, whereas the social worker strand made limited progress because their normal responsibilities did not leave sufficient capacity to deliver assessments as well. Elsewhere, the first site to complete any assessments was using an externally recruited practitioner to deliver assessments.

Sites reported four other enablers of their pilots:

- The **use of care-experienced children and young people to design the template for the written output**, which led to most templates being more child-centred and friendly, with several sites that had not involved care-experienced young people adapting a template from a site that had involved these young people in template design (although, as noted earlier, the templates could be improved to provide a more useful output for professionals)
- **Shared learning across sites and between VMHLs** – a number of examples were given including the presentation by an IRO at a programme learning event encouraging other sites to involve their IROs, adapting written outputs, and considering how to best apply some of the tools.
- **Technology** – when the Covid pandemic led to the lockdown, the massive shift to home-working and use of video-technology actually had some benefits including facilitating shorter, more frequent sessions with children (some of whom responded well to the different mode of engagement, perhaps because of reduced stress associated with travelling for an assessment meeting in an unfamiliar institutional environment), improving access to other members of staff who might not often be in the same office (one site reported being able to hold meetings with all Children In Care team managers during the early part of the lockdown), improving access to training where it could be delivered online, an overall increase in productivity because of reduced time lost to travel, and a catalyst for designing a more focused template for the written outputs that worked more effectively on a screen.
- **Dedicated project management and admin resource** was identified by sites as valuable in supporting implementation by ensuring logistical and administrative tasks were completed in a timely fashion and allowing the VMHL to focus on the quality of the assessment process.

Barriers and challenges

Sites faced considerable challenges in delivering the pilot, as evidenced by the low numbers of completed assessments against anticipated completions. To some extent,

low numbers of completions was because the timescale for delivery assessments was curtailed: instead of March 2019, delivery of the assessments did not start until July 2019 at the earliest and some sites were not ready to embark on delivery until October 2019. The Covid-19 pandemic and lockdown restrictions then caused considerable disruption for around three to six months. However, even after delivery officially started, there was slow progress in moving children through the assessment process, meaning that by the time the pandemic hit (twelve months after delivery should have started and around six to eight months after it actually did), only twelve children had completed their assessment process across two sites.

There were a range of reasons for delayed mobilisation. Fundamentally, it took more time for VMHLs to be recruited and in post than anticipated, and for practitioners to be trained in delivering the new assessments. In hindsight, the five-month timeframe for preparation for delivery for all sites was too ambitious.

Another key reason for delayed starts to delivery of assessments and lower than expected throughput was **challenges in identifying eligible children based on the target cohort** selected by the site. Although sites had done some preliminary work for their application to choose which children to focus on during the pilot, for some sites there were lower than anticipated numbers of eligible children. In some cases, although the child fell into the target cohort, other circumstances meant it was not appropriate to include the child in the pilot, for example if they were in an unstable placement. One site had selected children and young people going through care proceedings for their cohort but most of these children were not in sufficiently stable circumstances to undergo the assessment. In general, sites had identified demographic characteristics for their cohort but underestimated or had not considered practical factors like readiness or suitability.

A significant reason for delay in mobilisation was **uncertainty among sites regarding pilot requirements,** for example the number of meetings, duration of assessment, how many tools to use, how to write the journal with the voice of the child, the form and content of the written output, and what counted as completion. The pilot model was intended to set some core principles that could be applied flexibly to myriad real-world scenarios. However, real-world application posed a number of questions that took time to be resolved. AFC issued additional guidance on various aspects of the approach, which were taken on board more fully by some sites than others.

Of course, the **new approach was demanding**, both because the mentalising stance requires emotional commitment from the practitioner and because it was new (to some extent, depending on the site). Earlier assessments thus perhaps naturally took longer than they may if or when the approach becomes more embedded.

Some sites had additional challenges because of the **nature of their cohort**: sites opting to assess under-fives, UASC, and children with particular additional needs had to source

appropriate or translated versions of the measures, consider how to deliver the measures differently, perhaps including use of an interpreter or simply use different tools.

One of the main challenges to ongoing throughput was the **capability and confidence of frontline practitioners,** particularly those with limited experience of mental health work who tended to defer to professionals with clinical expertise. In some cases, social workers were sceptical of the approach, or insufficiently enthused, meaning sites struggled to get them to undertake and complete assessments. Sometimes this was due to a perception among practitioners that the pilot assessment process added to their workload, particularly in terms of having to use the measures and complete written outputs or duplicated their existing work. Other practitioners were unconvinced of the applicability of the approach to specific cohorts. For example, in one site social workers did not see the value of conducting assessments with very young children, particularly weeks old babies, although practical experience of the pilot helped overcome some resistance. While training and supervision were implemented to support frontline practitioners, high turnover among social workers in particular, meant that there was a continual loss of the knowledge, skills and relationships that underpin effective assessment.

Perhaps even more importantly, delivery was challenged by **capacity among social workers.** Sites readily identified that their existing practice was fundamentally challenged by the limited capacity of social workers to adopt different ways of working that might require more time spent with each child. Prior to Covid, social workers reported that they had high caseloads and had to balance the pilot process with other priorities such as safeguarding and court proceedings. The pandemic exacerbated capacity constraints by placing additional pressures on families and placements, leading to increased need and increased complexity of need. The national lockdown complicated social work by compelling social workers to change ways of working to account for social distancing. In some cases, telephone or video contact was convenient and reduced travel time but it also made some children harder to access and engage. Online assessments also changed how a practitioner could learn about a child, reducing visual cues and informal interactions and observations. Completing the assessment was more difficult where it was felt important to have a final face-to-face meeting. Staff also had their own personal concerns during this time such as sickness and caring for family members.

Individual sites also experienced service level challenges such as a poor Ofsted inspection, which led to a programme of improvement that has required extra time from social workers, or a service restructure that reallocated social workers to different teams, affecting who was involved in the pilot.

Sustainability

Overall, the sites reported valuing key elements of the pilot, particularly the mentalisation stance and the VMHL, and to a lesser extent the measures and the written output. However, at the time of writing, it was uncertain that the majority of sites would be able to retain much beyond the individual skills and experience gained by staff involved in delivery and perhaps their specific commitment to using the mentalisation approach and some of the measures.

Of the four sites that exited the programme at the time originally planned, three were unable to continue delivery due to limited capacity: one could not find continued funding for their VMHL, and the other two sites had their staff redeployed on other priorities (related to Covid and Ofsted). The fourth site concluded that an extension would not offer significant additional learning. This site, as well as one of the others, did not perceive the pilot to be sufficiently distinctive and additional to warrant continuation. Both sites already had practitioners with mental health expertise embedded within social work and felt they understood how to undertake child-centred mental health assessment although they did value the introduction to some of the different measures and the inclusion of different members of the child's network to the assessment process. The other two sites were more positive about actively maintaining elements of the pilot approach including the mentalisation stance, network meetings, a written output and the measures but did not have ringfenced resource to do this.

Even the sites that extended delivery to March 2021 did not close with comprehensive sustainability plans, with the exception of one site that had obtained funding from social care to continue with the present pilot for an additional year. This site had particularly high engagement from the Assistant Director for Children's Services. The other four sites were all in the position of trying to obtain commitment from senior leaders in order to elicit support for follow on work, even where senior leaders were genuinely interested in the new assessment approach. Two of these sites had lost their original senior champions, who it was felt might have been able to back up interest with commitment, one was undergoing a service restructure and the other was not as high up on the agenda as other interventions.

In planning for sustainability, the following issues arose for sites:

- Capacity – the new process is clearly more resource-intensive than previous approaches. It also requires more time and willingness to learn and deploy a new set of skills from social workers, who it is widely accepted are struggling with capacity to meet demand. Given limited budgets and multiple priorities, sites reported that they have struggled to make the case for ongoing funding from local budgets. The scale of the pilot and the limited evaluation evidence does not offer much additional support.

Fidelity to the model and quality of delivery – high turnover of staff and limited resources and opportunities for comprehensive, effective training present challenges to ensuring frontline practitioners are able to undertake assessments to a consistently high standard. The VMHL functions as a way to monitor the understanding of practitioners and the quality of the written output but the role would need to be scaled up in proportion to any extension of the process to the entire looked after children population.

Chapter 5: Costs of the new approach

Summary

- The costs questionnaire received a wide range of responses, suggesting some issues with data quality, especially when comparing across sites
- All sites reported that the pilot approach was more resource intensive than standard assessment process
- The additional costs were generated by each element of the pilot approach, including consultation with the child and their network, contact between professionals and producing the written output.

To calculate the cost of implementing the Mental Health Assessment Pilots a questionnaire was sent to the five sites that continued delivery to March 2021. The aim was to measure the difference in costs between the pilot process and the standard process (the assessment that the children would have received if the pilot assessment process was not available).

Availability of data and quality of questionnaire completion varied between sites due to differences in interpretation, understanding and assignment of the costs involved at each stage of the assessment process. Quality assurance of data was restricted because the cost questionnaire was issued later than originally planned (due to slower than anticipated throughput of completed assessments). In particular, the quality of the data collected on set-up costs and non-staff time costs was poor, so these aspects of the pilots are not included in this report.

In addition, the impact of Covid-19 on the programme meant that when the cost questionnaire was issued, there were fewer sites than expected. This further weakened the evidence base as it was then based on a smaller number of observations.

In light of the challenges arising from potentially conflicting site interpretations of the cost questionnaire, the findings below are restricted to:

- Cross-site comparison on the overall delivery cost of the business-as-usual approach compared to the pilot approach
- Review of the cost of each stage under the business-as-usual approach compared to the pilot approach within each site.

The cost findings for the pilot should be considered alongside the other research evidence to gain an informed understanding of the value of the pilot. It was not intended that cost savings would be a key objective of the pilot. Indeed, the Expert Working Group

clearly pointed to the societal cost of inaction and the ethical need for intervention[6] to support the mental health needs of children and young people through the development of a new model. It is also reasonable to expect that, when initiating a new process, additional time and resource will be required to ensure that each stage of the process is delivered as well as intended. In particular, additional costs would be expected from practitioners undertaking more appointments with a child to assess their mental health needs as well as with their wider network. Additional support to produce the written output (wellbeing journals) would be expected as practitioners learn the most effective way to present the child's needs, and spend time securing the agreement of the child on the output.

Once the pilot process is standardised and fully integrated into the care pathway, it could be expected that the cost of delivering the pilot will decrease (as will the time spent on delivery in certain stages). However, monitoring the pilot for a longer timeframe is out with the scope of this evaluation, and as such no comparison with potential future cost savings is possible.

Method

SQW presented the cost questionnaire to all sites during a cross-site call in February 2021. Subsequently, the cost questionnaire was sent to all sites. Sites were supported by SQW site leads to complete and deliver their cost template where required. Where exact information was not available, sites were asked to provide their best estimate. All sites completed and returned their cost questionnaire by early April 2021. Data requested from sites covered the running costs of the pilot and standard assessments, and set-up costs for the pilot process.

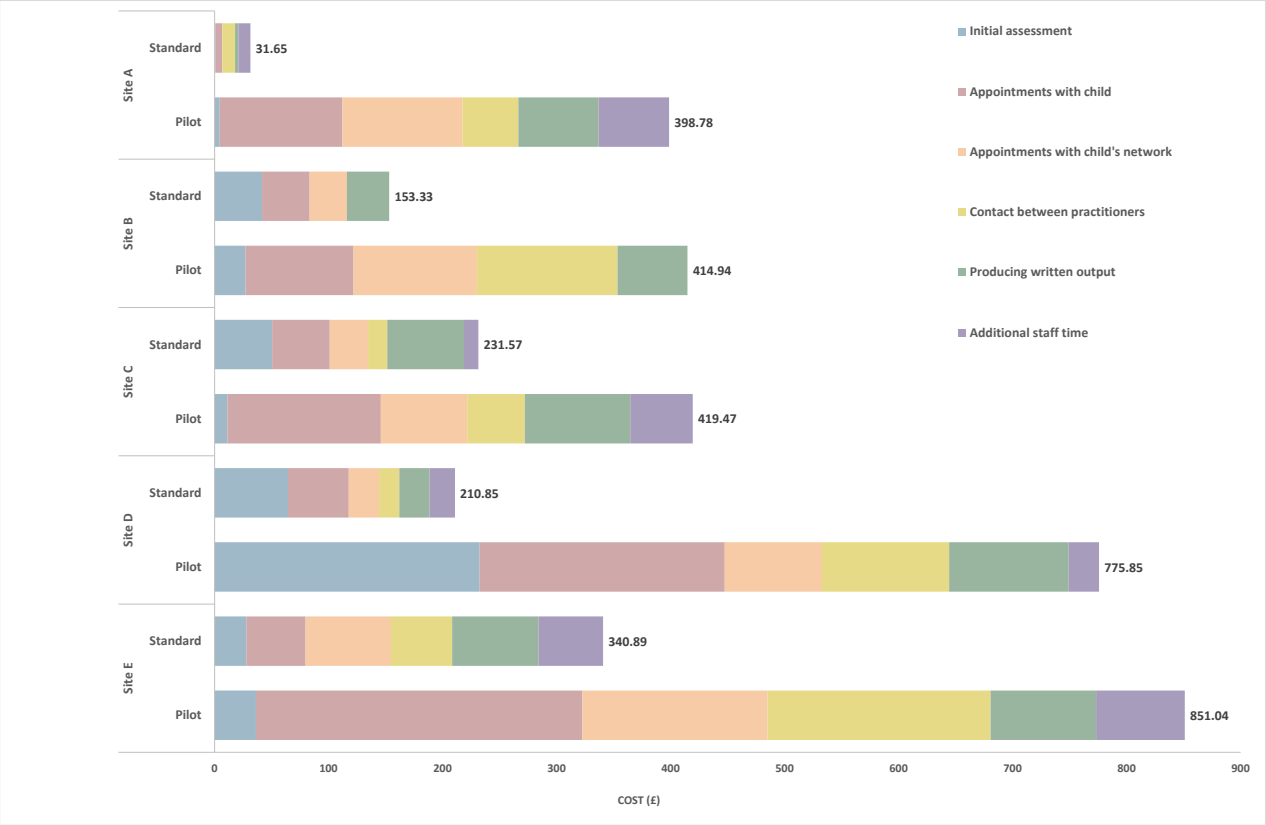
The approach to calculating the cost comparison was the same for all stages of the process. The salary information provided by sites was used to calculate the hourly rate[7] for practitioners. The hourly rate was then used to calculate the cost of the time inputs by each practitioner involved in each stage for each site for both the standard and pilot approaches (e.g., cost per contact, appointment, output, additional time spent). These costs were combined to show the total cost per site for the stage in the standard and pilot approaches.

[6] Social Care Institute for Excellence (2017) Improving mental health support for our children and young people
[7] All calculations were based on a 40-hour working week.

Delivery cost comparison

Figure 2 shows the total delivery cost and cost composition per site, according to the key stages of the standard and pilot assessment process.

Figure 2: Total delivery cost (and cost composition) per site by key stages of the standard and pilot assessment process



Source: SQW analysis of cost questionnaires returned by sites - April 2021

There was a substantial difference in the delivery costs of the standard assessment between sites ranging from £31.65 to £340.89. However, Site A is an outlier, reporting a substantially lower cost for delivering the standard, 'business as usual' assessment compared to other sites, although its estimated costs of the new approach appear in line with the others. This may be one example of a site having a significantly different interpretation of how to report the costs or it may genuinely represent the inputs to the standard process. However, feedback from the site suggests there may be slightly more input to their standard assessment than recorded here.

The range for pilot costs was also large: from £398.78 to £851.04. Within that, Sites A, B and C reported similar pilot delivery costs in the region of £400, while Sites D and E reported slightly higher costs in the region of £800. This is mainly accounted for by Site D recording more contacts with a child before initiating the assessments than other sites,

and both Sites D and E recording more appointments with a child than other sites. Site E's practitioners also spent more time talking to members of the child's network, and meeting with each other about the pilot. Qualitative feedback from sites did not specifically explore the duration of each stage of assessment but the description of their approach corresponds with the findings from the cost analysis that D and E spend particularly long on building trust with the child, reflecting on the process and developing the written output.

Table 4 below shows how the delivery cost of each stage of the pilot assessment compared to the standard assessment. As expected, at every stage of the process across all sites, with the exception of the initial assessment within two sites, the pilot approach cost more than the standard approach.

Table 4: Comparison of the delivery cost difference by site between the standard and pilot approaches by key stages of the process (%)

Stage of Assessment	Site A	Site B	Site C	Site D	Site E
Initial assessment	517	-35	-78	261	30
Appointments with child	1691	128	167	304	451
Appointments with child's network	n/a	230	125	220	116
Contacts between practitioners	338	n/a	200	528	265
Producing written output	2333	65	38	294	22
Additional staff time	474	n/a	328	20	37
Total % change from standard to pilot	**1160**	**171**	**81**	**268**	**150**

Note: A number of sites had time at zero for the standard assessment and thus calculating the cost difference between the standard and pilot assessment was not possible
Source: SQW analysis of cost questionnaires returned by sites - April 2021

While the cost of the pilot was substantially more than the standard assessment process for all sites, it is interesting that there was no stage that represented the largest percentage increase for all or most sites: the overall increase was generated by different increases at various points for each site. Site A is an outlier in terms of the scale of increased cost due to the significantly lower value attributed to their standard assessment.

The main new cost for sites delivering the pilot approach in comparison to the standard approach is the VMHL. Table 5 shows the cost of the VMHL for each site.

Table 5: VMHL salary costs by site (£)

	VMHL salary (£)	Proportion of Full Time Equivalent (FTE) working on the pilot	Cost of VMHL in pilot (£)
Site A	44,606	0.2	8,921
Site B	48,000	0.2 x 2 members of staff	19,200
Site C	35,890	0.8	28,712
Site D	46,845	0.2	9,369
Site E	53,168	0.6	31,901

Source: SQW analysis of cost questionnaires returned by sites - April 2021

Based on the VMHL salary and FTE commitment to the pilot reported by sites, the cost of the VMHL in the pilot ranged from £8,921 to £31,901. The variance was largely driven by the time commitment although there was one site using a more senior professional at a salary of £53k and one site using a less senior practitioner on £36k.

Chapter 6: Outcomes for children and young people

Summary

- There were examples of good practice in gathering information from children and young people in an engaging, child centred way, using a range of approaches. However, this was not done consistently across cases.
- The extent to which assessments led to positive change subsequently was mixed, in part due to limited evidence. Change was most likely where assessments had been shared and in schools.
- There was some concern from the expert panel that important issues flagged in the assessment did not appear to lead be addressed in the actions set out.
- Some carers/families gained greater insight into the scale of issues that children faced.
- Practitioners reported being more confident/ skilled in undertaking assessments.
- There was no evidence that the new approach to assessments had created an evidence base to influence future commissioning.

This section presents findings on the outcomes of the programme for children and young people, their carers/family, the workforce, and services and the health and social care system. Evidence was drawn from interviews with children and young people and their carers, written outputs from assessments for children that were the subject of interviews, feedback from site stakeholders, and the views of the expert panel. The conclusions which can be drawn from these outcomes in terms of the wider, cross-cutting outcomes set out in the logic model are the focus of the next chapter of this report.

To reiterate some of the caveats presented in section 2, the evidence base is limited. The findings are based on self-reported data and feedback from pilot sites and a small amount of evidence directly from carers and children (20 children in total across five sites) who self-selected to participate in the evaluation research. Moreover, some of the carers and children interviewed struggled to clearly recall the assessment process and the written output as distinct from other interactions with professionals as part of the care process. The findings on outcomes, and particularly outcomes for children and young people, should therefore be taken as being indicative of the potential impact of the programme.

Outcomes for children and young people

These outcomes can be divided into two main categories: outcomes resulting from the experience of the assessment process, and outcomes arising following the assessment.

Experience of the assessment process

A key objective of the pilot was for the assessment process to be more child centred. There were a number of examples of carers describing how the process itself was done well, engaging the child through a range of methods, making them feel comfortable and allowing them to express themselves.

> "I think they went about it the right way…the way kids think, and the way [child] has expressed her thoughts, she has been quite open about her thoughts and what her family mean to her. And what makes her happy, what makes her sad." (Child's nana)

These positive experiences were reported by both practitioners and carers as making children feel like they were being listened to.

> "[Child] enjoyed the focused attention…I think it's not like if you normally have an adult come to visit and they chat to the other adults. This adult was interested in them as individuals and wasn't just interested in taking notes and ticking boxes because they didn't see any of that. [The assessor] was interested in them as people. And I think they picked up on that." (Foster carer)

> "I asked [child] how did the assessor help you to feel comfortable and reassure you? And she said, 'well, he listened'. I then asked her, did you feel able to tell [assessor] how you were feeling? And she said, 'yes, I did'. I said, did you feel you were able to be honest? And she said, 'yes, I felt I could just tell him how I was feeling'." (Foster carer)

The expert panel reported that while some the assessments that they reviewed clearly used evidence which had been gathered in a child centred way, others were less convincing, although it was noted that the evidence available for their review (interview transcripts and written assessment outputs) would not necessarily be able to demonstrate such practice. However, there were some examples of good practice to highlight, for example using drawings or other creative methods as appropriate to the child's age and interests to elicit information.

Some carers and children reported that the experience of the process had improved relationships between siblings, or between the child and their carer, or helped the child to understand other relationships in their life.

> "Yeah, I mean, I think one thing that was particularly like, as [child] mentioned, it was helpful for them two, to be speaking in front of each other, of how they were both feeling and kind of, in terms of, you know, understanding each other." (Carer of siblings)

However, even when the process was done well, some carers reported that there was nothing really new that came up and thus no change was made to the support offered to the child. One carer did clarify that whilst most of the information wasn't new,

> "It's nice to put this [the assessment] on paper. Because then other people, other professionals can hear it from the child and not just me, because a child doesn't always open up to a social worker." (Carer)

There was one example of a carer who was very unhappy with the assessment process although it appears that the process was not carried out well and the VMHL was able to work with the carer to rectify it.

> "I nearly cried when I read [the written output]. The social worker clearly had no idea about [child] at all so [VMHL] and I sat down together via Teams and looked at the whole passport together and I was able to input into it." (Carer)

This example related to a very young child, which possibly caused problems for the original assessor in capturing the voice of the child. Generally, the expert panel considered that the quality of assessments for the much younger children was poorer than for older children. The panel still felt there were outstanding issues with this assessment, including a failure to identify any actions or goals for the child or any supportive interventions for the carer such as high quality psychologically informed parenting strategies.

Outcomes from the assessment

The focus of the evaluation was on the assessment process. It was agreed that subsequent receipt of services or support was beyond scope, as these issues were not the focus of the changes sought and subject to wider influences such as the availability of local services. It is also relevant to note that the evaluation did not examine any related documents, such as professional-specific versions (if these existed), to put these child-centred documents in context.

Feedback on outcomes resulting from the assessment findings was mixed. There were some direct positive outcomes reported by carers and practitioners, often because the written output had been shared with others, for example the child's teacher, who was going to take action to support them, or a formal referral had been made, for example for bereavement counselling.

The greatest number of examples of positive outcomes related to schools. In one case the child's school was made aware of sensitivities relating to the way in which families were discussed in lessons to avoid upsetting the child. Another child's school made adjustments to the subject sets to be more aligned with their abilities and provided support with transitions between lessons after the child explained that this was something they struggled with. Carers could not always directly attribute outcomes, including referrals to the written output but felt that the process and document had expedited the referral.

However, the expert panel expressed concern that in some cases there would not be a suitable follow-up to the assessment. In their review they highlighted examples of issues where there was a lack of evidence that relevant action was going to be taken. For example, one child noted in their journal that they had trouble sleeping but there was no suggestion in the document of ways to address the problem. Perhaps more worryingly, the panel queried whether potential signs of conditions such as anxiety, ADHD and trauma may have been missed because remarks about the child's mental state was not matched by a set of relevant actions such as further clinical assessment.

Outcomes for carers/families

It was anticipated that carers/ families would be more satisfied with the assessment process and that they might learn more about any issues the child was facing. There were a few examples of more information being discovered through the new assessment process, including one instance of feedback from a child's school that the child was popular, whereas the foster carer had concerns that the child had no friends. Overall, however, there was limited evidence of outcomes for carers and families except from a few mentions from carers about the value of seeing a practitioner undertake the assessment so that they could learn more about how best to interact with the child.

> "We always closely observe professionals whose strategies are effective. [The assessor] was very skilful so we have we have probably subconsciously rather than overtly taken on board his approach using art in a therapeutic way." (Foster carer)

Some sites reported benefits to carers in terms of easing their anxieties about the mental health of the children in their care, whether because no serious concerns were identified,

behaviours were better understood, or troubling issues were named, and actions selected. A couple of sites were beginning to use carers of children to deliver assessment meetings with those children (as a trusted individual with a stable relationship with the child) and these carers may have improved their understanding of the young person and the state of their mental health.

Outcomes for the workforce

Despite the numerous challenges discussed in section 4, the practitioners interviewed for the evaluations identified positive outcomes for staff involved in the pilots. Many of them stated that they have improved their knowledge and understanding of how to help support young people with their mental health and consequently their confidence in broaching the subject of mental health with young people compared to how they felt before the pilot. Importantly, as noted by one VMHL, having carried out assessments and developing or viewing journals, social workers are likely to have improved knowledge of the mental health status of young people on their caseloads. This placed the social workers in a better position to understand and support the young people in question. The expert panel also concluded that there was good evidence that practitioners were well-trained and competent in using the tools.

Consultees from sites attributed these outcomes to:

- training on the mentalisation approach, which helped social workers to adapt and improve their practice. Even where the mentalisation approach was not new to them, they picked up new theories and techniques from the training. A social work manager stated,

  > "It [the mentalisation training] is quite beneficial as social workers needed to know how to have emotional wellbeing conversations, as these are quite difficult to have, and this helped social workers focus on asking the right questions." (Social work manager)

- reflective supervision from the VMHL, which both frontline practitioners and VMHL described as giving assessors space to think and reflect, and permission to pause from their job and learn
- the tools, which were reported by VMHLs and practitioners to have supported meaningful conversations with young people about their mental health
- the written outputs, which a few staff said were helpful as a way to champion the voice of the child in interactions with other professionals.

Outcomes for services/the health and social care system

Ultimately the expectation was that the pilot would lead to better commissioning of services that more accurately reflect the mental health needs of children in care and more appropriate support available to meet their needs. However, at the outset of the evaluation it was observed that these outcomes were likely to be beyond the timeframe of both the programme and the evaluation.

In practice, outcomes for the wider health and care system from the pilot have been limited, as might be expected given the impression that few actions were taken forward at an individual level. Also, the lack of identified interventions in the majority of assessments was noted by the expert panel, which alongside the small number of cases in the pilot would limit any evidence about future commissioning needs.

That said, the pilot has engendered more and improved joined up working within the health and care systems of sites. Partly this has been through closer working relationships between CAHMS and social care. This was remarked on by consultees in at least two of the sites. One practical outcome was a better sense among social workers about which young people should and shouldn't be referred to CAHMS through multi-disciplinary conversations about the young people on the pilot. The programme has also renewed a commitment to joint working within some sites, having highlighted where it is currently working well and where it could be improved. For one site, the positive reception of the pilot among the workforce was being used to leverage support for co-located, health run provision inside the children in care teams.

Chapter 7: Reflections and learning

This section presents reflections based on the preceding discussion. It examines the extent to which the logic of the programme, as outlined in the theory of change (Chapter 2), was evident through implementation. It concludes with some learning that might be applied to future developments in relation to mental health assessments.

Evidence base

The programme was established with considerable ambition, albeit in a limited number of places and in a fairly limited timetable. The small-scale nature of the pilot, which was reduced even further during the lifetime of the programme, and the consequent scaled back evaluation activity, means the findings and reflections presented herein should be considered as only a preliminary verdict on the pilot approach. The programme generated considerable learning that could be applied and taken forward to refine the key elements and test those in a more robust way than has been possible so far.

Achievements

The programme succeeded in developing a new child-centred approach to the mental health assessment of children entering (and in) care and applying it in a range of circumstances. With one or possibly two exceptions, sites were positive about their own learning from the pilot. In this light, it is somewhat disappointing that only one site is continuing with the pilot largely in its current form. The six other sites with a positive perception of the programme want to retain aspects of the pilot approach but, for various reasons, are unable to do so, apart from allowing participating staff to continuing using the skills and experience they have gained.

It is plausible that given the limited evidence available to local authorities of direct benefit to children and carers, continuation of the pilot with local funding was not deemed to be a priority in a context of tight public funds and other pressing needs. The evaluation found limited evidence on positive outcomes from children and their carers. While the process was mostly done well, there were only a handful of examples of tangible results in terms of referrals or other concrete supportive action. The main visible legacy of the assessment process, the written outputs, were assessed by the expert panel to be mixed quality, with clear scope for improvement in terms of child-friendliness and the coverage of issues, and with insufficient information to be of much use to an outside professional, although they could potentially sit usefully alongside other documents not shared with the evaluation.

In terms of achievement of an assessment process that meets the EWG criteria of thoroughness, quality, accuracy, timeliness and extent to which they are person-centred,

evidence from the children themselves, or their carer, in the form of interviews and their journals, would suggest that some good practice exists but there is considerable scope for improvement. Elements of the approach piloted appear to require further refinement and further evidence is required, at scale, to demonstrate effectiveness.

Pilot effectiveness

The modest success of the programme can be summed up by indicating the partial achievement of most of the interim outcomes identified in the programme theory of change (Table 6).

Table 6: Evidence against outcomes in theory of change

Outcome	Evidence
Assessments are more effective, more timely and more person-centred	A small number of examples of assessments met these criteria but in general evidence is lacking both in the number of assessments that we could review and the content of those which were re-viewed.
Professionals capable of using new approach	Mixed evidence with professionals reporting confidence but other corroborating evidence such as consistently high quality written outputs absent.
CYP feel informed, included, understood, and that they are treated sensitively	Some evidence that this is the case for some but not all of those who could recall, although recall was difficult for the majority.
Families/carers are more satisfied with the assessment process	Some evidence carers are satisfied with the process although accurate recall was difficult for the majority.
Mental health needs of children entering care more effectively identified	Some needs identified but written outputs did not indicate this was done comprehensively.
All professionals involved in care of children better informed of mental health needs	Limited evidence that written outputs were consistently shared although examples of positive outcomes for individuals reported.
Commissioning better informed about mental health needs of children entering care	Small scale of pilot means insufficient information regarding needs of children to provide to commissioners.
Good practice identified to inform wider rollout.	Learning generated by small-scale pilot available to inform further development of model.

Source: SQW

The longer-term outcomes, namely more accurate commissioning of services reflecting children's needs and more appropriate support provided, were outwith the scope of the evaluation.

Learning for further development of mental health assessments

The programme has generated some important learning, particularly about how the various elements of the approach work. The mentalisation stance appears to be important with the other aspects, namely the VMHL, the tools and the written output, functioning as practical ways to operationalise the approach. Broadly speaking, the tools seem to be the least problematic element. It took time for assessors to get comfortable with using them but there was acknowledgement that the right tool for the child can be a useful aid. The written output and the VMHL require further consideration.

In both cases, the concept was widely accepted. However, the written outputs were not always particularly informative, and in some cases struggled to be child centred. There is a lot of good practice about how to produce child-centred documents that could be learned from and applied. It also needs to be clearer how the document from the child's perspective fits with other professional formulations. While the VMHL did seem to play a significant role in supporting frontline practitioners to undertake assessments, and was perceived as fundamental by the sites, the lower than hoped for quality of the written outputs and limited positive outcomes as reported by carers and children means a note of caution should be sounded about the value added by the VMHL. The principles of the role are entirely sensible but how the VMHL meets the strategic aspect of the role in enabling a site to deliver consistently good quality assessments needs to be further developed. This is especially important given the role is a significant additional cost for the assessment process and thus clearly has to demonstrate on-going value for money. Interestingly, some of the reasons for which the VMHL was valued could be understood as support during a trial period, with the VMHL performing a change-agent role. In this light, it could be explored how the VMHL might be adapted in a business-as-usual scenario.

Other aspects for further consideration include:

- How to ensure the workforce, at scale, is trained and supported to deliver consistently good quality assessments, especially given high levels of turnover among social workers.
- How to adapt the assessment process for cohorts with particular needs, such as language and age? Given the limited scale of the pilot, there is still much to work through for children without these additional needs.

- How the approach can be relevant for child during times of instability. The pilot sites only successfully worked with children in stable placements but there is a statutory duty to assess children as they enter care, often a period of instability. The pilot assessment approach might need to be adapted for use with children during a period of instability, given the legal obligation to conduct these assessments for children entering care. As part of the challenge of delivering the process to children during instability was the changing roster of social workers supporting them, there is also a case to consider which professionals are best placed to undertake the assessment, if a stable relationship between assessor and child is viewed as a key element of the assessment.
- The extent to which it would be helpful to be more prescriptive on certain elements of the approach. As a programme, considerable flexibility was extended to sites in their application of the pilot approach. This meant sites were able to adapt it to suit local circumstances. However, there is a challenge in assessing the quality of localised variations, shown by the mixed quality of the templates for the written documents.
- There was a positive response to the range of tools used. At present the SDQ is prescribed. There may be scope to provide more options from which practitioners could choose the most appropriate.
- Likewise, there is a general challenge in assessing the quality of practice within sites. The VMHL helps to ensure the quality of the frontline assessors' work and might be expected to review the quality of assessments as part of this, but there is no mechanism for assessing the VMHL. A couple of the pilots had involved IROs, indeed one pilot had two VMHLs, one of whom was an IRO. Embedding the assessment process within statutory frameworks could be the route to managing quality.
- One of the most significant enablers identified by sites was engagement of the workforce and senior stakeholders, which was linked to their existing interest in and experience of mentalisation or similar practice. In seeking to extend and/or develop the approach, the level of local engagement is likely to be critical to effective implementation and, as such, it is worth considering how this might best be achieved.
- Source of future funding – clearly the costs of the pilot approach are larger than the standard assessment process. Of course, improving the assessment process was not about reducing the cost of assessment. Over time, it might be expected that more effective assessments plus more appropriate interventions will identify problems at an earlier stage and improve outcomes for children and young people, which may reduce service use. However, this is beyond the scope of the evaluation and beyond the recommendations of the EWG, which was concerned with improving the experience and outcomes for children. The experience from the

pilot suggests that given the many pressures on local authorities at the moment they are unlikely to find the resources to invest in the new approach.

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For any enquiries regarding this publication, contact us at:
maura.lantrua@education.gov.uk or www.education.gov.uk/contactus

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