

Business Consultancy Services

Post Project Evaluation of Healthy Happy Minds Counselling and Therapeutic Pilot for Primary Age Pupils

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1. EXECUTIVE SUMMARY

1.1 Introduction

Business Consultancy Service (BCS) of the Department of Finance (DoF) was appointed by the Department of Education (DE) to complete an independent Post Project Evaluation (PPE) of the Healthy Happy Minds (HHM) Counselling and Therapeutic Pilot for Primary Aged Pupils for the period 1st November 2021 to 31st October 2022¹. The following sub-sections set out a summary of findings from each section of this evaluation.

1.2 Programme Background and Scope

International evidence states that experiences of children in their earliest years is key to outcomes in later life therefore, DE has been focusing on the emotional health and wellbeing challenges facing children and young people and how the education system can effectively support them to help build skills needed to adapt to challenges and opportunities that life brings.

In response to this the Primary Schools Counselling pilot is a therapeutic and counselling service available for all primary aged pupils in mainstream primary schools, special schools at primary level and primary Education Other Than at School (EOTAS) provisions. It provides a broad range of therapeutic interventions including counselling, play, drama, music, art and equine assisted therapy aimed at providing one to one or small group support focusing on preventing/reducing mental health issues. No other regional provision is available at primary school level across Northern Ireland however, some primary schools use other funding sources to make counselling and therapeutic interventions available to pupils and have done so for some time.

The proposal to consider introducing counselling and therapeutic services primary school provision has been endorsed by Ministers for some time however, funding for a pilot only became available in 2021 through Covid-19 funding. A total cost of £6.15m was set out in the business case and an addendum. The pilot was operational, during term time, between November 2021 and March 2023.

This evaluation covers the November 2021 to October 2022 period and evaluated if the project was delivered to time, cost, specification and anticipated outcomes and if it managed risk, was governed and generally managed effectively. This report contains information collected from schools for the purposes of monitoring and reporting. It should be noted that the information may not represent all schools who took part in the pilot as some did not submit returns. Furthermore, due to variances in how schools completed the forms the information provided in the report should not be considered as statistically valid, rather the information is intended to be illustrative.

1.3 Strategic Context and Landscape Analysis

The pilot programme is well aligned with a number of relevant strategies and policies including:

1. Draft Programme for Government 2016-2021
2. DE's Corporate Goals for 2020/21 (as set out in their Business Plan)

¹ NOTE: DE had commenced work to commission BCS to conduct the evaluation prior to approval to extend the pilot to 31 December 2022 and then to March 2023.

3. DE's Children and Young People's Strategy 2019-2029
4. Children's Services Co-operation Act (Northern Ireland) 2015
5. Mental Health Action Plan (2020)
6. Protect Life 2 Strategy (2019-2024)
7. DE's Framework for Children & Young People's Emotional Health and Wellbeing in Education (2021)

Therefore, the pilot is considered to be providing a good strategic fit within the wider strategic environment.

Through the HHM provision Northern Ireland is leading the way in helping and improving children and young people's mental health and wellbeing by providing government funding for counselling services for all children in primary school settings. No other region within Great Britain and Ireland offers counselling services in schools for all children within primary schools and special schools – see Section 3.3 Landscape Review.

In Wales government funding is provided to local authorities for pupils in Year 6 and in Scotland from 10 years up. England does not provide any government funding and the Republic of Ireland has just secured funding for a pilot programme scheduled to commence this year.

1.4 Analysis of Programme Activity

The programme development included a range of stakeholders including commissioned procurement expertise, most of the stakeholders engaged throughout the evaluation, see [Appendix 4](#) for full list. Some felt they should be more involved in the development of monitoring and reporting mechanisms for any future provision.

Programme activity included a wide range of services, and these interventions were deemed by stakeholders to be effective in the delivery of HHM pilot.

In terms of outputs, the programme achieved the number of sessions anticipated, however not all schools were able to avail of service provision due to a lack of providers on the framework and this was a particular issue in rural areas due to a lack of tender applications in relation to these areas and the willingness of counsellors/therapists to travel or move from a school where they were already established. Some practitioners found the e-procurement process challenging and feedback from providers who were successful indicated that others in their profession simply weren't aware the e-tendering was taking place. Schools feedback indicated that some framework providers were reluctant to travel to rural areas and some providers indicated fuel costs as one of the reasons for this.

A robust system was established for pilot governance and management however, data returns from schools were slow and feedback from schools indicated that although sub cover was available to support the administrative tasks to be carried out by schools, reporting was an administrative burden; and data submitted from schools was inconsistent. In addition to this it should be noted that teaching unions were operating on an Action Short of Strike basis around the time the reminder was issued for returns to be submitted for the evaluation which is further likely to have impacted on the returns submitted from schools. The pilot lead in time was challenging for EA to develop a procurement exercise while supporting schools initially, however once dedicated staff resources were in place evidence indicates that communications and support improved.

Monitoring and Reporting were appropriate for a pilot of this size and scale. Monitoring forms were updated as some data wasn't included, however, once this was done reporting was satisfactory; as mentioned above although subcover was available to schools it was reported that monitoring and reporting was an administrative burden for schools, and a number of stakeholders have suggested that this would be better placed as a responsibility of the providers in future. As stated, above schools understanding of how to complete the returns varied.

The business case contained a robust risk assessment, however risk associated with the lack of providers on the framework should be considered going forward, particularly in rural areas.

The promotion campaign faced challenges associated with lead in time for funding and pilot extensions. Promotion to children was, in some cases, constrained due to lead in times and uncertainties regarding the timing and level of funding available as was the EA's promotion to providers and schools. Some providers missed attempts to raise awareness of the tendering so were unable to apply.

1.5 Primary Research Findings

The research process for the evaluation captured the views of key stakeholders. Two online surveys were conducted with providers and schools. As well as these consultations took the form of one-to-one interviews and key stakeholders consulted included:

- Client: DE [REDACTED]
- Education Authority: [REDACTED]
- One-to-one consultations with a range of providers including 2 larger providers and 2 sole traders – See [Appendix 4 - List of Consultees](#).

The Review Team planned to gather feedback directly from a sample of parents of children who participated in the pilot from a North Belfast primary school, however, on the day of the virtual workshop none of the parents who had agreed to participate attended. However, secondary parental feedback, gathered by practitioners and shared with the Review Team, is included in the evaluation.

The DE Project Steering Group has considered that it is not appropriate for the BCS review team to engage with children directly as part of the evaluation process. This is because of the age of the primary school children involved and the fact that many of these could be vulnerable children. However, a sample of qualitative evidence gathered by providers, from children participating in the HHM pilot, has been included to provide an indication of their views and outcomes in relation to clinical improvement.

1.5.1 Schools and Counsellors / therapists Surveys Summary Findings

Table 1 – Summary Findings of Schools and Counsellor / therapists Surveys

Section	Summary Conclusions
Strategic context and landscape	It is concluded that the HHM pilot was well aligned with a number of relevant strategies and policies in NI and provides a good strategic fit. Having conducted a high-level landscape review it is concluded that the HHM, as a regional primary school counselling provision, is unique to NI and ahead of the other UK regions and the ROI.
Programme activity	In terms of outputs, the programme did achieve the numbers of sessions as set out in the business case and addendum, however, demand outweighed supply and not all children wishing to avail of services received them due to supply issues.

Section	Summary Conclusions	
	Target Session numbers (Business Case)	Actual Session numbers (Data submitted to DE)
	OBC	4,549
	Extension within OBC tolerance	1,853
	Addendum	1,348
	TOTAL	7,750
		15,976
		15,976
Objectives	<p>It is concluded that HHM has been somewhat effective in achieving the over-arching pilot objectives set in business case. Indeed, responses indicate 60% of practitioners confirmed identification and appropriately referred child protection issues. A lack of provision on the procurement framework (especially in rural areas), difficulty evidencing impact on pupil achievement and data not being captured to measure the identification, progress and resolution of safeguarding / child protection issues* were challenges in fully achieving objectives.</p> <p>The purpose of the HHM pilot, as a feasibility study, was to help DE learn how a larger scale project might work in practice and by highlighting areas for improvement the pilot has been successful in achieving that aim. See Section 4.3 Programme Objectives for full details. It has also been noted that the business case and procurement process were undertaken at pace due to the Covid-19 funding becoming available at short notice.</p> <p><i>*Note: Whilst the objective 'To identify child protection issues at an early stage' was met in full, once a safeguarding / child protection issue is identified the existing processes in place across school settings and within the Education Authority would be the appropriate route for addressing such matters. It would not be appropriate for the HHM pilot to collect information regarding the resolution of safeguarding/child protection matters and to do so may be unethical. This is known only to the relevant agencies and the family. Wording in future business cases should consider the appropriateness of gathering any safeguarding / child protection information.</i></p>	
Governance	<p>The Wellbeing Framework Programme Board oversaw the implementation of the pilot and received progress updates based on monitoring returns data. Formal assurance was also sought in relation to appropriate governance arrangements. Overall, this level of governance is considered reasonable for a pilot of this nature and scale. See Section 4.7 Governance & Management/Staffing for full details.</p>	
Staffing	<p>Staffing arrangements, once in place, appear to be appropriate, however, stakeholder feedback indicated demand for support especially at tendering stage was a challenge. The short lead in time for funding left no opportunity to recruit the Assistant Advisory Officer in time for the pilot commencing. See Section 4.7 Governance and Management/Staffing for full details.</p>	
Monitoring and reporting	<p>Having reviewed the monitoring and reporting, it is concluded that reporting mechanisms were reasonable however issues arose including: slow reporting filtering in from schools; schools indicated reporting was an administrative burden; forms had to be amended as some data categories were missing; there were issues at the design phase regarding monitoring of data; monitoring forms had to be refined and there were issues with getting these forms appropriately completed and returned. Therefore, some data was incomplete, some data sets submitted from schools did not corroborate with others. Issues with monitoring returns are likely to have been impacted by ongoing industrial action. See Section 4.8 Monitoring & Reporting for full details.</p>	
Risk	<p>Throughout the implementation of the programme risk was managed via the production and updating of the Wellbeing Framework specific risk register, in line with good practice.</p> <p>The original business case contained a risk assessment; however, this did not identify the risk or appropriate mitigation measures associated with lack of provision on the framework in some rural areas. See Section 4.9 Risk Management for full details.</p>	

Section	Summary Conclusions										
Promotion	It is concluded that promotion to children and parents by schools was constrained to an extent due to short lead in times relating to the availability of initial funding and pilot extensions. Therapist feedback indicated a lack of understanding in schools of interventions being offered beyond counselling. Promotion to providers was impacted by the short lead in time to funding becoming available. See Section 4.7 Promotion for full details.										
Primary research findings	The primary research process for the evaluation captured the views of key stakeholders, including schools, providers and other stakeholders. Primary research findings indicate that 85% of schools surveyed availed of pilot services and from EA data we know 24% of all primary settings did not avail of services; impact was believed to be positive for children and the wider school community; most schools would be unable to provide counselling without the pilot, provision was an issue for 52% of schools surveyed, particularly in rural areas. Despite the availability of sub cover, monitoring was an administrative burden for schools and promotion was somewhat restrained due to lead in time issues. Importantly, child protection issues were being identified through participation in the pilot. Significantly, 204 child protection issues or disclosure/referrals were made as a result of participation of the pilot (according to monitoring data). See Section 5 Primary Research Findings for full details.										
Stakeholder views	<p>The primary research process for the evaluation captured the views of key stakeholders, including schools, providers and other stakeholders including DE and EA – See Appendix 4 for full list. Primary research findings indicate that 85% of schools surveyed availed of pilot services and from EA data we know 24% of the total number of primary settings could not avail of services. Impact was believed to be positive for children and the wider school community, indeed:</p> <table border="1" data-bbox="459 1010 1386 1435"> <thead> <tr> <th colspan="2" data-bbox="459 1010 1386 1048">Primary Research: Key Impact Stats</th> </tr> <tr> <th data-bbox="459 1057 922 1086">Schools</th> <th data-bbox="930 1057 1386 1086">Practitioners (Therapists/Counsellors)</th> </tr> </thead> <tbody> <tr> <td data-bbox="459 1095 922 1211">96% of respondents strongly agreed/agreed that the pilot enhanced the emotional/mental wellbeing of children who participated.</td> <td data-bbox="930 1095 1386 1211">97% of respondents strongly agreed/agreed that the pilot enhanced the behaviour of the children who participated.</td> </tr> <tr> <td data-bbox="459 1220 922 1337">96% of respondents strongly agreed/agreed that the pilot enhanced the wellbeing of children who participated,</td> <td data-bbox="930 1220 1386 1337">98% of respondents strongly agreed/agreed that the pilot enhanced the emotional/mental wellbeing of children who participated.</td> </tr> <tr> <td data-bbox="459 1346 922 1435">93% of respondents strongly agreed/agreed that pilot positively impacted on the schools who participated.</td> <td data-bbox="930 1346 1386 1435">99% of respondents strongly agreed/agreed that pilot positively impacted on the schools who participated.</td> </tr> </tbody> </table> <p>87% of schools who responded would be unable to provide counselling without the pilot, provision was an issue for 52% of schools surveyed, particularly in rural areas. Importantly, 60% (50 practitioners) of therapists/counsellors surveyed believed child protection issues were identified, or disclosure/referrals were forwarded because of participation in the pilot. This is a positive impact of the pilot as child protection issues were identified at an early stage.</p> <p>Monitoring was an administrative burden and for schools and promotion was somewhat restrained due to lead in time issues. See Section 5 Primary Research Findings for full details.</p>	Primary Research: Key Impact Stats		Schools	Practitioners (Therapists/Counsellors)	96% of respondents strongly agreed/agreed that the pilot enhanced the emotional/mental wellbeing of children who participated.	97% of respondents strongly agreed/agreed that the pilot enhanced the behaviour of the children who participated.	96% of respondents strongly agreed/agreed that the pilot enhanced the wellbeing of children who participated,	98% of respondents strongly agreed/agreed that the pilot enhanced the emotional/mental wellbeing of children who participated.	93% of respondents strongly agreed/agreed that pilot positively impacted on the schools who participated.	99% of respondents strongly agreed/agreed that pilot positively impacted on the schools who participated.
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93% of respondents strongly agreed/agreed that pilot positively impacted on the schools who participated.	99% of respondents strongly agreed/agreed that pilot positively impacted on the schools who participated.										
Economy	Whilst DE spend was considerably below what was anticipated (with a variance of -48%) due to less providers tendering for the framework, HHM did largely achieve the objectives and outcomes it sought to as set out in the original business case. However, there were challenges with children receiving interventions in rural areas. See Section 6.4 Economy for full details.										
Effectiveness	Overall, the pilot was successfully delivered in line with most of its objectives. Evaluation evidence suggests that it largely achieved its original qualitative and quantitative objectives however demand outweighed supply (providers did not tender for all areas). The broad BCS evaluation findings support the view that implementation										

Section	Summary Conclusions
	of the programme by schools has had positive impacts that would not have been achieved in the absence of the pilot. It is therefore concluded that the programme has been somewhat effective. See Section 6.5 Effectiveness for full details.
Efficiency	It is concluded the delivery of HHM represented reasonable efficiency, from a programme implementation perspective. See Section 6.6 Efficiency for full details.

1.5.2 Summary Consultation Summary Findings

Table 2 – Consultation Summary Findings

Heading	Summary
Strategic Fit	DE and EA considered the pilot to be a good strategic fit. See Section 3 Strategic Context and Landscape Review for full details.
Delivery	Procurement law stipulated that a procurement exercise was required, and a procurement framework was subsequently put in place within a tight time frame. See Section 4 Analysis of Programme Activity, Section 5 Primary Research and Section 6 Value for Money for full details.
Impact	DE and EA believed the pilot was very effective in meeting its objectives. Providers believe the pilot impacted positively on children and the wider school community and teachers became more trauma informed. See Section 4 Analysis of Programme Activity, Section 5 Primary Research for full details.
Promotion	The pilot was promoted by schools, DE, EA and providers via a range of appropriate methods. Whilst DE and EA worked to ensure as many providers as possible knew about the tender process some providers indicated they knew of others who missed the tender opportunity as they did not know about it. See Section 4.10 Promotion for full details.
Relationships	Relationships between stakeholders were generally positive and stakeholders worked together to deliver the pilot. See Section 5 Primary Research for full details.
Governance	DE governed the pilot through a Programme Board including risk management. Governance arrangements between EA and DE were informal with meetings on a semi regular basis. See Section 4.7 Governance and Management/Staffing for full details.

1.6 Value for Money Assessment

The Value for Money (VFM) assessment indicates that the HHM pilot was delivered **economically** and projected expenditure was substantially lower than actual expenditure (due to delays in setting up an appropriate procurement framework as required by law and a lack of suppliers on the framework).

The pilot appears to have been **effectively** delivered and achieved most of its objectives. However, demand outweighed supply especially in rural areas. Due to the many factors impacting underachievement, it was not possible to identify evidence to determine if the specific HHM intervention reduced underachievement and improved the life chances of young people.

Findings suggest that the pilot has also been delivered **efficiently**. Counselling and therapy ran successfully and resulted in positive impacts for the children involved as well as their wider school communities that would not have been achieved in the absence of the pilot.

On the basis of the totality of the evidence gathered over the course of the evaluation it is concluded the delivery of HHM pilot represented good value for money as, in terms of effectiveness it achieved most objectives, in relation to economy it was within budget and management costs were within 20% indicating it was reasonably efficient.

1.7 Conclusions

The following table sets out the conclusions as per each of the original TOR for this evaluation:

Table 3:- Conclusions against original Terms of Reference

Terms of Reference	Conclusions
1. To ensure that primary pupils have access to a consistent, high quality counselling provision.	<ul style="list-style-type: none"> • Target: <i>100% of primary pupils wishing to avail of counselling will be able to. Partially Achieved:</i> 24% of the total number of primary settings did not avail of HHM services and schools surveyed believe this was due to a lack of provision. This was corroborated by other evaluation evidence. It should be noted that a number of schools already provided similar provision and therefore did not avail of the HHM services. • Target: <i>A variety of counselling models including at a minimum talking, art, music and play-based therapies. Achieved:</i> A variety of counselling models was delivered. • Target: <i>An independent evaluation of the quality of counselling sessions. Achieved:</i> This report is the output of an independent Post Project Evaluation. In terms of the quality of sessions, this was considered as part of the evaluation and was based on information as reported by schools and therapists / counsellors. • Target: <i>Measure the impact on both the children and the school staff. Achieved:</i> Impact was measured on both the children and the wider school community.
2. To reduce under achievement and improve the life chances of young people by enhancing their educational development and fostering their health, wellbeing and social inclusion.	<ul style="list-style-type: none"> • Target: <i>Measurable data will be collated to confirm achievement levels compared to peers and prior to interventions. Not Achieved:</i> Due to the many factors impacting underachievement, it was not possible to identify evidence to determine if the specific HHM intervention reduced underachievement and improved the life chances of young people, and stakeholders unanimously agreed evidencing a difference in achievement levels as a consequence of therapeutic services was not possible due to the many factors impacting underachievement. • Target: <i>Guidance is provided to schools, informed by the ICSS Post Primary Handbook. Achieved:</i> DE produced a guidance document which was issued to schools and available on the EA website.
3. To identify child protection issues at an early stage.	<ul style="list-style-type: none"> • Target: <i>Collation of measurable data from schools to confirm that child protection issues have been identified, progressed and resolved. Achieved:</i> Measurable data was collated via the monitoring reports, relating to the number of referrals raising "Safeguarding Concerns", however no data was captured on how these issues were "progressed and resolved". <i>*Note: Whilst the objective 'To identify child protection issues at an early stage' was met in full, once a safeguarding / child protection issue is identified the existing processes in place across school settings and within the Education Authority would be the appropriate route for addressing such matters. It would not be appropriate to collect information regarding the resolution of safeguarding/child protection matters and to do so may be unethical. This is known only to the relevant agencies and the family. Wording in future business cases should consider the appropriateness of gathering any safeguarding / child protection information. All child protection issues were addressed as per the DE guidance².</i>

² Safeguarding and Child Protection in Schools - A Guide for Schools | Department of Education (education-ni.gov.uk)

1.8 Recommendations

Listed below are a number of BCS recommendations that have been proposed as a result of the evaluation of the HHM programme.

Table 4:- Recommendations

Heading	Recommendations
Monitoring and Reporting	<p>Recommendation 1 – Monitoring Design to include key stakeholders. All key stakeholders should be involved in the design of monitoring processes for any future provision.</p>
	<p>Recommendation 2 – Monitoring responsibilities to sit with providers. Service providers should be responsible for submitting monthly monitoring returns to EA, similar to roles and responsibilities within the ICSS provision, to ensure robust monitoring information is available throughout any future provision and to reduce the administrative burden for schools. The Review Team also recommend that future provider contracts include targets in relation to monitoring data to improve Management Information evaluation robustness.</p>
	<p>Recommendation 3 – Maintain electronic monitoring records only. Monitoring returns should be submitted to EA in online format only. Hardcopy returns should only be accepted in exceptional circumstances and transferred to electronic format.</p>
Risk Management	<p>Recommendation 4 – Greater focus on risk at Business Case stage. The risk associated with the lack of provision on the framework in some areas for this broad range of counselling and therapeutic approaches at primary school level should be included in the Business Case risk assessment for any future provision.</p>
	<p>Recommendation 5 – Rural Proofing. A rural proofing exercise should be conducted in alignment with the statutory requirement to rural proof any future primary school counselling provision.</p>
PR	<p>Recommendation 6 – Promote any future provision in advance of commencement. Any future provision is promoted to providers with as much advance notice as possible prior to tendering to attract a greater response with the view to securing more providers.</p>
	<p>Recommendation 7 – Build understanding in schools settings. EA should build understanding in school settings of therapeutic provisions being offered, beyond talking therapies.</p>
Governance	<p>Recommendation 8 – Conduct routine DE/EA meetings until any future programme is embedded. Routine meetings should take place between DE and EA until any future programme is embedded.</p>
VFM	<p>Recommendation 9 – Procurement framework should be more dynamic and include provider support at tender stage. A more dynamic framework arrangement is used for any future provision i.e., with entry points to add providers during the contract duration and include support for providers at tendering stage in line with procurement rules and process.</p>
	<p>Recommendation 10 – Explore workforce expansion. DE should continue their work with universities, professional associations and other relevant stakeholders to explore expansion of this profession / workforce to meet the needs of any future provision.</p>
	<p>Recommendation 11 – Consider if the impact on achievement is a key objective for any future programme and if so, develop a mechanism to measure the impact of therapeutic services on achievement. DE should consider the feasibility and value of including the impact of therapeutic services on achievement as a measurable objective, and if necessary, develop a mechanism to measure the impact of therapeutic services on achievement.</p>

Heading	Recommendations
	<p>Recommendation 12 – Training for providers on EA specific safeguarding policy and procedures. EA should train providers in EA specific safeguarding policy and procedures. (It is noted that at the time of reporting EA were planning for this to commence).</p>
	<p>Recommendation 13 – Include in-house management costs in Business Case for any future provision. DE should include in-house management costs in the Business Case for any future provision to reflect the total costs to department.</p>
	<p>Recommendation 14 - Consider merging primary and post primary counselling/therapeutic provisions. DE should give consideration to aligning primary provision with the post-primary ICSS provision as a single point of access providing tailored primary and post primary support, with the view to reduce running costs and ensure greater joined up provision, complementing the draft PFG around strategic planning for joined up action.</p>

2. INTRODUCTION

2.1 Introduction

In October 2022, the Department of Education (or the Department) commissioned Business Consultancy Service to complete an independent Post Project Evaluation (PPE) of the Healthy Happy Minds (HHM) Counselling and Therapeutic Pilot for Primary Aged Pupils for the period 1st November 2021 to 31st October 2022³.

2.2 Background and Context

The Primary Schools Counselling pilot is a therapeutic and counselling service pilot launched by the Minister for Education in November 2021, originally operating to the end of March 2022. The pilot was extended to December 2022 and then again to March 2023 as a result of two separate Ministerial Directions. These further periods are not covered in this evaluation. This counselling service pilot is available for all primary aged pupils in mainstream primary schools, special schools at primary level and primary Education Other Than at School provisions.

Alongside counselling, the pilot provides the opportunity for a broad range of therapeutic interventions including play, drama, music, art and equine assisted therapy.

This pilot was proposed at a time when schools were (and continue to be) under significant pressure supporting the emotional health and wellbeing needs of their pupils. This pressure has intensified with the impact of the Covid-19 pandemic with the closure of schools, academic uncertainty and restricted contact with support networks. This is especially so at primary school level in the absence of an equivalent to the post primary Independent Counselling Service for Schools (ICSS).

The ICSS has been available to post primary pupils since 2007 and a commitment was made by the Education Minister in 2014 to roll out a counselling model to primary schools' pupils by extending the current ICSS model. This priority for primary school counselling has been long endorsed by subsequent Ministers, however, due to financial constraints funding was not established. In 2021, funding was provided for the pilot from Covid-19 ring-fenced funds provided through the Department of Finance, however with school closures due to the pandemic, funding was not made available until November 2021.

DE has been focusing on the emotional health and wellbeing challenges facing children and young people and how the education system can effectively support them to help build skills needed to adapt to challenges and opportunities that life brings. This is based on international evidence which states that the experiences of children in their earliest years is key to outcomes in later life.

In 2017, the DE commissioned the National Children's Bureau to undertake research to:

1. Identify the main challenges, threats and risks to children and young people's emotional health and wellbeing;
2. Establish the most effective interventions to support children and young people's emotional health and wellbeing; and

³ NOTE: DE had commenced work to commission BCS to conduct the evaluation prior to approval to extend the pilot to 31 December 2022 and then to March 2023.

3. Produce proposals for a draft framework and its implementation.

This research was presented to the Department in May 2019 and DE worked collaboratively with other Government departments and agencies to develop a framework for Children and Young People's Emotional Health and Wellbeing in Education⁴, published in February 2021.

The overall aims of this framework are:

1. To ensure that children and young people are empowered and assisted to take care of their emotional health and wellbeing;
2. That their needs are met early and effectively when required;
3. To establish an integrated model that supports an early help, support and intervention focus on children's emotional health and wellbeing needs; and
4. That fewer numbers of children and young people will require specialist intervention from Mental Health Services.

In implementing the Framework, a number of key interventions have been identified which reflect the Cross Governmental and multi-agency approach being taken. Each intervention is aligned to the Framework under a range of support strands including training, awareness and capacity building for education staff as well as support for the children and young people themselves. The counselling pilot has been developed as part of a range of measures to support the framework's implementation.

The aim of the pilot was to provide a universal/whole school support for primary school age pupils with a focus on preventing/reducing mental health issues. Whilst many primary schools provide counselling support from within their own resources (whether through their Common Funding Formula, Targeting Social Need (TSN) funding or the Extended Schools Programme), this pilot was introduced for the 2021/22 year across all primary schools and primary cohort of Special Schools and EOTAS with the availability of Covid-19 specific funding through the Department of Finance. The total cost of the pilot in 2021/22 set out in the original business case was £4,994,064⁵, see [Appendix 3](#).

2.3 Terms of Reference

The Terms of Reference (TOR) for this evaluation were to:

1. Evaluate if the project was delivered to time;
2. Evaluate if the project was delivered to cost;
3. Evaluate if the project was delivered to specification;
4. Evaluate if the project has delivered anticipated outcomes;
5. Evaluate if the project effectively managed risk; and
6. Evaluate if the project was effectively governed and managed.

2.4 Programme Scope

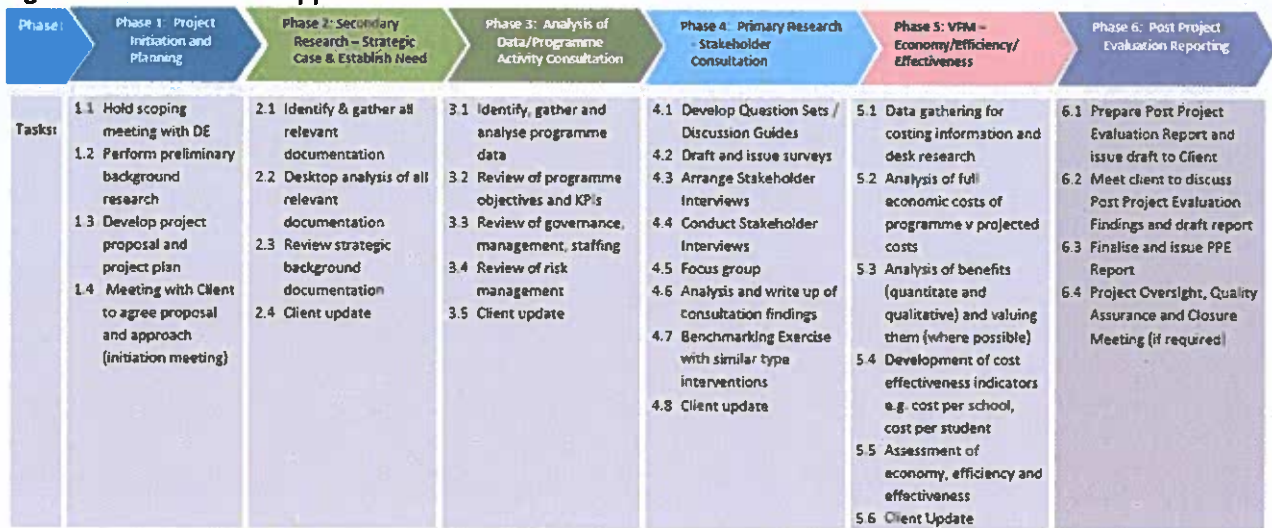
The scope of this project was an evaluation of the pilot covering the period from November 2021 to the end of October 2022 however, the pilot was operational, during term time, between November 2021 and March 2023.

⁴ <https://www.education-ni.gov.uk/articles/emotional-health-and-wellbeing>

⁵ OBC Primary School Counselling Pilot 2021-22

2.5 Approach

Figure 1:- Overview of Approach



2.6 Acknowledgements

BCS would like to thank the Project Steering Group for its insight, oversight and guidance during this evaluation. BCS would also like to thank the wide range of stakeholders who took part in interviews and surveys to inform the evaluation. A full list of stakeholders consulted with is included in [Appendix 4](#).

3. STRATEGIC CONTEXT & LANDSCAPE REVIEW

3.1 Introduction

This section sets out the background to the development of the Primary Schools Counselling pilot, it identifies the legislative framework that underpins the pilot and establishes the ongoing strategic fit with wider Government policies and strategic needs.

3.2 Strategic Context Analysis

The following table provides a summary of the strategic context analysis.

Table 5:- Strategic Context Analysis

Strategy Document	Overview	Analysis of strategic fit
3. Draft Programme for Government 2016-2021	The 2016-2021 Draft Programme for Government focuses on 14 strategic outcomes supported by 42 key indicators which when taken together, the Executive believes best describes the society we wish to have. Outcome 4 states that “We enjoy long, healthy, active lives” and one of the indicators within this is <u>improving mental health</u> . Another Strategic Outcome (12) is that “we give our children and young people the best start in life”, also supported by the key indicator of improving mental health.	The primary schools counselling pilot directly aligns to the outcomes 4 and 12 of the Draft Programme for Government as it provides a high-quality counselling/therapeutic service for all pupils in a primary school setting. The programme aims to prevent, reduce and improve mental health amongst primary school children.
4. The Department of Education Corporate Goals for 2020/21 (From the Department of Education Business Plan 2020/21)	The Department of Education Corporate Goals for 2020/21 all support the wellbeing of children and young people in education and include: <ul style="list-style-type: none"> • Supporting vulnerable children and young people, including children with special needs; • Increasing access and improving the learning environment for all; and • Raising standards and tackling underachievement to ensure learners get the best possible education. 	The primary schools counselling pilot directly contributes to the Corporate Goals as it ensures that a high quality, professional and independent counselling service is available and provided to all pupils in mainstream primary schools, special schools at primary level and EOTAS provisions. The pilot’s aim is to reduce under achievement and improve the life chances of these young people by enhancing their educational development and fostering their health, wellbeing and social inclusion.
5. The Department’s Children and Young People’s Strategy 2019-2029	The Department’s Children and Young People’s Strategy ⁶ 2019-2029 aims to improve the wellbeing of all children and young people by providing effective services to support those children and young people who are flourishing so that they can continue to be the best they can be. For those children and young people who are more vulnerable,	The primary schools counselling pilot aligns with this strategy as it offers an effective counselling/therapeutic service for all children in all primary school settings including those who are very vulnerable and are experiencing difficult

⁶ <https://www.education-ni.gov.uk/sites/default/files/publications/education/2019-2029%20CYP%20Strategy.pdf>

Strategy Document	Overview	Analysis of strategic fit
	<p>have fewer opportunities or who are experiencing difficult circumstances and challenges in their lives, this strategy commits to provide the extra help and support they need to achieve their maximum potential.</p>	<p>circumstances and challenges in their lives. The pilot offers extra help and support which will improve their health and well-being and enhance their educational outcomes.</p>
<p>6. The Children's Services Co-operation Act (Northern Ireland) 2015</p>	<p>On 22 January 2020, the Executive announced the establishment of a new Executive Working Group on Mental Wellbeing, Resilience and Suicide Prevention with a clear commitment across the Executive to joint working to improve mental wellbeing. It was recognised that this would require a strategic, co-ordinated and sustained approach across government departments (which is in line with the requirement of the Children's Services Co-operation Act (Northern Ireland) 2015, and a duty on government departments and agencies to improve the wellbeing of children and young people⁷).</p>	<p>The primary schools counselling delivers a service aimed at improving the well-being of children and young people though working along with other government agencies.</p>
<p>7. Protect Life 2 Strategy (2019-2024)</p>	<p>The Protect Life 2 Strategy⁸ highlights that suicide is preventable and stresses the importance of services, communities, families and society working together to help prevent suicides. This includes the promotion of universal mental health in schools and emphasising the benefits of a broader positive mental health approach focussing on strengthening pupil's self-esteem and emotional resilience.</p>	<p>The primary schools counselling pilot contributes to this strategy as schools are provided with a service that provides interventions to promote positive mental health and help strengthen self-esteem and emotional resilience.</p>
<p>8. Mental Health Action Plan (2020)</p>	<p>The Department of Health has published a Mental Health Action Plan⁹ which includes a response to the impact of the COVID-19 pandemic, recognising that closure of schools, academic uncertainty, restricted contact with support networks and increased exposure to social media and 24/7 news outlets are all likely to have an adverse effect on the mental health of children and young people both now and in the future. The Action Plan references the expectation of a surge in referrals to Child & Adolescent Mental Health Services (CAMHS), due to the negative impacts of the pandemic, noting that it is important that children and young people know how, where and when to get help.</p>	<p>The pilot contributes to the Plan as it provides an effective counselling/therapeutic service which is available for all pupils in the primary school setting. The service is promoted within the school settings, so pupils and parents are aware of the service and know where and when to get help. The pilot's aim is to provide help prevent and reduce mental health issues in the long term and reduce the number of children and young people who will require specialist intervention from Mental Health Services.</p>
<p>9. DE Framework for Children & Young</p>	<p>In specific response to the prevailing circumstances and issues facing children & young people, and those working with them, DE has been working collaboratively with</p>	<p>The primary schools counselling pilot is aligned to the DE Framework for Children and Young People's Emotional Health</p>

⁷ <http://www.legislation.gov.uk/ni/a/2015/10/contents>

⁸ <https://www.health-ni.gov.uk/sites/default/files/publications/health/pl-strategy.PDF>

⁹ <https://www.health-ni.gov.uk/sites/default/files/publications/health/mh-action-plan-plus-covid-response-plan.pdf>

Strategy Document	Overview	Analysis of strategic fit
<p>People's Emotional Health and Wellbeing in Education (2021)</p>	<p>other Government departments and agencies to develop a Framework for Children & Young People's Emotional Health and Wellbeing in Education¹⁰ which was published in February 2021. The overriding aims of the Framework are:</p> <ul style="list-style-type: none"> • To ensure that children & young people are empowered and assisted to take care of their emotional health and wellbeing; • That their needs are met early and effectively when required; • To establish an integrated model that supports an early help, support and intervention focus on children's emotional health and wellbeing needs; • That fewer numbers of children and young people will require specialist intervention from Mental Health Services. 	<p>and Wellbeing in Education (2021) as the pilot provides a quality counselling/therapeutic service for all pupils in a primary school setting which will assist to take care of their emotional wellbeing at a young age. The counselling/therapeutic service ensures that the pupils needs are met early and provides a broad range of counselling/therapeutic techniques such as play, art, drama, music and equine which are chosen depending on the age and developmental stage of the child and their emotional health and wellbeing needs.</p>

3.3 Landscape Review

Currently Northern Ireland (NI) is leading the way in helping and improving children and young people's mental health and wellbeing by providing government funding counselling services for all primary aged children through the pilot programme. No other region within Great Britain and Ireland offers counselling services in schools for all children within primary schools, special schools and EOTAS settings.

In **Wales**, the government provide funding to all local authorities to ensure that all children and young people in Year 6 in primary school and throughout secondary school have access to a counselling service in school. The provision does not apply to younger children in primary schools therefore they need to provide their own counselling services or are signposted to independent services for counselling. The Welsh government are making recommendations to embed a whole school approach for counselling which will include nurseries, primary schools and special schools¹¹.

Scotland is similar to Wales and provides state funding for high quality and effective counselling support to primary, secondary and special schools pupils from 10 years up. However, the Scottish government is continuing to make recommendations to improve the ability of primary schools and special schools to have access to counselling services¹². The Scottish government is also implementing a whole school approach framework to support children and young people's mental health and wellbeing.¹³

England is lagging behind the rest of Great Britain and currently does not provide any government funded counselling in primary or secondary schools. However, there are calls for state funded school counselling due to the provision existing in Scotland, Wales and Northern Ireland.

¹⁰ <https://www.education-ni.gov.uk/articles/emotional-health-and-wellbeing>

¹¹ [school-and-community-based-counselling-operating-toolkit.pdf \(gov.wales\)](https://www.gov.wales/school-and-community-based-counselling-operating-toolkit.pdf)

¹² *Mental health services for schools in Scotland: Mentally Healthy Schools*

¹³ www.gov.scot/publications/whole-school-approach-mental-health-wellbeing

Even though not all children in primary schools in Scotland, Wales and England have access to mandated school counselling, a national charity school counselling service Place2be¹⁴ works with primary and secondary schools to provide a series of interventions to aid children's mental health.

Republic of Ireland (ROI) currently have no provision for in-school counselling in primary schools however, the Irish government have agreed to fund a €5 million pilot programme for counselling services in primary schools, to commence in September 2023¹⁵.

After reviewing the current landscape of primary school counselling in Great Britain and the Republic of Ireland, the HHM programme appears to represent a leading-edge approach in Northern Ireland. Indeed, Northern Ireland is leading the way for providing vital support for improving mental health and wellbeing for children and young people and other regions within Great Britain and the Republic of Ireland are following suit and hoping to provide a similar government supported interventions for children and young people.

Research published in the **European Child and Adolescent Psychiatry Journal** (2021) states a key finding that *"a one-to-one counselling intervention delivered to children in UK primary schools leads to improvements in children's mental health above and beyond that observed in a matched comparator group of children. These improvements in mental health were maintained over a 2-year follow-up period."*¹⁶ This research suggests that counselling children and young people in primary schools is effective in reducing children's mental health difficulties and maintaining this improved mental health in the longer term. This research highlights the importance of the pilot programme as its aim is to provide early intervention in primary schools to reduce mental health issues in the long term and reduce the number of children and young people who will require specialist intervention from Mental Health Services.

3.4 Summary and conclusions

Having reviewed the strategic context it is evident that the pilot programme is well aligned with a number of relevant strategies and policies and provides a good strategic fit within the wider strategic environment. Having reviewed primary schools counselling provision in other GB regions and the ROI, it is apparent that NI is leading the way by providing funding for primary school counselling.

¹⁴ Improving children's mental health in schools – Place2Be

¹⁵ In-school mental health counselling for primary pupils on the way in ground-breaking initiative - Independent.ie

¹⁶ <https://link.springer.com/article/10.1007/s00787-021-01802-w>

4. ANALYSIS OF PROGRAMME ACTIVITY

4.1 Introduction

The purpose of this section is to set out the operational context of the Healthy Happy Minds Counselling and Therapeutic Pilot and assess the effectiveness of its operational delivery. This draws on key factual information relating to the programme activity during the period under evaluation.

4.2 Programme Development

The following table provides a high-level summary of the Primary Schools Counselling Pilot development process.

Table 6:- Primary Schools Counselling Pilot development

Period	Developments
2007	ICSS available to post primary schools
2014	Education Minister commits to roll out counselling model to primary schools
2017	National Children's Bureau conducted research (to identify the main challenges, threats and risks to children and young people's emotional health and wellbeing; the most effective practice and produce proposals for a draft framework and its implementation)
2019 - May	Research ¹⁷ presented to DE
2019 - May	DE commence work with the Department of Health, Public Health Agency, Health & Social Care Board and the Education Authority to develop Children and Young People's Emotional Health and Wellbeing in Education Framework
2021 - Feb	Children and Young People's Emotional Health and Wellbeing in Education Framework published
2021 - June	Original Business Case (OBC) approved (for 1 September 2021 to 31 March 2022 period)
2021 - Oct	BC Addendum 1 approved (still within limits due to an underspend) extending the pilot from 1 April 2022 to 30 June 2022
2021 - Nov	Funding available
2021 - Nov	Pilot launched
2021 - Nov/Dec	EA procurement exercise
2022 - Feb	HHM Framework in place
2022 - Aug	BC Addendum approved following a Ministerial decision extending the pilot from 1 Sept 2022 to 31 Dec 2022
2022 - Sept	Independent Post Project Evaluation commenced for completion in June 2023
2023 - March	Pilot completion. Note: this evaluation covers the period November 21 to October 22 only.

4.3 Programme Objectives

The following table sets out the objectives for the pilot programme as set out in the original business case (June 2021).

¹⁷ <https://www.education-ni.gov.uk/sites/default/files/publications/education/informing%20the%20development%20of%20an%20emotional%20health%20and%20wellbeing%20framework....pdf>

Table 7:- Programme Objectives

Objective	Target
1. To ensure that primary pupils have access to a consistent, high quality counselling provision.	1. All primary pupils (including those in Special Schools & EOTAS) will have access to counselling provision. 100% of primary pupils wishing to avail of counselling will be able to avail of it (where it is clinically appropriate).
	2. A variety of counselling delivery models will be provided, given the age and range of ability/competence of the children concerned. This will include at a minimum talking, art, music and play-based therapies.
	3. An independent evaluation of the quality of counselling sessions will be undertaken.
	4. Measurement of the impact on both the children and the school staff as a result of this intervention being available will be undertaken.
2. To reduce under achievement and improve the life chances of young people by enhancing their educational development and fostering their health, wellbeing and social inclusion.	5. Measurable data will be collated to confirm achievement levels and compared not only to peers but to themselves based on earlier performance.
	6. Guidance will be provided to schools to assist them in securing appropriate and quality provision for their needs, informed by the ICSS Post Primary Handbook.
3. To identify child protection issues at an early stage.	7. Measurable data will be collected from schools to confirm that child protection issues have been identified, progressed and resolved.

4.4 Data gathering and data sources

Monitoring data was captured throughout the pilot from reporting and monitoring mechanisms included in the pilot guidance as follows:

- a) **FORM A: Monthly Monitoring Returns (MMR) from the schools**
- b) **FORM B: Counselling Evaluation Forms from the providers**

Forms are available at [Appendix 6](#).

The forms were developed by DE in line with British Association for Counselling and Psychotherapy (BACP) advice on recommended outcome measures for evaluation.

Form A: The purpose of this return was to provide a clear quantitative and qualitative evidence base to determine the appropriateness of an independent counselling and therapeutic service for primary schools on a permanent basis going forward, subject to securing the necessary resources.

Schools collected data about the service provided including:

- Numbers of children attending sessions;
- Number of sessions per child;
- Stage of the child - Foundation/Key Stage 1/Key Stage 2;
- Reason for referral - presenting and other issues raised in counselling session e.g., domestic violence, abuse, neglect;
- Gender of the child;
- Number of referrals to other agencies; and
- The immediate impact of counselling/therapy for the pupils and the broader impact within the school.

EA provided schools with online guidance for the completion of the Monthly Monitoring Returns¹⁸.

Returns were submitted by the school's Key Contact by the second Friday of the following month on which schools were reporting or in bulk at the end of the pilot. Returns were to be submitted to EA online via Google Forms however, a small number of schools provided returns in hardcopy.

Form B: This form was completed by the counsellors/therapists and returned to the school's Key Contact upon completion of the counselling intervention. The form includes a Strengths and Difficulties Questionnaire (SDQ) devised to assess the child's state of wellbeing at the start of each session and at the end. This was designed in line with good practice and professional standards, to be a collaborative approach between the parent/carer, school, counsellor/therapist and could include the child depending on their age/stage.

This was then included by the school with the relevant monthly return to EA via completion of a Whole School Evaluation Form¹⁹. EA also provided online guidance for the completion of the Whole School Evaluation Form²⁰.

The SMT and Key Contact worked with the counselling/therapy provider to agree and set out how the intervention worked within the school including the names of key personnel, the level of service to be provided, the process for making referrals and the evaluation process.

Early in the pilot the guidance was updated as providers raised concerns that some of the standard categories' children could present for intervention with were not included in Form B. The form was updated accordingly, and updated guidance was issued in January 2022.

The Review team analysed Form A and B returns submitted between 1st November 2021 and 31st October 2022 for this evaluation.

Note on Form A & B: It is important to note that analysis of data DE provided from schools indicated that some forms were incomplete and there may have been variance in how those completing the form interpreted the questions, therefore, not all data sets will corroborate with each other. In addition to this, the forms were updated after the first few months of use therefore, early data contains slightly less information compared to later data.

4.5 Programme Outputs (Form A)

The programme was available to all 836 primary settings (795 primary schools, 35 special schools and 6 EOTAS) and 634²¹ no. (or 76%) availed of the HHM services. This means 202 no. (or 24%) did not, feedback from school suggests this was for various reasons including:

- Lack of providers, especially in rural areas; and
(52 of 53 school survey respondents provided this reason)
- Lack of pupils wanting to use the service.
(1 of 53 school survey respondents provided this reason)

¹⁸ Available at: *Online MMR Guidance Healthy Happy Minds.docx (live.com)*

¹⁹ Available at: <https://www.eani.org.uk/sites/default/files/2022-02/Whole%20School%20Evaluation%20Excel.xlsx>

²⁰ Available at: *Whole School Evaluation Guidance Healthy Happy Minds.docx (live.com)*

²¹ Source: EA

Note: Lack of providers was due to a number of factors including:

- some potential providers found the e-procurement process challenging,
- some potential providers were unaware of the tender exercise.
- some providers were unsuccessful as they didn't meet the criteria within the specification.

Potential providers had the opportunity to tender for up to 11 council areas and therefore perceived gaps in availability of providers were due to a lack of tender applications in relation to these areas and the willingness of counsellors/therapists to travel or move from a school where they were already established.

The following tables provides a summary of the key outputs from the pilot as gathered via the Form A returns from schools. A total of 1,647 no. Form A's were returned and analysed for this exercise, however it is recognised that this may not represent all schools who took part in the pilot as some did not submit returns. Furthermore, due to variances in how schools completed the forms the information provided in the following tables are not statistically valid, rather they are illustrative.

Table 8:- Healthy Happy Minds Outputs - Referrals

HMM Outputs	Nov 21 Pre-Update	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Sep-22	Oct-22	TOTAL
No. of referrals received from Child	16	22	168	74	100	101	50	45	29	18	0	623
No. of referrals received from Parent/Carer	80	111	803	259	281	407	190	207	200	258	0	2796
No. of referrals received from School	122	138	1190	575	631	667	278	286	294	223	0	4404
No. of referrals from other sources	0	5	468	398	646	719	106	106	607	420	90	3565
Total no. of referrals	218	276	2629	1306	1658	1894	624	644	1130	919	90	11388
% of referrals received resulting in therapy/counselling provision	66	81	74	81	65	69	77	84	94	69	100	
No. on waiting list	134	185	1353	769	840	845	460	413	388	236	0	5489

Table 9:- Healthy Happy Minds Outputs- Therapy Counselling Sessions

HMM Outputs	Nov 21 Pre-Update	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Sep-22	Oct-22	TOTAL
No. from Foundation Stage receiving individual therapy/counselling	16	24	243	155	221	232	119	131	104	41	41	1327
No. from Key Stage 1 receiving individual therapy/counselling	42	69	634	288	395	417	260	256	242	255	17	2875
No. from Key Stage 2 receiving individual therapy/counselling	98	94	1411	613	743	794	432	438	413	416	66	5518
Total no. receiving individual therapy/counselling	156	187	2288	1056	1359	1443	811	825	759	712	124	9720
No. of groups/class sessions held with Foundation Stage children	11	18	242	94	183	213	79	103	78	43	1	1065
No. of groups/class sessions held with Key Stage 1 children	18	65	387	194	326	377	116	153	122	86	1	1845
No. of groups/class sessions held with Key Stage 2 children	43	108	761	327	477	542	174	319	260	154	1	3166
Total no. of groups/class sessions held	72	191	1390	615	986	1132	369	575	460	283	3	6076
Average no. of sessions per child	3	4	3	4	5	4	3	4	3	4	3	40
TOTAL (individual and group sessions held)	228	378	3678	1671	2345	2575	1180	1400	1219	995	127	15796

Table 10:- Healthy Happy Minds Outputs- Cohort of Vulnerable Groups receiving therapy/counselling

HHM Outputs	Nov 21 Pre-Update	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Sep-22	Oct-22	TOTAL
No. of Newcomer children receiving therapy/counselling	NA	NA	NA	30	42	52	0	0	0	19	0	143
No. of Children Looked After receiving therapy/counselling	NA	NA	NA	51	62	71	●	●	●	22	●	215
No. of children with SEN receiving therapy/counselling	NA	NA	NA	386	641	647	8	11	13	180	20	1906
No. of safeguarding concerns raised	10	5	65	19	18	27	18	22	17	8	5	204
% boys	50	58	53	57	57	54	54	54	55	51	43	54
% girls	49	40	46	41	43	44	45	45	45	48	57	45
% other	1	2	0	2	0	2	0	1	0	1	0	1

Note: There may be cross-over in the first 3 categories.

Table 11:- Healthy Happy Minds Outputs - % Types of therapy/counselling

HHM Outputs	Nov 21 Pre-Update	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Sep-22	Average
Types of Therapy											
% of children receiving Talking Therapy	33	38	38	33	35	36	34	35	35	39	36
% of children receiving Play Therapy	25	27	22	26	18	21	24	27	27	24	24
% of children receiving Music Therapy	0	2	4	7	9	8	7	6	6	8	6
% of children receiving Art Therapy	19	17	17	14	15	15	23	21	16	22	18
% of children receiving Drama Therapy	3	3	2	2	2	2	0	1	1	1	2
% of children receiving Group Therapy	7	6	6	10	10	7	5	4	7	4	7
% of children receiving Equine Therapy	1	0	1	1	1	1	3	2	5	0	2
% of children receiving Other therapy	13	7	10	6	11	10	3	5	4	2	7
Total %	100	100	100	100	100	100	100	100	100	100	100

Table 12:- Healthy Happy Minds Outputs - Presenting Issues assessed before Intervention

HHM Outputs	Nov 21 Pre- Update	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May- 22	Jun-22	Sep-22	Oct-22	TOTAL
No. assessed presented with Anxiety	104	131	1243	477	566	597	283	333	289	309	6	4234
No. assessed presented with Stress	52	49	820	221	269	327	167	167	210	131	0	2361
No. assessed presented with Family problems	52	64	859	297	391	400	201	221	188	218	8	2847
No. assessed presented with Relationship with Peers	40	44	661	282	283	290	134	165	159	114	0	2132
No. assessed presented with Low Mood	49	53	637	174	202	263	134	145	154	107	0	1869
No. assessed presented with Anger	32	31	619	170	214	228	116	137	155	103	0	1773
No. assessed presented with Self-Esteem	59	100	951	356	408	531	207	241	257	200	0	3251
No. assessed presented with Academic	16	17	354	116	132	129	57	59	101	68	0	1033
No. assessed presented with Bereavement	20	●	287	109	104	109	83	81	79	53	●	927
No. assessed presented with Bullying concerns	8	11	58	24	19	39	31	35	42	15	0	274
No. assessed presented with Other	30	41	465	110	116	99	53	●	51	106	●	1083
TOTAL PRESENTING ISSUES (Multiple issues may be selected for each case)	462	●	6954	2336	2704	3012	1466	●	1685	1424	●	21784

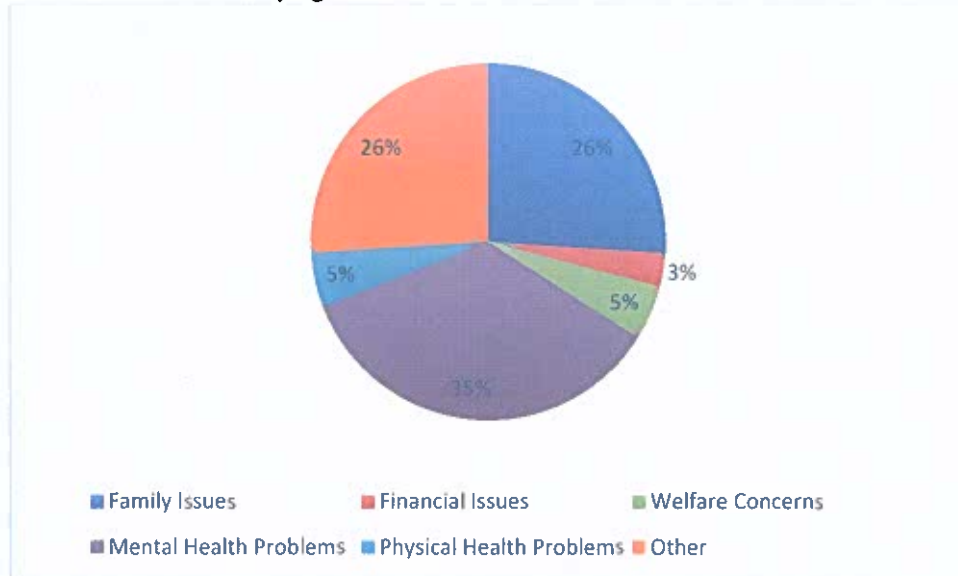
Note: Multiple presenting issues may be recorded for the same cases

4.6 Programme Outcomes (Form B)

DE provided outcomes data from Form B's which was captured from 105 no. schools over the period of the evaluation.

4.6.1 Pre-Assessment Underlying Issues

Figure 2:- Pre-Assessment Underlying Issues



The chart above shows the total percentage of identified underlying issues presented by children before they received therapy/counselling during the pilot programme.

The majority of children (35%) presented with mental health issues. 26% of children identified with other presenting issues which included bereavement, friendships, Covid, self-expression, self-esteem, suicide, attachment, behavioural, Special Educational Needs (SEN), and anger management²².

4.6.2 Strengths and Difficulties Questionnaire

Form B contained a strengths and difficulties questionnaire, which the therapist/counsellor would complete for each child at the onset of the intervention and at the end of the intervention to assess the child's state of well-being. The table below illustrates the total percentage of children who presented with the issues at the onset of the intervention and at the end of the intervention.

²² It is noted that the categories do not match Form A underlying issues. Ideally, going forward these should not be different.

Table 13:- Assessment of Strengths and Difficulties Questionnaire

Presenting Issues	Outset of Intervention			End of Intervention		
	Not True	Somewhat True	Certainly True	Not True	Somewhat True	Certainly True
Considerate of other people's feelings	18%	40%	42%	5%	26%	69%
Restless, overactive, cannot stay still for long	34%	29%	37%	55%	29%	16%
Often complains of headaches, stomach aches, sickness	51%	26%	23%	73%	20%	6%
Shares readily with other children	18%	36%	46%	6%	28%	67%
Often has temper tantrums or hot tempers	49%	25%	26%	71%	22%	8%
Rather solitary, tends to plan alone	47%	30%	24%	67%	25%	8%
Generally obedient, usually does what adults request	18%	36%	46%	14%	24%	62%
Many worries, often seems worried	18%	34%	48%	45%	42%	14%
Helpful if someone is hurt, upset or feeling ill	12%	35%	53%	10%	23%	68%
Constantly fidgeting or squirming	36%	29%	35%	55%	29%	15%
Has at least one good friend	12%	28%	60%	6%	18%	77%
Often fights with other children or bullies them	74%	17%	9%	83%	10%	6%
Often unhappy, down-hearted or tearful	36%	34%	30%	66%	28%	6%
Generally liked by other children	11%	31%	58%	7%	19%	74%
Easily distracted, concentration wanders	27%	33%	41%	49%	35%	17%
Nervous or clingy in new situations easily loses confidence	31%	31%	38%	54%	33%	13%
Kind to younger children	8%	32%	60%	5%	20%	75%
Often lies or cheats	76%	13%	11%	86%	8%	6%
Picked on or bullied by other children	80%	14%	6%	88%	9%	2%
Often volunteers to help others (parents, teachers, etc)	21%	34%	45%	14%	27%	58%
Thinks things out before acting	38%	36%	26%	20%	35%	45%
Steals from home, school or elsewhere	89%	4%	7%	90%	3%	7%
Gets on better with adults than with other children	56%	28%	16%	64%	25%	10%
Many fears, easily scared	36%	29%	35%	62%	29%	10%
Sees tasks through to the end, good attention span	40%	34%	25%	21%	33%	46%

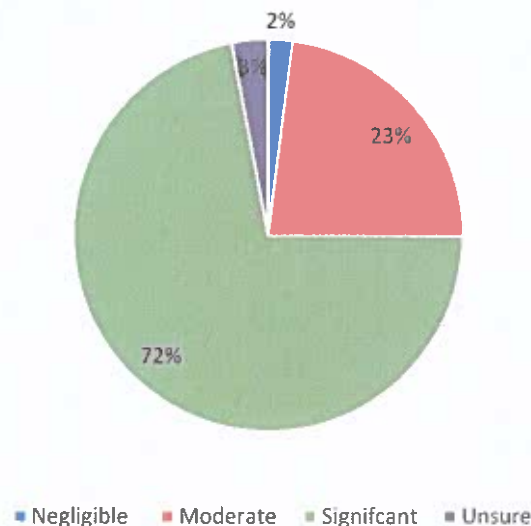
Colour Key:

	Improved
	Partially Improved
	Didn't Improve

From the table above, it is evident that the percentage of children who presented with certain issues at the onset decreased significantly at the end of the intervention. The data demonstrates that, according to the provider, the therapeutic/counselling sessions had a positive impact on a significant number of children who received therapy/counselling and improved their health, well-being and social inclusion.

4.6.3 Impact of the Therapy/Counselling

Figure 3:- Impact of Therapy / Counselling



The chart above shows the total percentage of therapist/counsellor who believed the therapeutic/counselling sessions had a positive impact on the children who received counselling/therapy.

72% of counsellors/therapists believed the intervention had a significant positive impact on children and only 2% believed it was negligible.

4.7 Governance and management / staffing

4.7.1 Governance

The Wellbeing Framework Programme Board was responsible for overseeing the implementation, monitoring and evaluation of the HHM pilot along with other associated projects in the framework programme. This group met every 6 months during the HHM pilot.

Monitoring requirements were set out for the implementation of Wellbeing Framework which included the HHM pilot. These included formal assurance that appropriate governance arrangements were in place. As the EA managed the pilot funds on behalf of DE, this was a shared responsibility between the two organisations. DE’s Director of Inclusion and Wellbeing sought assurance from EA on the following:

- There was regular, meaningful monitoring of risks (via risk register);
- The requirement to stress test was considered;
- Appropriate commercial expertise was considered and acquired;
- Information and assumptions in the business case were regularly reviewed;
- Assumptions were tested; and

- Where appropriate there was a means to control demand.

Assurance was also requested that, where necessary, risks would be escalated to the Wellbeing Framework Programme Board for consideration.

The Programme Board included representatives from the following key stakeholders:

Table 12:- Wellbeing Framework Programme Board Members

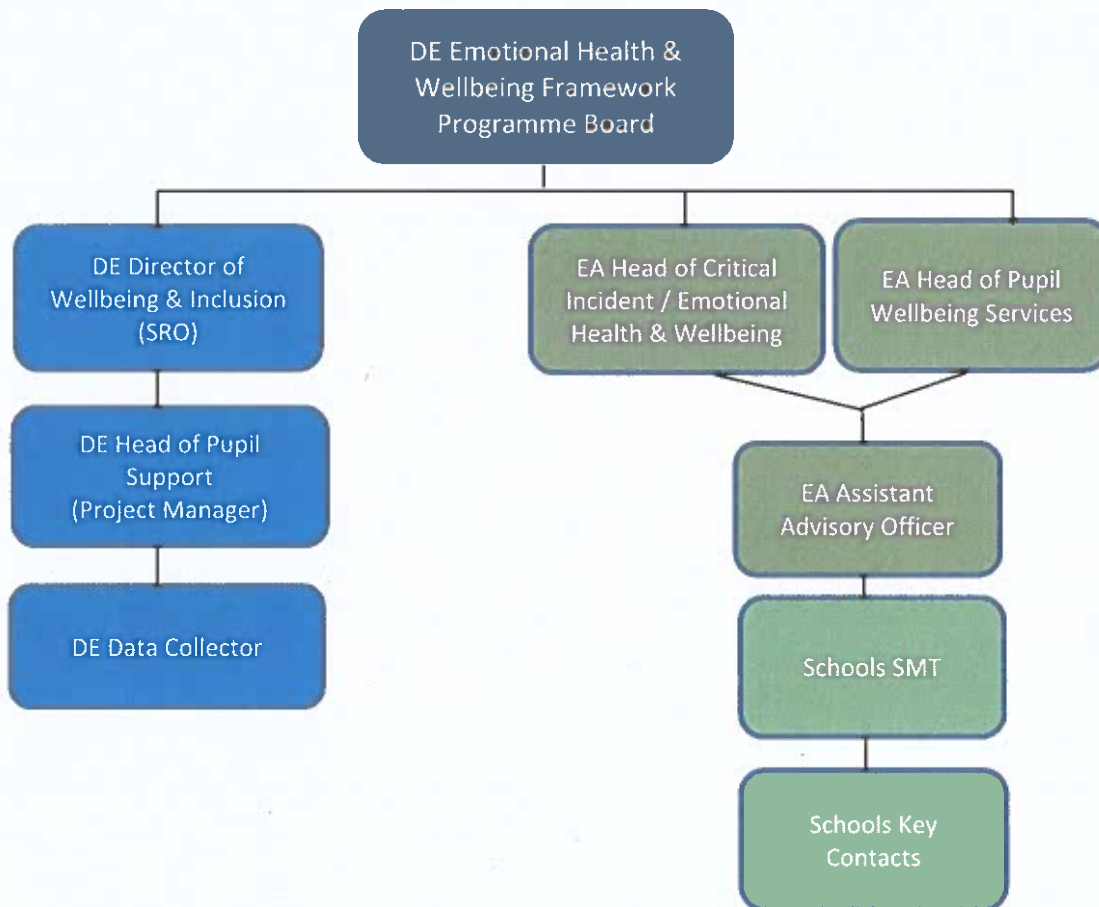
Project Board Members	
Department for Education	• Director of Raising Aspirations, Supporting Learning and Empowering Improvement - since January 2023. (previously the Director of Wellbeing and Inclusion) (SRO)
	• Head of Pupil Support Team (Project Manager)
Department of Health	• Director of Population Health
	• Director of Mental Health, Disability and Older People
Public Health Agency	• Head of Health Improvement
	• Lead Allied Health Professional (AHP) Consultant (Children, Young People & Interagency)
Education Authority	• Acting Director, Children & Young Peoples Service
	• Assistant Director, EA Youth Service
Health & Social Care Board	• Commissioning Lead CAMHS Service
	• Children’s Services Planning Professional Advisor
Department of Justice	• Chief Executive, Youth Justice Agency
Department for Communities	• Director of Engaged Communities
Mental Health Champion for NI	• Mental Health Champion for NI

The Review Team conclude that given a pilot of this nature and scale, the governance measures adopted for HHM were reasonable.

4.7.2 Management and staffing

The diagram below shows the management and staffing structure of the HHM pilot.

Figure 4:- HHM Management and Staff Structure



Throughout the period of the pilot one member of EA staff was appointed and worked full time on HHM in the role of Assistant Advisory Officer and was managed by the Head of Critical Incident / Emotional Health and Wellbeing. DE staff (20% of a Grade 7 and 5% of a Staff Officer) and the EA Heads of Service worked on the pilot in conjunction with their other delivery objectives.

Each school had a nominated Key Contact for the pilot who was supported by SMT in implementing the pilot within the school. The SMT and Key Contact worked with the counselling/therapy provider to agree how the intervention would work within the school including the evaluation process.

Staffing arrangements, once in place, appear to be appropriate, however, stakeholder feedback indicated demand for EA support especially at tendering stage was a challenge. The short lead in time for funding left no opportunity to recruit the Assistant Advisory Officer in time for the pilot to commence and EA received considerable complaints from schools about the lead in time.

4.7.3 Programme Evaluation

According to the Business Case evaluation was to be supported by progress reports to the Wellbeing Framework Programme Board on a 3 monthly basis. The actual Programme Board meetings were on a 6 monthly basis and progress reports included monitoring data gathered from schools were presented to the Board.

Standard Programme Board agenda items included:

- Project Update;
- Risk Register/Issues Log;
- Finance; and
- AOB.

From analysis of the agendas and minutes, it appears that these meetings covered the key discussion points that might be expected to arise including progress updates, reasons for delay, finance updates and risk.

Counsellors/therapists were directed to deliver their provision according to the 'Ethical Framework for Good Practice' of their registered and professional body (The British Association for Counselling and Psychotherapy's Framework²³ for counselling and other professional bodies for the other types of therapy offered). Professional frameworks included areas such as evaluation.

The Business Case and the Addendum set out provision for a comprehensive evaluation after the pilot had completed, which is the aim of this exercise. This was to be completed by June 2023.

Overall, this level of evaluation is considered reasonable for a pilot of this nature and scale.

4.8 Monitoring and reporting

As required and in line with good practice DE worked below Programme Board level on a semi regular basis with EA to manage the pilot and the frequency of meetings were amended according to project needs.

DE provided pilot guidance to schools which was issued through the EA and available on their website²⁴, see [Appendix 5](#). An online Key Actions for Schools guide²⁵ was also produced by EA.

The aim of DE's guidance was to outline how primary schools should undertake to secure counselling and therapy services to ensure the best and most appropriate service for the pupils who most need it. To ensure the counselling support provided to primary schools conformed to high professional standards and current best practice for school-based counselling, DE utilised the ICSS Handbook²⁶ which governs the operation of the post primary service, to inform the HHM guidance.

Having reviewed the monitoring and reporting mechanisms described at Section 4.4 – Data Gathering and Data Sources, it is concluded that monitoring and reporting arrangements were reasonable, despite some initial issues.

However, it is noted that the response rate for the submission of monthly monitoring forms from schools throughout the pilot was low and likely to have been impacted by ongoing industrial action.

Furthermore, not all data sets were completed in returns and this corroborates with feedback from schools which indicates they found the monitoring process administratively burdensome in

²³ Children and young people competences and curricula (bacp.co.uk)

²⁴ Available at: [Healthy Happy Minds Therapeutic and Counselling Service Pilot | Education Authority Northern Ireland \(eani.org.uk\)](#)

²⁵ Available at: [Key Actions for Schools.docx \(live.com\)](#)

²⁶ Available at: [ICSS Handbook | Department of Education \(education-ni.gov.uk\)](#)

their already pressured environments despite subcover being available to support the administrative tasks to be carried out by schools. Again, industrial action impacted on the monitoring process. Providers also raised concerns about the credibility of monitoring data as schools understanding and approaches differed.

Feedback from EA suggests that as experienced collators of monitoring information re the ICSS provision (where they are responsible for ensuring providers comply with the contract requirements and the service meets the specified standards, operational management, and ongoing development of the programme) they should be significantly engaged in the design of the monitoring process of any future provision to tighten reporting mechanisms and make monitoring data more easily accessible for project evaluation. EA also raised concerns about the impracticality of dealing with hardcopy returns which some schools chose to submit despite this not being an option, as there are 836 primary settings, and suggest that returns in this format should not be accepted going forward and all submissions should be via their online²⁷ option only.

Recommendation 1 – Monitoring Design to include key stakeholders

All key stakeholders should be involved in the design of monitoring processes for any future provision.

Recommendation 2 – Monitoring responsibilities to sit with providers

Service providers should be responsible for submitting monthly monitoring returns to EA, similar to roles and responsibilities within the ICSS provision, to ensure robust monitoring information is available throughout any future provision and to reduce the administrative burden for schools. The Review Team also recommend that future provider contracts include targets in relation to monitoring data to improve Management Information evaluation robustness.

Recommendation 3 – Maintain electronic monitoring records only

Monitoring returns should be submitted to EA in online format only. Hardcopy returns should only be accepted in exceptional circumstances and transferred to electronic format.

4.9 Risk Management

Risk was managed in the production and updating of the Wellbeing Framework specific risk register. As part of the monthly returns provided to the Department in advance of the meetings, formal assurance mechanisms also requested that, where necessary, risks would be escalated to the Wellbeing Framework Programme Board for consideration. The updated risk register was presented and summary of open risks provided that would require Programme Board attention. Reports from the meetings highlight that DE regularly went through the risk/issues log.

The original business case contained a risk assessment and identified appropriate mitigation measures. BCS found that 2 of 3 risks identified have been realised and these were regarding:

- Delay due to time taken to develop specification and tender for service providers; and
- Demand exceeds supply.

Risk was not realised regarding:

- Low uptake due to administrative burden, particularly if resources are limited.

²⁷ Sample of online submission process, available at: [Healthy Happy Minds Therapeutic and Counselling Service Pilot November 2021 \(google.com\)](https://www.google.com)

However, one other risk transpired that had not been anticipated at the outset:

- The risk associated with lack of provision in some areas.

As no other primary school counselling and therapeutic service exists in Northern Ireland, especially with such a range of provision, and it was anticipated that demand might outstrip supply, however it was not anticipated that availability of provision across all areas would also be a potential risk.

Recommendation 4 – Greater focus on risk at Business Case stage

The risk associated with the lack of provision on the framework in some areas for this broad range of counselling and therapeutic approaches at primary school level should be included in the Business Case risk assessment for any future provision.

Recommendation 5 – Rural Proofing

A rural proofing exercise should be conducted in alignment with the statutory requirement to rural proof any future primary school counselling provision.

4.10 Promotion

The role of promotion to children and parents/carers sat with schools and counsellor/therapists as follows. Principals and Key Contacts were to liaise with the provider to discuss how the service would be promoted within the school. The providers were to provide relevant information to schools to share with parents/carers regarding the types of therapy available and the referral process. Schools could share this information through school news sheets, messages through the school app, websites, information leaflets etc.

The role of promotion to providers and schools sat with DE and EA and the short lead in time relating to the availability of initial funding and pilot extensions impacted this. EA wrote to schools and conducted awareness raising workshops however, these sometimes turned into complaints platforms.

For providers, EA advertised a Prior Information Notice (PIN) on ETenders in November 2021, the tender was issued on ETenders in December 2021 (see tender specification at [Appendix 7](#)), it was advertised on the Government Find a Tender Service, on all social media platforms and LinkedIn. DE also wrote to relevant professional organisations informing them of the tender opportunity. DE also liaised with the professional bodies who contacted all of their registered counsellors/therapists about the pilot²⁸.

Feedback from around half of counsellors/therapists responding to the survey indicated the pilot was effectively promoted by schools to children and parents/carers. While nearly two thirds believe it was effectively promoted to schools and counsellors/therapists.

Feedback from schools responding to the survey was slightly better with 58% believing the pilot was effectively promoted to children and parents/carers, 84% believing it was effectively promoted to schools and 59% believing it was effectively promoted to counsellors/therapists. While some positive comments were made, most related to inefficiencies such as:

²⁸ *New opportunities for CYP counsellors in Northern Ireland (bacp.co.uk)*

- The short lead in time, tight turnaround for schools to use funding and short notice of 2 extensions impacting on providers ability to promote services effectively;
- Schools and parents having little knowledge of therapy other than counselling, e.g., art therapy, play therapy and their professional bodies, which reduced the amount of referrals;
- Missed opportunity by schools regarding promotion to children to make them aware the self-referral process;
- Some counsellors withdrew services due to uncertainty around the pilot start and end dates and their need for guaranteed work;
- Promotion was restrained for fear of raising expectations and not being able to offer this service to more children than finance was available for; and
- Parents need greater promotion as they don't always read school notes, promotion needs to be very clear.

Promotion to children and parents/carers seems to have been only somewhat effective and the main factor impacting this was the short lead in time to funding and the extensions. Future promotion and promotion campaigns should be more effective with an appropriate lead in time and better understanding in schools of therapeutic provisions being offered, beyond talking therapies. Furthermore, a more effective campaign is required to successfully attract sufficient counsellors/therapist to a more dynamic tender and reduce the risk of insufficient provision in future.

Recommendation 6 – Promote any future provision in advance of commencement
Any future provision should be promoted to providers with as much advance notice as possible prior to tendering to attract a greater response with the view to securing more providers.

Recommendation 7 – Build understanding in schools settings
EA should build understanding in school settings of therapeutic provisions being offered, beyond talking therapies.

4.11 Summary and Conclusions

Table 14:- Programme Activity – Summary and Conclusions

Summary and Conclusions
<p>Programme Development: A range of stakeholders were consulted in the development of the programme and expertise was commissioned to ensure the procurement exercise was appropriate and professionally delivered. All key stakeholders should be involved in the design of monitoring processes for any future provision. An appropriate lead in time for procurement development including support for tenderers should be considered going forward.</p>
<p>Programme Activity: A wide range of services were provided for schools to support the delivery of the HHM pilot. These were talking, play, music, art, drama, group and equine therapy. These interventions were deemed by stakeholders to be effective in the delivery of HHM pilot, as evidenced in Section 5.</p>
<p>Programme Output: The pilot largely achieved its objectives. In terms of outputs, the programme achieved the number of sessions as set out in the 2021 business case, however not all schools were able to avail of service provision due to a lack of providers and this was a particular issue in rural areas.</p>
<p>Programme Governance and Management/ Staffing: A robust system was established for the governance and management of the HHM. However, data was slow feeding back from schools to DE. This is discussed in Monitoring and Reporting Section 4.4. The lead in time was challenging for EA to develop a procurement exercise. As EA contracted out the procurement exercise, two different sets of staff were dealing with support of the schools and procurement queries which was problematic. Once EA had dedicated resources in place evidence indicates that communications and support improved. The number of staff involved in the design of the pilot and throughout was appropriate.</p>

Summary and Conclusions

Monitoring and Reporting: Having reviewed the monitoring and reporting BCS can conclude that this is appropriate for a pilot of this size and scale. Monitoring forms had to be altered to fully capture reasons why children were presenting for therapeutic interventions and forms also had to be moved online, however, once this was done reporting mechanisms were satisfactory. It was reported that monitoring and reporting was an administrative burden for schools, although sub cover was available. Monitoring and reporting would be better placed as a responsibility of the providers in future. Reporting from schools was slow as there was an option to do this in bulk at the end of the pilot. Obviously, this would not be the case for any permanent programme going forward.

Risk Management: The 2021 business case contained a risk assessment to identify appropriate mitigation measures. The risk associated with the lack of providers on the framework was not recognised at the outset of the project and should be considered going forward, particularly in rural areas.

PR: The PR campaign faced challenges associated with lead in time for funding and pilot extensions. Promotion to children by schools, was, in some cases, constrained due to lead in times and uncertainties regarding the timing and level of funding available as was the EA's promotion to providers and schools.

5. PRIMARY RESEARCH FINDINGS

5.1 Introduction

This section of the report sets out the primary research findings from surveys and consultations from key stakeholders involved in the pilot. This includes:

- School views gathered via a school survey
- Provider views (i.e. therapists and counsellors) gathered via a provider survey and provider interviews
- EA views gathered via interviews
- DE views gathered via interviews
- Children’s views gathered via therapist / case study

DE agreed for the review team to consult with parents through a focus group to gather their views of the pilot. BCS arranged a virtual workshop with parents from a North Belfast primary school who participated in the pilot but no one attended.

The Review Team, in consultation with the project steering group, designed 2 online survey’s to capture the views from the schools and the counsellors/therapists who participated in the pilot. The following table shows the key statistics in relation to this sample and response rate of each survey:

Table 15:- Summary of Survey responses

Stakeholder Group	Consultation Approach	Sample Size	Number of responses	Response rate %
School’s Survey	Online survey	836	268	32%
Therapists/Counsellors Survey	Online Survey	236	83	35%

Overall commentary from these surveys are the opinions of schools and therapists/counsellors as there was no evidence base in support of these statements.

The full responses to both survey’s including comments have been included at [Appendix 8](#).

The research process for the evaluation also captured the views of other key stakeholders, via semi structured interviews led by the Review Team. A list of stakeholders consulted is included at [Appendix 4](#).

5.2 School views

School views were gathered via an online survey. The school survey was issued to circa 795 primary schools, 35 special primary schools and 6 EOTAS settings.

The survey was issued through EA and BCS received 268 responses which equates to a response rate of circa 32%. For an online survey, conventionally, a response rate of 20% or more is considered as a good response rate and therefore it is considered that this response rate is a reasonable return and a sample on which to interpret the research findings.

Of course, it would be advantageous if the response rate was higher, however given that teachers and Principals were participating in Action Short of Strike, including the staff being instructed not to provide "information or data" to DE or EA, it was agreed with the Project Steering Group that this was a reasonably good response rate given the circumstances.

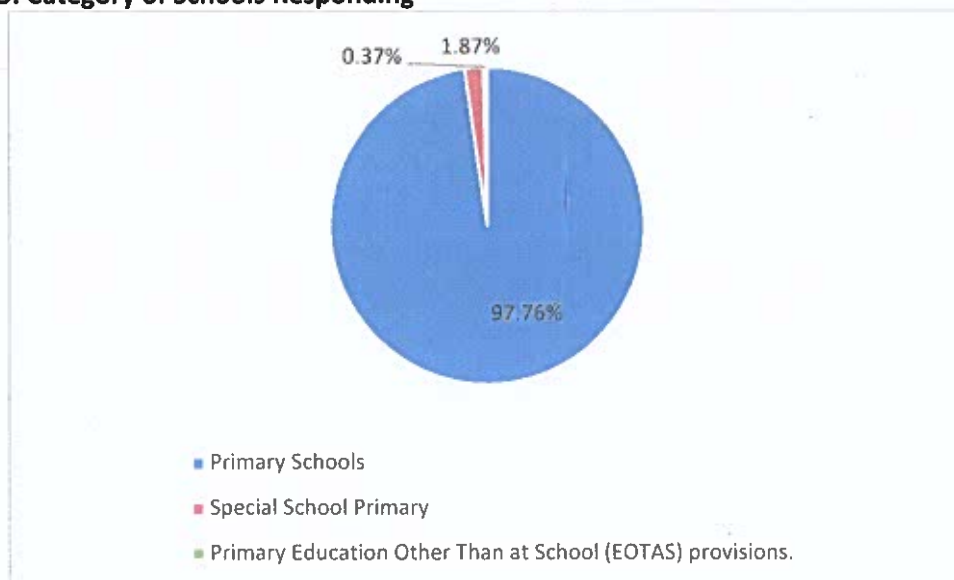
It should be noted that due to rounding the figures in the following tables may not always add to 100 per cent.

5.2.1 Background of respondents

Background information was captured to set some context to responses.

The following chart outlines what best describes the schools the respondents represent. From the 268 responses, 262 schools (98%) described their school as a Primary school and 6 schools (2%) described their school as a Special Primary school or Primary Education Other than at School (EOTAS) provisions.

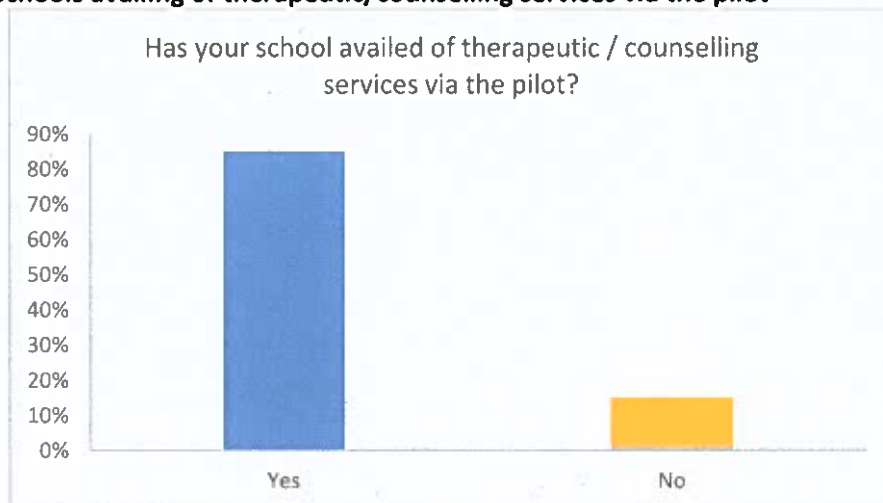
Figure 5: Category of Schools Responding



262 of 268 respondents answered this question.

Respondents were asked if their school availed of therapeutic / counselling services via the pilot. As shown in the following chart that the majority of respondents (85%) have availed of therapeutic/counselling services via the pilot.

Figure 6: Schools availing of therapeutic/counselling services via the pilot



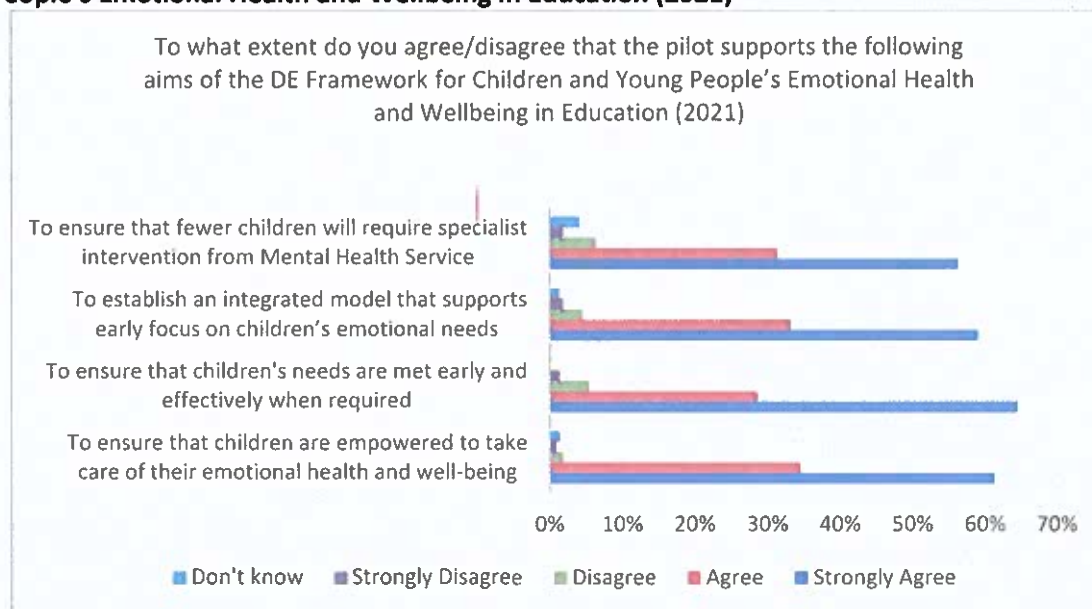
267 of 268 respondents answered this question.

The results demonstrate that not all schools availed of HHM services. Whilst the reasons for this are not known in every case, some could not avail due to a lack of availability. Equally, a number of schools already had counselling and therapeutic provision in place.

5.2.2 Strategic Fit

Schools were asked to what extent they agreed/disagreed that the pilot supported the aims of DE’s Framework for Children and Young People’s Emotional Health and Wellbeing in Education (2021). A breakdown of the responses to is included below.

Figure 7: Schools: Extent of pilot meeting the aims of DE’s Framework for Children and Young People’s Emotional Health and Wellbeing in Education (2021)



220 of 268 respondents answered.

Responses indicated that:

- **96%** of respondents strongly agreed/agreed that the pilot supported the aim to ensure that children are empowered to take care of their emotional health and well-being.

- **93%** of respondents strongly agreed/agreed that the pilot supported the aim to ensure that children's needs are met early and effectively when required.
- **92%** of respondents strongly agreed/agreed that the pilot supported the aim to establish an integrated model that supports early focus on children's emotional needs.
- **88%** of respondents strongly agreed/agreed that the pilot supported the aim to ensure that fewer children will require specialist intervention from Mental Health Service.

The results demonstrate that the majority of respondents feel the pilot is strategically aligned to the DE's framework for Children and Young Peoples Emotional Health and Wellbeing in Education (2021).

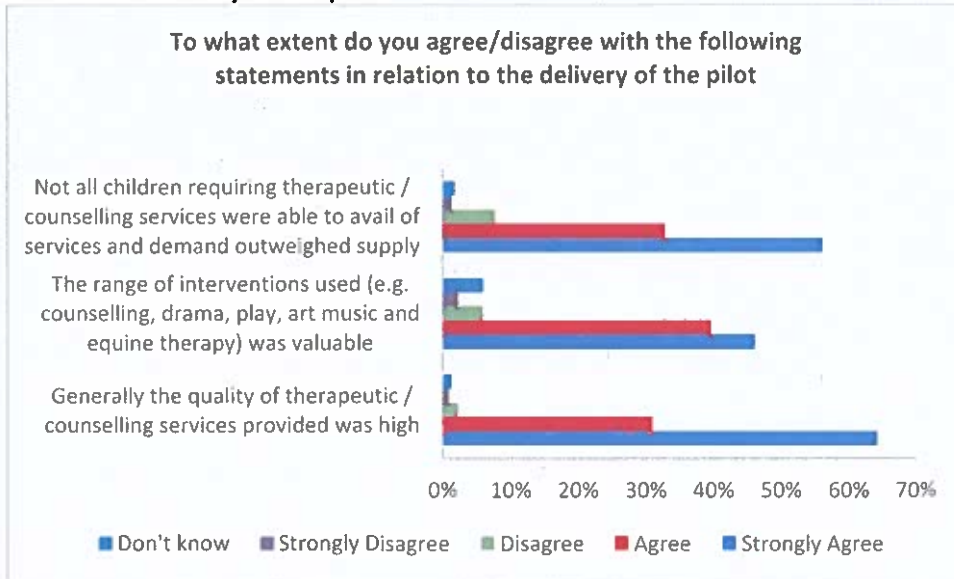
A sample of additional comments in relation to strategic fit included:

- *"Pupils have been supported by school counselling for students' range of complex needs including bereavement, negligence and sexual abuse. Pupils have been supported and cared for by an experienced counsellor which would have been beyond the school's capacity".*
- *"This pilot allowed us to give support to pupils who most needed it and to give intervention in a timely manner. We were able to identify children and give them a 6-week intervention that gave them an opportunity to develop emotional resilience. It is essential that the funding for this programme continues".*
- *"This service has been integral to our children especially when situations arise at home and families require help and don't know what to do or where to go".*
- *"This service has been integral to meeting the needs of our children especially when situations arise at home and families require help and don't know what to do/where to go".*
- *"We have been varying out for this essential support for years. We have been able to address underachievement in literacy and numeracy by addressing the emotional and well-being issues that have impacted on the children and left the children in a place where they are happier, feel safe and are able to reach their academic potential".*
- *"Not always able to accommodate all children".*
- *"We have found this funding stream an excellent avenue to access professionals in their field to support children's mental health. We did have difficulty sourcing an adequate professional at the start".*
- *"Unfortunately, the limitations imposed upon what the funding could be spent upon greatly reduced the benefit to children. Considerable time was consumed sourcing providers and agreeing timetables. Need continues to outweigh availability resulting in 66% of children referred not receiving support".*
- *"We feel funding should be coming from Health Trust for these services.... not swallowing up educational funding. There is money for this, but we haven't money to buy reading books!!"*
- *"Geographically spread of available therapy and therapist has led to rural schools and those west of the Bann being totally disadvantaged. The rates of pay for therapist is a scandalous waste of money. Lack of strategic direction and focus to ensure delivery at the point of need."*

5.2.3 Delivery

Schools were asked to what extent they agreed/disagreed with the various statements in relation to the delivery of the pilot. A breakdown of the responses to this question is included below.

Figure 8:- Schools: Delivery of the pilot



219 of 268 respondents answered this question.

As outlined in the chart above, the % of respondents that strongly agreed/agreed to the statements in relation to the delivery of the pilot are as follows:

- **95%** of respondents strongly agreed/agreed that the quality of therapeutic/counselling services was high.
- **84%** of respondents strongly agreed/agreed that the range of interventions used was valuable.

These results demonstrate a very positive response regarding schools agreeing that the pilot delivered its aims successfully within the schools.

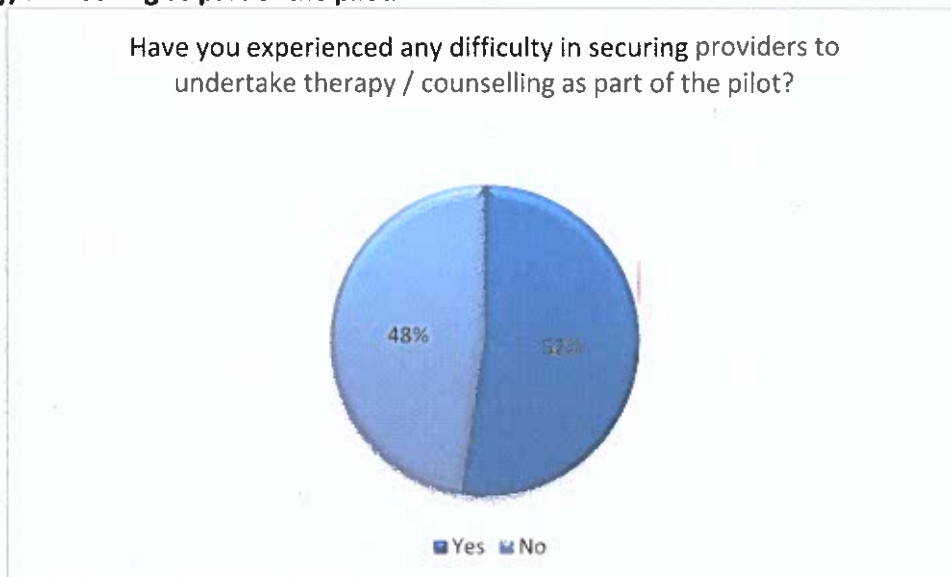
However, **89%** of respondents strongly agreed/agreed that not all children requiring therapeutic/counselling services were able to avail of services and demand outweighed supply. This would align with desktop research showing that demand for counselling/therapeutic services is high within schools even with the on-going pilot. The main reasons for demand outweighing supply were due to insufficient numbers of suitably vetted and qualified therapists/counsellors on the EA's procurement framework to provide therapeutic/counselling sessions, short lead time and tight turnaround to use funding and short notice of pilot extensions. Smaller schools also highlighted an issue with limited funding as funding was allocated according to school size rather per child and these schools couldn't offer the invention to all children who required help. Some schools in rural areas also reported difficulties in securing providers due to remote locations.

A sample of additional comments in relation to delivery of the pilot included:

- *"We have a waiting list for services but compared to other agencies the waiting list is a few weeks rather than the months or even years that other services have children waiting for".*
- *"We have a waiting list of children who require this therapeutic service that we the school was able to avail of. This essential funding will help us to continue to support children who need help with emotional needs."*
- *"The programme was very workable with our children and within our school environment."*
- *"Again, being able to have in-school facilities to assist with the emotional needs of pupils was excellent. When I think back to pupils in the past who could have really benefited from this service, I realise how important it is."*
- *"The range of interventions was broad but there were too few approved suppliers."*
- *"There is always a waiting list, and we could have done with more days with the therapist".*
- *"Sourcing of therapists proved difficult at times - they simply weren't available at times."*
- *"There are so many children and not enough money. I also feel there are many in my school that need the support yet as a small school we do not get the funding. I believe funding has not been distributed correctly and should be per child not by size of school."*
- *"Demand far outweighs supply, and we were only able to provide the service for five pupils this term, we have many more who would have benefitted if the finance had been available. Also, there are not enough counsellors to meet demand."*
- *"Geographical issues mean schools can't access local therapists. Several children and families wanting and need access, but I can't provide through the DE programme."*

Schools were asked had they experienced any difficulty in securing providers to undertake therapy/counselling as part of the pilot. A breakdown of the responses to this question is included below.

Figure 9: Schools: Experienced difficulties in securing providers to undertake therapy/counselling as part of the pilot.



206 out of 268 respondents answered this question.

The chart above shows that 52% of respondents experienced difficulties in securing providers to undertake therapy/counselling. As mentioned previously reasons for difficulties securing providers were due to insufficient numbers of suitably qualified and vetted therapists/counsellors within the framework. This meant that there was a reduced availability of a pool of therapists/counsellors for a number of specialist therapies, especially in rural areas. Therapists/counsellors were either booked up for services in other schools, could not travel to the rural areas due to long distance and fuel costs, or did not tender for an area. Also, the uptake

for therapists/counsellors for tendering to be added to the EA framework was low and once the procurement exercise was closed no therapists/counsellors could be added to it during the pilot.

A sample of additional comments in relation to difficulties securing providers during the pilot:

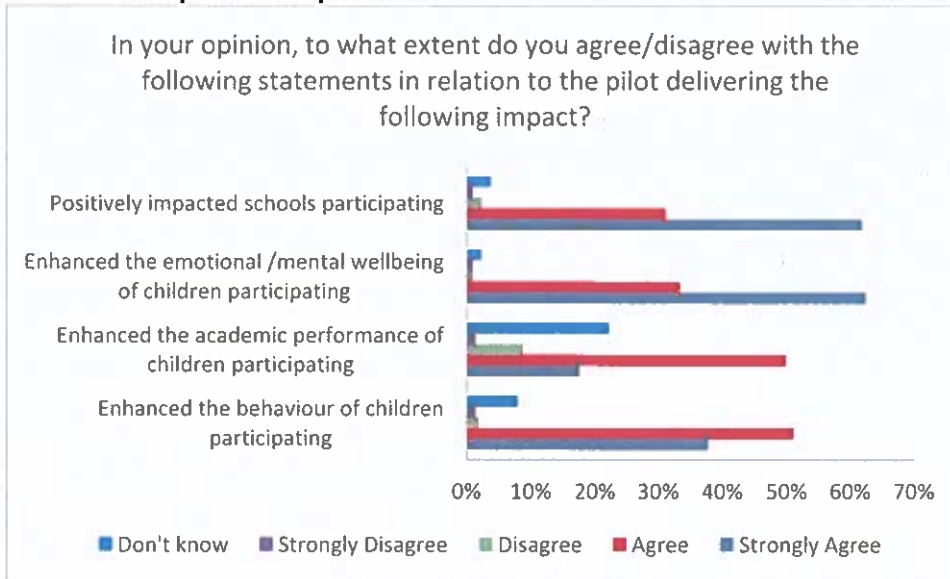
Comments –Have you experienced any difficulty in securing providers to undertake therapy / counselling as part of the pilot?

- *"We were lucky - we had dealt with a counselling organisation in the past so already had a relationship with the personnel. We got in quickly."*
- *"It took whole of Term 1 of the year of introduction to find a suitable provider. Once found the Provider the school uses have been exemplary."*
- *"At the beginning of the programme we did have difficulty but once our counsellor agreed to work with our school we have not looked back."*
- *"When the pilot opened far too many were people chasing far too few service providers in their locality. Demand outstripped supply. Now we have organisations and individuals emailing and promotion their services to us as they know you provide a pot of money that they want!"*
- *We couldn't secure a provider last year. I emailed the EA several times but received no support or response. Finally, we were able to organise a therapist for this school year but trying to organise payment has been challenging."*
- *"As mentioned before, limited list of available professionals in the Fermanagh area."*
- *"Not enough to spread across all the schools".*
- *"Being tied to a limited range of providers on the approved list who were not already fully booked and who were within reasonable travelling distance of our school."*
- *"Not all counsellors/therapists were able to access the EA Tender and could not be used. A lot of time was spent trying to find someone suitable."*
- *"Demand outweighed supply. Uncertain as to where to locate an up-to-date list of providers."*
- *"Not enough therapists - few in the Newry area and none in the South Armagh area - the area covered by the tender is too wide - Newry, Mourne and Down District Council covers a wide area and distances therapists would be expected to travel totally unrealistic especially at today's fuel costs."*

5.2.4 Pilot Impact

Schools were asked in their opinion what extent they agreed/disagreed with the various statements in relation to the impact of the pilot. A breakdown of the responses to this question is included below.

Figure 10: Schools: Impact of the pilot



216 of 268 respondents answered this question.

As outlined in the chart above, the % of respondents that strongly agreed/agreed to the statements in relation to the impact of the pilot are as follows:

- **89%** of respondents strongly agreed/agreed that the pilot enhanced the behaviour of the children who participated.
- **96%** of respondents strongly agreed/agreed that the pilot enhanced the emotional/mental wellbeing of children who participated.
- **68%** of respondents strongly agreed/agreed that the pilot enhanced the academic performance of the children who participated and 22% did not know.
- **93%** of respondents strongly agreed/agreed that pilot positively impacted on the schools who participated.

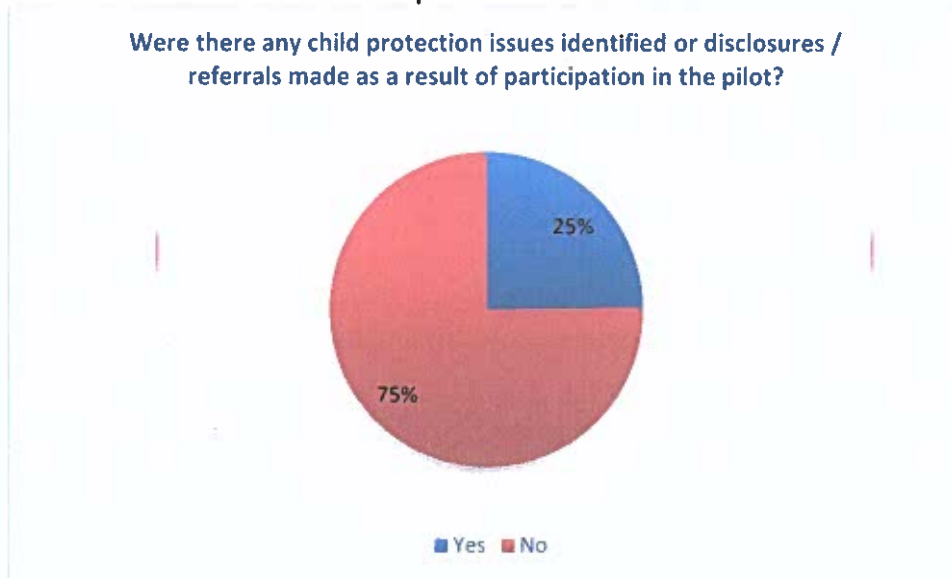
Overall, the results indicate that the pilot has had very positive impact on the behaviour, emotional/mental wellbeing and academic performance of the children who participated and had a positive impact on the school as a whole.

A sample of additional comments in relation to impact of the pilot included:

- *"This has had a very positive impact on the vulnerable children in our school."*
- *"The sessions were beneficial to our children who participated. It provided them with a safe and familiar environment in which to engage with the counsellor over a period of weeks. The sessions provided most of the children involved with skills and strategies on how to view things and to give ideas on what to do help them when they feel anxious or emotional."*
- *"The emotional well-being of children noticeably improved - this in turn enhanced their ability to connect with the curriculum."*
- *"A really important and valuable spend of money - early intervention is key to the emotional well-being of so many of our pupils."*
- *"The pilot makes a huge impact to our pupils - we could not have provided the support from therapists to our pupils if not for this funding."*
- *"Those who were able to participate benefited but some of the therapy delivered finished abruptly when the second funding was announced."*
- *"I feel the variety of needs at the moment does not always mean that enhanced behaviour or enhanced academic performance is not fully measurable at the moment. It is the start, but I certainly have identified new issues with this year's P1 intake."*
- *"As principal I want my children all to have good emotional health and as finance is limited children are missed."*
- *"This pilot had little to no impact on the children in our school. I believe they have been deprived of support due to the poor planning and execution of the pilot and as a direct consequence to where they live. This is totally unacceptable, unfair and unjust. All children across NI should have been given equal access."*

Schools were asked if there were any child protection issues identified or disclosures/referrals made as a result of participation in the pilot. A breakdown of the responses to this question is included below.

Figure 11: Schools: Identification of child protection issues



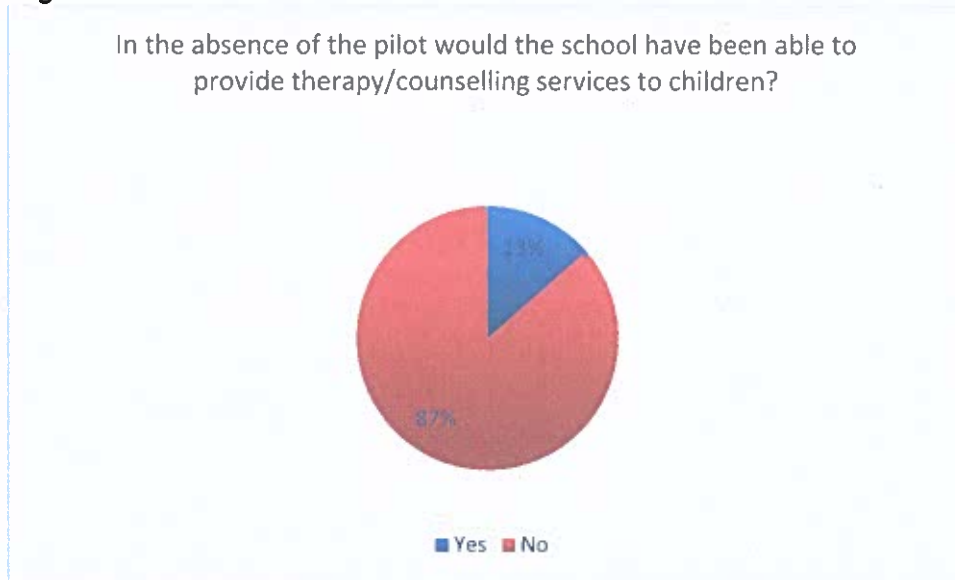
216 of 268 respondents answered this question.

The chart above outlines that 25% of respondents stated that child protection issues were identified, or forward disclosure/referrals made because of the pilot. This result demonstrates that the pilot did achieve the key outcome and anticipated benefit within the Business Case to identify child protection issues at an early stage.

Schools were also asked how many child protection issues were identified or disclosures/referrals made as a result of the pilot. **According to schools consulted, circa 106 child protection issues or disclosure/referrals were made as a result of participation of the pilot²⁹.**

Schools were asked in the absence of the pilot would the school have been able to provide therapy/counselling services to children. A breakdown of the responses to this question is included below.

Figure 12:- Schools: In the absence of the pilot would schools be able to provide therapy / counselling services



215 of 268 respondents answered this question.

As outlined in the figure above, **87%** of respondents confirmed that without the pilot schools would not have been able to provide a therapy/counselling service to primary school children. This indicates high levels of additionality.

A sample of the responses relating to if the school had no funding would they been able to provide therapy/counselling services is included below.

²⁹ Note: 204 no. child protection issues were recorded 1647 no. MMRs submitted during the evaluation period.

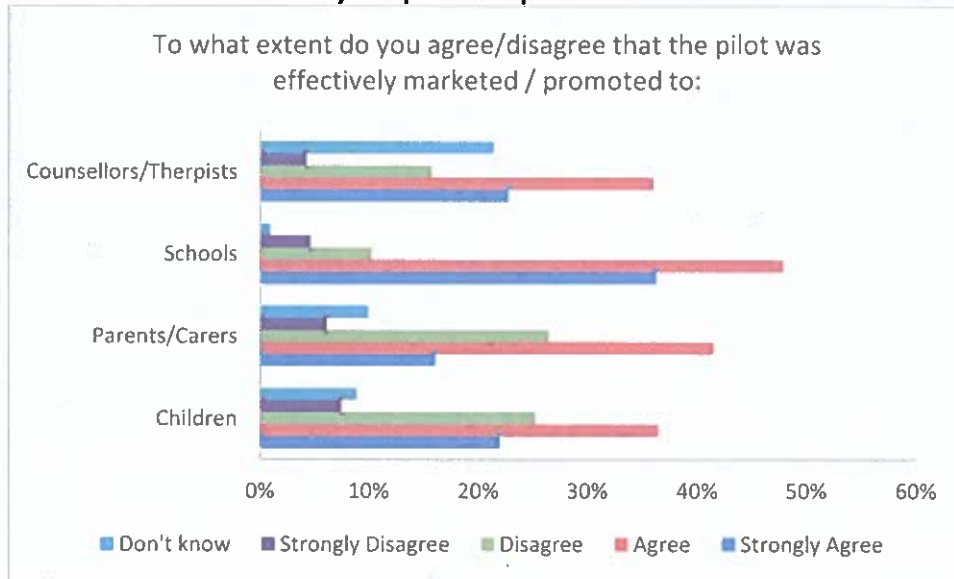
Comments – In the absence of the pilot would the school have been able to provide therapy/counselling services to children?

- *"A more limited programme through Extended Schools. However, our funding for that programme depends on our Free School Meals share and that hovers around the cut-off point so there may be years we don't qualify for that. It is great to have funding such as HHM that is not FSM dependent."*
- *"With budget cuts our counselling service alone had been cut to one morning a week. The pilot allowed us to open this up to a full day. We were also able to gain access to other therapies including Equine Therapy which would not have happened."*
- *"Counselling through extended schools funding, however, the additional services we received would not be available without this funding."*
- *"In the absence of counselling, I have continued to meet with one pupil who is still in need of support in school. I don't have time to meet more, or I would. The counselling service was vital for us."*
- *"We would have been able to offer a minimal service. The programme enhanced provision to enable a known onsite Counsellor to be available one day a week. Our need is much greater than this. The Counsellor was able to support families also."*
- *"The HHM funding permitted us introduce Music Therapy last year and continue into this year. However due to funding being cut not as many sessions could be obtained and we had to use school funding to enhance. It is extremely difficult to secure places with the limited list of approved therapists and therefore without prior notice of confirmation of funding and quantity of funding it was very difficult to forward plan and secure services."*
- *"This year we would have been able to fund one day but as previously stated this would not be enough to meet needs of all our pupils."*
- *"We had, for the last few years, allocated a small amount of our school budget to provide some play therapy as the demand for support was so high and access through the community was extremely difficult. We were, as a school, prioritising emotional health and wellbeing and following a TiP to supporting pupils."*
- *"We use our local services / community organisations to access a range of services over the school year. The funding is so ad hoc it is hard to plan form year to year and programmes only are funded for 2 years at a time. Not sustainable."*
- *"One of our staff has received a qualification as a [REDACTED] practitioner but parents would unfortunately have to pay for the service!"*
- *"This should be funded from central funding as this is an essential area of early intervention in the primary school."*
- *"Unfortunately, we wouldn't have the funding to provide such a service."*

5.2.5 Promotion

Schools were asked in their opinion to what extent they agreed / disagreed with how effectively the pilot was promoted to various stakeholder categories. A breakdown of the responses to this question is included below.

Figure 13:- Schools: How effectively the pilot was promoted



215 of 268 respondents answered this question.

As outlined in the chart above, the % of respondents that strongly agreed/agreed that the pilot was effectively marketed/promoted to various groups are as follows:

- **58%** of schools strongly agreed/agreed that the pilot was effectively marketed/promoted to children.
- **58%** of schools strongly agreed/agreed that the pilot was effectively marketed/promoted to parents/carers.
- **59%** of schools strongly agreed/agreed that the pilot was effectively marketed to therapists/counsellors.
- **84%** of schools strongly agreed/agreed that the pilot was effectively marketed/promoted to schools.

The results demonstrate that one third of respondents strongly disagreed/disagreed that the pilot was effectively marketed/promoted to children, parents/carers and therapists/counsellors. Reasons for this were due to the short lead time and tight turnaround for funding short notice of, extensions and issues with the procurement of therapists/counsellors.

A sample of additional comments in relation to how effectively the pilot was marketed / promoted is included below:

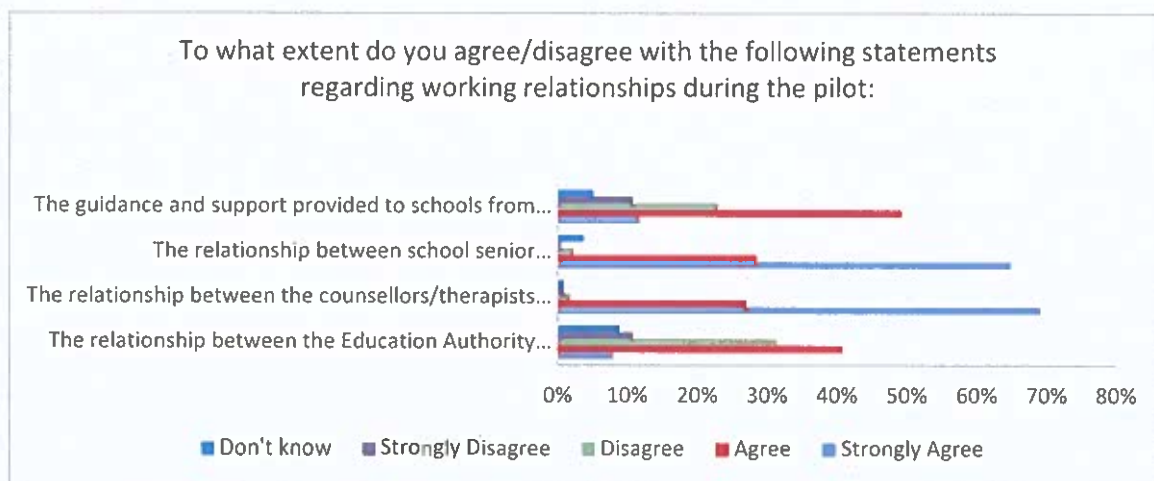
Comments – what extent do you agree/disagree that the pilot was effectively marketed / promoted

- *“Schools were given money at the last minute, for which we were very grateful but there was little or no forward planning. We were lucky to secure a therapist. The school and therapist promoted the service within the school.”*
- *“Once our counsellor agreed to work with our school, we had no problems whatsoever promoting the service and I must say we are absolutely delighted with the pilot and its ongoing outcomes for all.”*
- *“There was a need for some children in school to immediately access the Pilot. It was great that the schools were made aware of the information.”*
- *“I strongly agree that it was marketed effectively to parents and carers since we took the lead in this ourselves. I’m not aware of any promotion through DE or EA.”*
- *“Feel that the pilot came upon schools very quickly and planning time was short. Being in the northwest of the province also made it difficult to access services which appeared to be centred around the Belfast area.”*
- *“We could not market this programme the way we would have liked as it would have raised expectations from the parents that we were going to be able to offer this service to many more children than we had finance for.”*
- *“Two disagree comments - only through our own discussions would it be promoted - not as widely known to parents.”*
- *“It would seem that communication with therapists was not shared with schools and vice versa. Communication was an area that needed developed. Both schools and therapists seemed to be very much in the dark re future provision of funding and thus continued support/ provision for the pilot and pupils. This made it difficult for us when speaking with parents and to plan for provision for those on a very long waiting list.”*
- *“The pilot was ‘landed’ on principals’ desks with no consultation, planning or input. Any promotion was misleading and did not access the stakeholders in an honest and effective manner.”*
- *“I do not want to say one bad thing about this initiative. But perhaps, with hindsight, it does need to be more effectively marketed. It was rushed, at the last minute, we all could have marketed it more effectively to pupils and particularly to parents. This is something to work on in the future.”*
- *“More to be done to highlight the programme to counsellors and therapists so that they can register through iproc system.”*

5.2.6 Relationships

Schools were asked in their opinion what extent they agreed / disagreed with the various statements in relation to the relationships with various stakeholders. A breakdown of the responses to this question is included below.

Figure 14:- Schools: relationships during the pilot



214 of 268 respondents answered this question.

As outlined in the chart above, the % of respondents that strongly agreed/agreed to the statements in relation to the effectiveness of working relationships within the pilot are as follows:

- **49%** of respondents strongly agreed/agreed the relationship between the Education Authority and the school was effective.
- **96%** of respondents strongly agreed/agreed the relationship between the counsellors/therapists and the school was effective.
- **93%** of respondents strongly agreed/agreed the relationship between school senior management team and the school key contact was effective.
- **61%** of respondents strongly agreed/agreed the guidance and support provided to schools from DE/EA was effective.

The results demonstrate that schools and therapists/counsellors had very effective working relationships, however, only half of schools responding reported effective working relationships with EA..

Comments suggests reasons for this were based on the short lead time and tight turnaround to use funding and short notice of extensions, the insufficient supply of therapists/counsellors, guidance being updated and the administrative burden on schools in relation to the pilot. Schools felt the pilot was rushed with little preparation and limited communication which effected working relationships with EA/DE. To improve relationships with EA/DE schools would like to see better communication, planning and more collaboration to improve any future provisions.

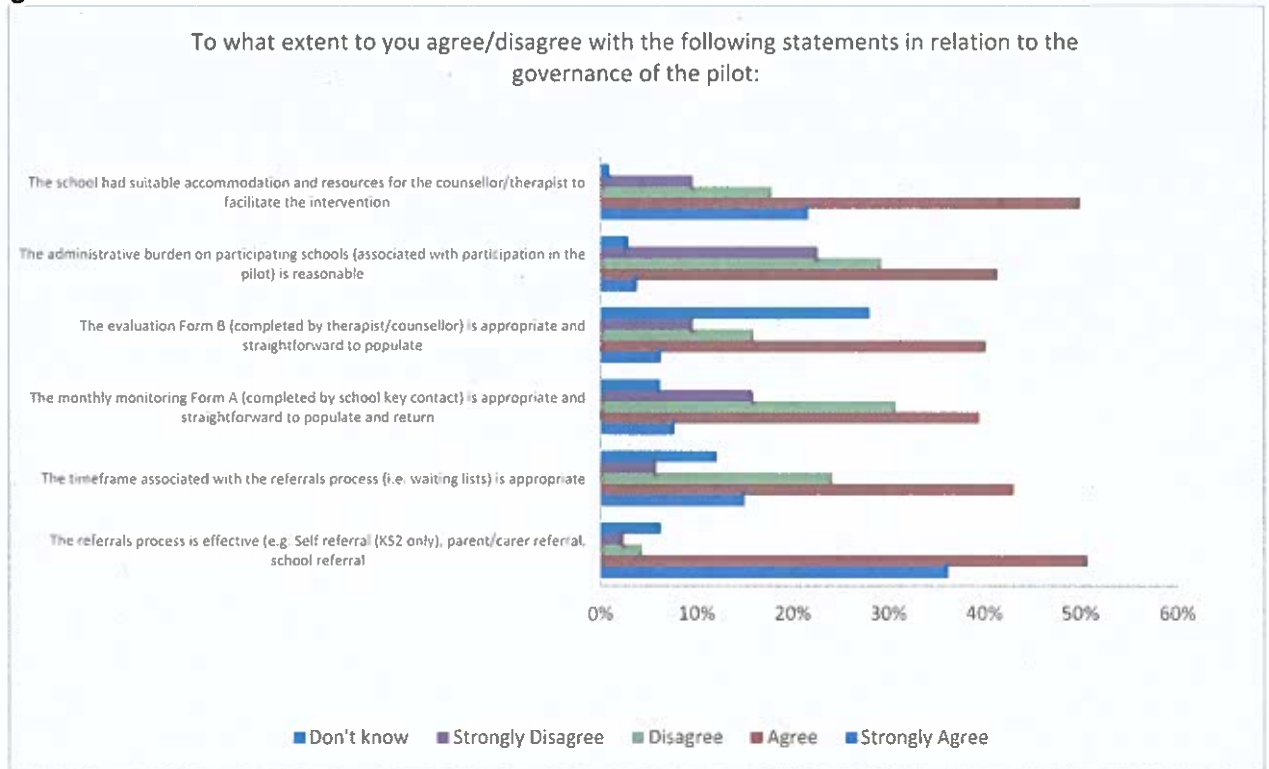
A sample of additional comments in relation to how effective working relationships were during the pilot are included below:

- *“Face to face or zoom meetings may have been useful particularly for school key contacts to plan ahead. Having the list of approved therapists sent out in term three along with confirmation of funding for the next academic year is necessary so that effective planning can take place.”*
- *“Once again, everyone did a good job and any time I had to speak to someone in the EA they were extremely helpful. But of course, all of these aspects could be improved on as improved communication always improves the product. I think it was all too rushed but again this is something that can be easily fixed.”*
- *“Guidance was adequate. Would have liked communication to be more effective and timelier to the academic school year as to when funding is available and for how long. This would enable more strategic decisions be taken at school level in relation to the implementation of the programme.”*
- *“It was very difficult to source the correct providers for the programme and it was not helpful that no member of EA was there to help. Difficult to get someone on the phone to discuss concerns with.”*
- *“The bureaucratic requirements relating to accountability and number crunching were an unnecessary and unwelcome evil. The DE and EA need to understand that schools operate under IMMENSE PRESSURE and BUSINESS CRITICAL and REDUCING THE BUREAUCRATIC BURDENS have become our modus operandi.”*
- *“In our experience 'working relationships' did not exist. There was no element of partnership, genuine guidance or support from DE or EA.”*
- *“Information was very late coming from the EA. It was difficult to plan ahead, and it was unfair to the counsellor and the children as we were informed about future funding much too late.”*

5.2.7 Governance of the pilot

Schools were asked to what extent they agreed/disagreed with the various statements in relation to the governance of the pilot. A breakdown of the responses to this question is included below.

Figure 15 : Schools: Governance of the Pilot



208 of 268 respondents answered this question.

As outlined in the chart above, the % of respondents that strongly agreed/agreed to the statements in relation to the governance of pilot are as follows:

- **87%** of respondents strongly agreed/agreed the referrals process is effective (e.g., Self referral (KS2 only), parent/carer referral, school referral).
- **58%** of respondents strongly agreed/agreed the timeframe associated with the referrals process (i.e., waiting lists) is appropriate.
- **72%** of respondents strongly agreed/agreed the school had suitable accommodation and resources for the counsellor/therapist to facilitate the intervention.
- **47%** of respondents strongly agreed/agreed the monthly monitoring Form A (completed by school key contact) is appropriate and straightforward to populate and return.
- **46%** of respondents strongly agreed/agreed the evaluation Form B (completed by therapist/counsellor) is appropriate and straightforward to populate.
- **45%** of respondents strongly agreed/agreed the administrative burden on participating schools (associated with participation in the pilot) is reasonable.

Overall, the results demonstrate that the governance is reasonable but there is room for improvement.

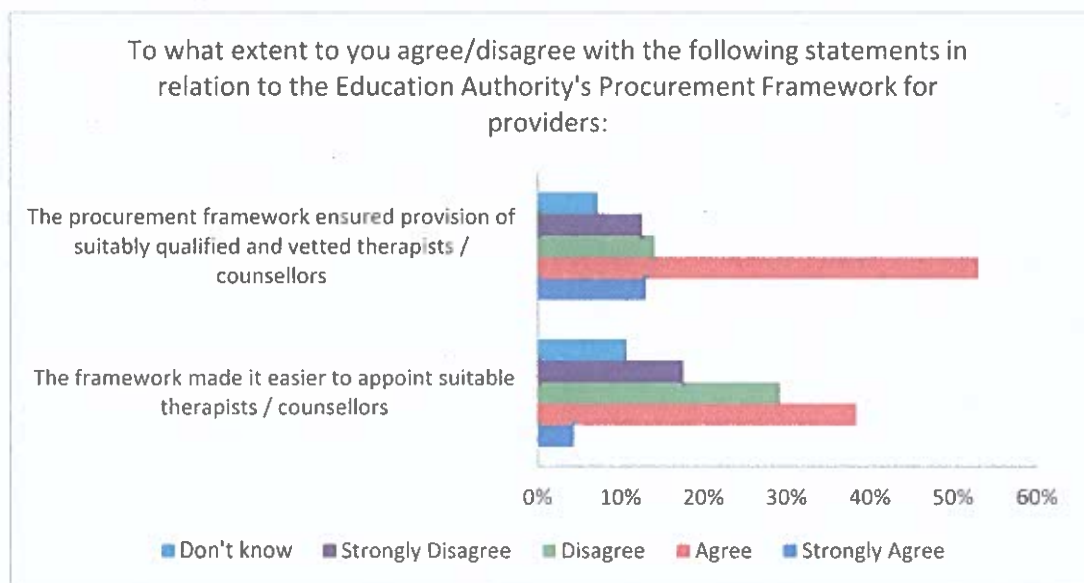
More than half of the respondents strongly disagreed/disagreed that the monthly forms A & B were appropriate and straightforward to populate. Reasons for this included that the guidance and forms were updated several times during the pilot to include standard categories children could present for intervention that were initially missing. Respondents suggested that return dates of the forms were confusing due to extensions of the pilot, the submission of online forms was not straightforward and there was poor guidance and communication from EA/DE regarding the process. This caused extra administrative burden on schools in an already pressurised environment. Results of the survey also demonstrate that more than half of the respondents

strongly disagreed/disagreed that the administrative burden is reasonable despite sub cover being available to schools.

Consultations and more collaboration with schools, therapists/counsellors' and EA/DE would be necessary to improve monthly forms to ensure the correct information is captured, and the forms are appropriate and straightforward to help ease the administration on schools.

Schools were asked to what extent they agreed/disagreed with the various statements in relation to the EA's procurement framework for providers. A breakdown of the responses to this question is included below.

Figure 16: Schools: Effectiveness of the Education Authority's Procurement Framework for providers



207 of 268 respondents answered this question.

As outlined in the chart above, the % of respondents that strongly agreed/agreed to the following statements in relation to the EA's procurement framework for providers are as follows:

- **66%** of respondents strongly agreed/agreed that the procurement ensured provision of suitably qualified and vetted therapists and counsellors and **27%** of respondents strongly disagreed/disagreed.
- **47%** of respondents strongly disagreed/agreed that the framework made it easier to appoint suitable therapists/counsellors and **43%** of respondents strongly agreed/agreed.

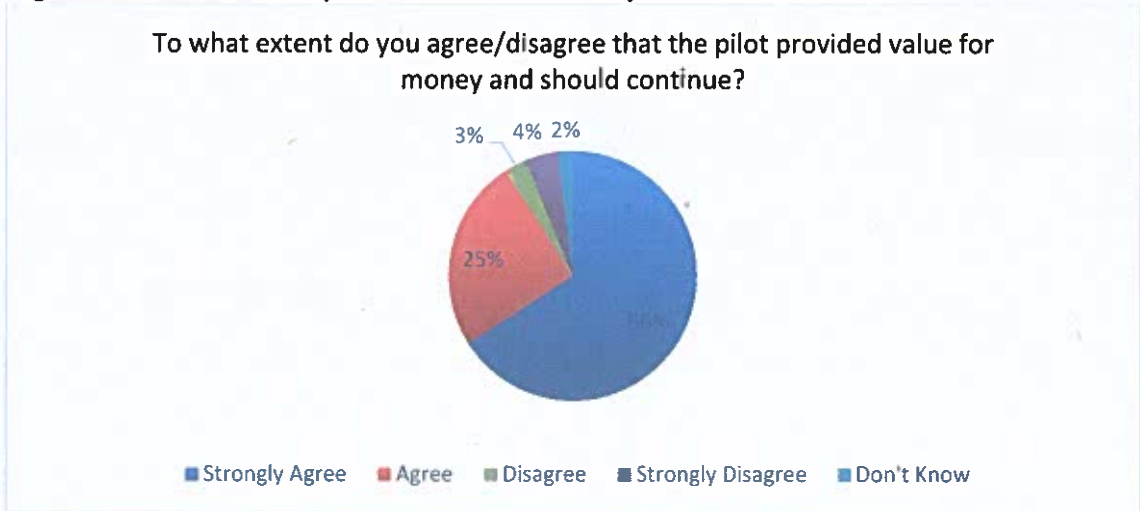
The results demonstrate that nearly half of schools found it difficult to appoint suitable therapists/counsellors from the framework. Reasons for this were due to the limited pool of suitable and qualified therapists/counsellors available especially for schools in rural areas. Suitable qualified therapists/counsellors were either not available, were not willing to travel to rural areas due the travelling time or cost of fuel or did not tender for the relevant areas etc.

A sample of additional comments in relation to the EA's procurement framework for providers within the pilot are included below:

- *"We had a counselling service which I was able to continue with."*
- *"We were already working with the provider so we acknowledge we didn't experience some of the issues others may have had."*
- *"We had a good experience in our school with our provider, but I know of other schools where the provider did not follow primary school counselling guidelines etc and obviously got through the procurement framework. Also, the EA process of counsellors having to have self-employment documentation and not telling providers when that had run out or not having enough staff to process payments puts extra pressure on school's administrative burdens and means that there is a lack of stability from good providers."*
- *"We were fortunate that we were able to continue our links with our existing provider - as relationships are already positive and our counsellor is well known throughout the whole community. I think this was a reason our intervention has been so positive. I'm not sure how effective it would have been if it had been a new range of provision or providers. We used it as an extension to our existing practice."*
- *"It may have ensured provision for suitably qualified therapists/counsellors but not enough of them and no alternative means of using the funding when no counselling was available yet demands for it to be spent by a particular date!"*
- *"There needed to be a register showing when therapists had availability rather than all schools ringing the same people to find out they were full. Someone in EA needed to manage this."*
- *"Very restricted pool of therapists due to procurement list."*
- *"Our school waited for a period of time for the original counsellor to reply to us and when they did, we were told that they would not travel to our part of NI."*
- *"Not enough time to initially find a provider and then the time scale of when funding must be spent changed. Information on the pilot for academic year 2022/23 issued late and initially on Facebook!"*
- *"Finding therapists in country areas is very difficult. I understand that counselling is a very specialist area, and it is important that they are all well vetted and qualified, but this should all have been sorted out prior to the programme being rolled out."*
- *"I am unable to use a provider as she is not on the new framework list. Her name was originally provided by EA in January 22."*
- *"The framework gave a list of therapists however with many schools all scrambling to get the same people it made it very challenging to book anyone with any availability."*
- *"Some counsellors and therapists did not make it onto the tender list. EA has refused to reopen the tender list for updating citing it is 'an expensive exercise to carry out'. With all the difficulties encountered over the last few years, EA can surely come up with an approach to reopen this as many schools in the Fermanagh area have not been able to source anyone to fulfil the programme."*
- *"Governance is needed, but this doesn't help those schools in rural areas - once again our children are being discriminated against in terms of access to resources."*

Schools were asked to what extent they agreed/disagreed that the pilot provided value for money and should continue. A breakdown of the responses to this question is included below.

Figure 17: Schools - If the pilot was value for money and should continue



207 of 268 respondents answered this question.

As shown in the chart above **91%** of respondents strongly agreed/agreed that the pilot provided value for money and should continue.

A sample of additional comments in relation to if the pilot is value for money and should it continue are included below:

Comments To what extent do you agree/disagree that the pilot provided value for money and should continue?:

- *"With the funding that we received we were only able to provide counselling sessions for six of our pupils. We would love for the programme to continue so that other children in need could avail of it. There is a considerable need for services like these in education in the present times."*
- *"Allow those who have counsellors to bid for the funding rather than just handing it out. Removing the service for us would be as ludicrous as stopping SEN provision. Adults and children are facing so many issues today in society and some pressures are caused due to failings of other sectors of society - example health service pressures for Mental Health support - therefore parents have nowhere else to turn. I have numerous real-life stories of how healthy minds have made a difference within my school community. It must continue."*
- *"I feel the programme was very valuable and would offer suggestions in terms of enhancing the list of approved therapists and committing to the same amount of funding for a number of years so that effective planning could take place."*
- *"No idea if it was VFM but strongly agree there is a great need for this service and it needs to be accessible to all pupils who need it, irrespective of the area in which they reside."*
- *"If we do not have this programme then health will be picking up these children. Early intervention for strategies is essential. Having it on site is essential for engagement and attendance at sessions. We just need the programme to continue."*
- *"Advance notice of allocated funding - Dec 6th 22... no idea of funding in Jan - March. Annual allocations going forward. No need to fill in a monthly review for each child...it's not enough time to see a change. Evaluations for each child at the start and end of counselling would be more appropriate. The evaluation statements are not all suitable for children."*
- *"Greater finance to allow us to meet the very real need of more pupils. An expanded list of providers. Cutting much of the pupil information out of the monthly monitoring form. Often you end up writing about the same children each month - this data could be collected at the end of a child's six sessions. All we should have to fill in is how many children availed of the programme and how much we have spent."*
- *"Commitment of funding long term then schools can plan ahead, and address needs systematically."*
- *"EA to allocate a suitable number and variety of providers to each EA area who are made available to the schools in that area. EA to source and ensure every school has a suitable supplier."*
- *"An extended list of providers. Budget to facilitate hire of buses to equine facilitated learning for example. Inclusion of sport services."*
- *"Future long-term planning so that the parents, children and staff can relate to our therapist. The project is on, the project is over, the project is on etc is not how an excellent support programme should work."*
- *"This pilot lined the pockets of a few providers. I believe the money could have been better spent to provide a longer-term solution e.g., train staff within school. We have excellent teachers and learning assistants who would have been eager and skilled to take on training to support the children in schools. Paying extortionate prices and travel to a few therapists/counsellors really makes no sense."*
- *"The programme urgently needs some sort of guarantee for funding for the therapists and for the parent body. I am concerned that we have introduced something of great proven value, and it will be stopped."*
- *"There should be a price cap on Play Therapists etc. Most are charging £[redacted] per session and the same price for parent interviews - in my opinion this is very over-priced. My small allocation of funding didn't stretch to more than 3 children per term only receiving 5 sessions."*
- *"I cannot justify the excessive charges and time allocated per child to Art therapist. Feedback was also so guarded it was not fit for use at class level to follow on."*
- *"I strongly agree that the programme should continue, but I disagree that it is value for money given the cost of some therapists employed by us. For example, one therapist charged us £[redacted] per session, the other charged £[redacted] per session. Both quite high costs. To improve, it would be good to reduce the cost of the therapy sessions. The competition for therapists with the announcement of this Pilot appeared to push their prices up as demand was high. Also, the therapists allocated six-week blocks to individual pupils. One week of this was to speak to parents at the beginning and during the final session so effectively the pupil had only 4 weeks. Moving forward, there should not be a limit on the number of weeks a pupil has access to this service if the need is still there."*

5.3 Provider Views

Provider views were gathered via online survey and follow up interviews. In conjunction with the Project Steering Group, BCS developed a brief “Counsellor/therapists” survey which EA issued to 88 providers on the framework.

BCS received 83 responses, which equates to a response rate of circa 35% and which is considered to be an excellent response rate and a sample on which to interpret the research findings.

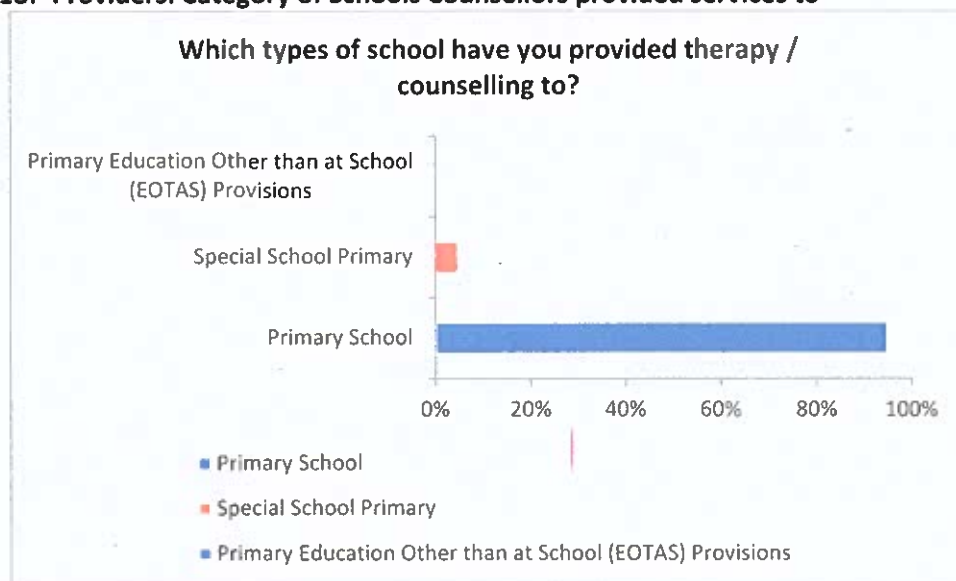
The survey question set was drafted in conjunction with DE and EA and were signed off by the Project Steering Group prior to issue.

It should be noted that due to rounding the figures in the following tables may not always add to 100 per cent.

5.3.1 Background of respondents

The following chart outlines what best describes the schools in which the counsellors/therapists provided a service to. 95% of respondents provided a service to a Primary school and 5% of respondents provided a service to a Special Primary school.

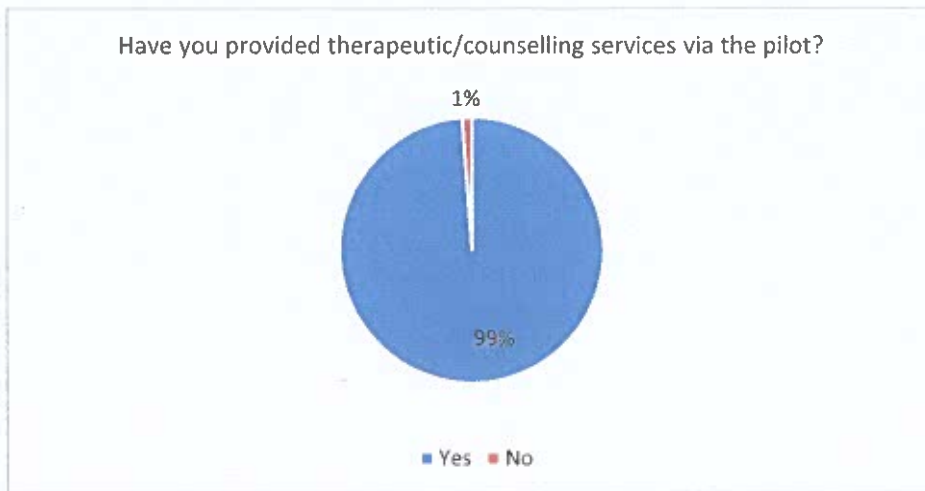
Figure 18:- Providers: Category of Schools Counsellors provided services to



82 of 83 respondents answered this question.

Respondents were asked if they have provided therapeutic/counselling services via the pilot to primary school children. As shown in the following chart the majority of respondents (99%) have provided therapeutic/counselling services via the pilot to primary schools.

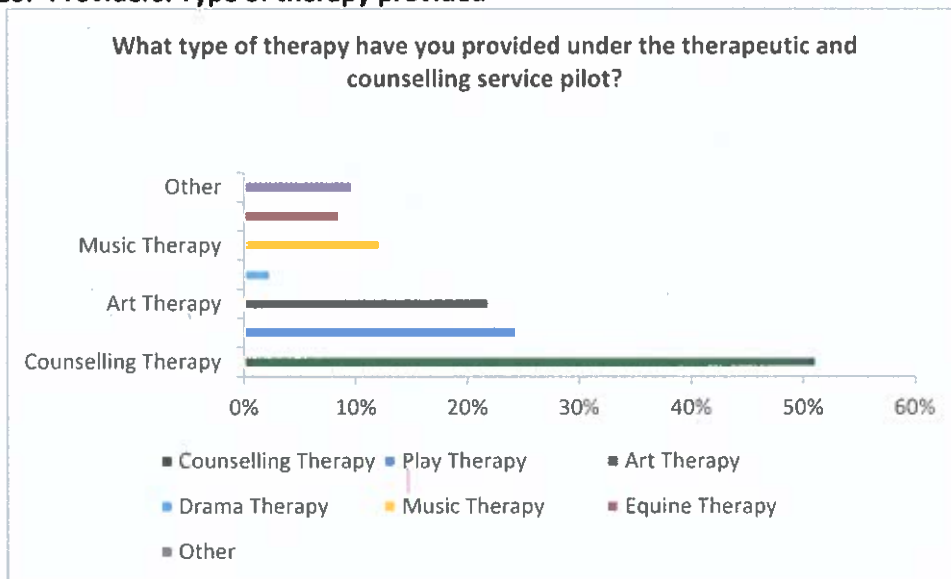
Figure 19:- Therapists/Counsellors provided therapeutic / counselling services via the pilot



83 respondents answered this question.

Therapists/Counsellors were asked which type of therapy they provided under the therapeutic and counselling service pilot. A breakdown of the responses to this question is included below.

Figure 20:- Providers: Type of therapy provided



82 out of 83 respondents answered this question.

The counsellors/therapists provided the following types of therapy as outlined below:

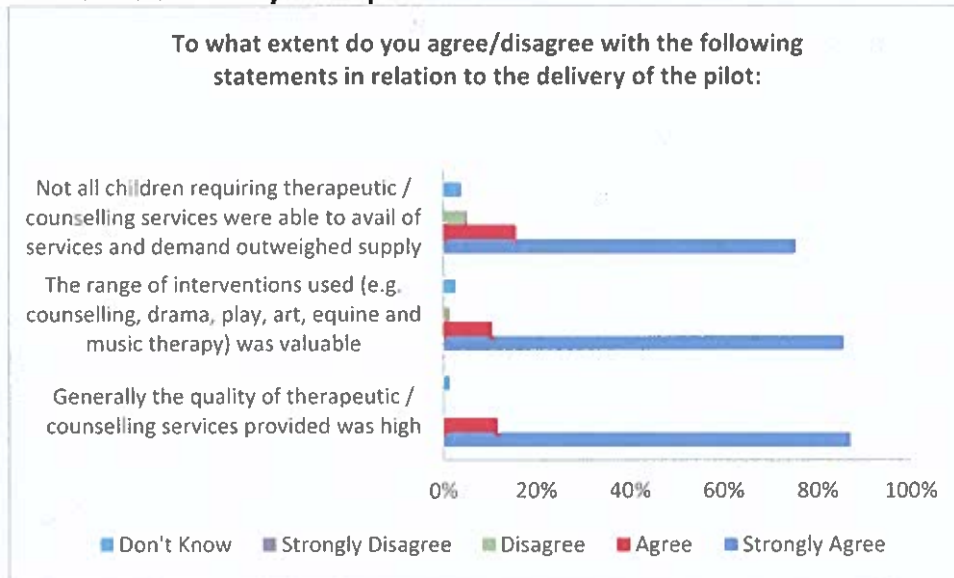
- Counselling Therapy (51%)
- Play Therapy (24%)
- Art Therapy (22%)
- Drama Therapy (2%)
- Music Therapy (12%)
- Equine Therapy (9%)
- Other (10%)

Other therapies which counsellors/therapists provided were CBT, Psychotherapy and Creative therapy.

5.3.2 Delivery

Therapists/counsellors were asked to what extent they agreed/disagreed with the various statements in relation to the delivery of the pilot. A breakdown of the responses to this question is included below.

Figure 21:- Providers: Delivery of the pilot



77 out of 83 respondents answered this question.

As outlined in the chart above, the % of respondents that strongly agreed/agreed to the statements in relation to the delivery of pilot are as follows:

- **99%** strongly agreed/agreed that the quality of therapeutic/counselling therapy services was high.
- **96%** strongly agreed/agreed that the range of interventions used were valuable.

The survey results demonstrate a very positive response and that based on the providers self-evaluation, the delivery of the pilot was of high quality and delivered an appropriate range of therapeutic services.

91% strongly agreed/agreed that not all children requiring therapeutic/counselling services were able to avail of services and demand outweighed supply. This result demonstrates that there is high demand for therapeutic/counselling therapy services within primary schools. Reasons for all children not being able to avail of therapeutic/counselling services was due to the limited numbers of appropriately qualified and accredited therapists/counsellors on the framework. Due to the uncertainty of funding for the pilot, a number of therapists/counsellors were not able to tender for the framework or participate in the pilot as they did not want to leave stable jobs and were not guaranteed long term work through the pilot.

A sample of additional comments in relation to delivery of the pilot included:

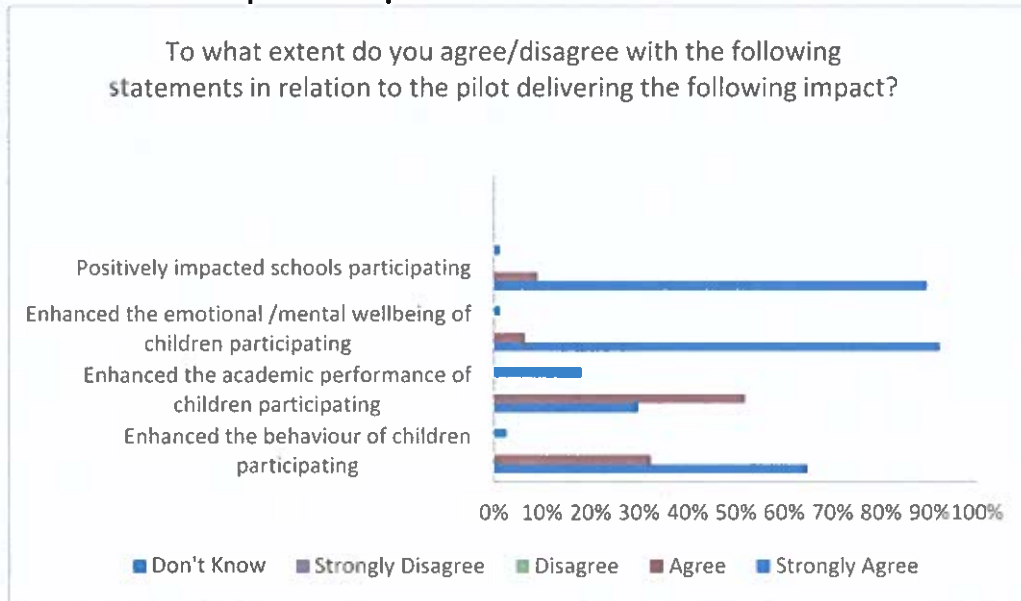
Commentary

- *“Feedback from the school principals and teaching staff has confirmed the positive impact that the counselling process has on children suffering from anxiety.”*
- *“The programme is fantastic. The need in primary schools is so high, especially after Covid-19. All schools have shown nothing but support and encouragement towards this programme and can see the value and difference that counselling/therapy has made in their pupils.”*
- *“It has been extremely beneficial to have had the scope and flexibility to provide both one-to-one and group music therapy allowed by HHM as these enabled interventions to be tailored towards the needs of children referred.”*
- *“These valuable interventions are necessary for many pupils to thrive in education & other areas of their lives & development.”*
- *“The only issue with maintaining a consistent high-quality service was not knowing until last minute if funding was secured for the next term.”*
- *“Whilst the range of interventions offered is good, I think schools would benefit from some guidance on how to appoint a therapist that meets the needs of their school community. I also think that primary schools would benefit from a more regulated approach to delivery like the ICSS contract. Schools do not necessarily have the expertise to oversee a therapeutic service.”*
- *“This programme is hugely needed. There is a great demand for it. The uncertainty of funding delays the start date for the schools and beginning of the therapeutic engagement. Therefore, impacts on how much therapeutic work can be carried out. If this was to be better organised and school funding allocation made known sooner, this could, I feel make the overall process more manageable and effective.”*
- *“There has been a bit of insecurity with the schools as to whether the pilot will continue. This translates down to the therapist's and then to the clients. This unsureness is not good for the therapeutic relationship, especially when working with children who need long term work.”*
- *“I had been contacted by many schools seeking service for their pupils but due to supply of appropriately qualified and accredited practitioners, the service was not accessible to many during the pilot. I feel many schools and pupils lost out on this crucial service and the funding allocated was unable to be utilised.”*
- *“I do not think the EA were aware of what play therapy is about and how the service should be provided to schools. All play therapists meet with parents and teachers initially before therapy with a child can begin to get an understanding of what the presenting issue is. However, I was told that money would not be paid out from the EA for these essential initial and end interviews.”*
- *“When the pilot opened, I was inundated with calls from schools wanting to avail of HHM funding, but there didn't seem to be enough therapists on the tender list to meet the demand. All the schools, including the 3 that I am currently working in, have waiting lists. It is a shame that so much of the HHM funding was left unused due to schools being unable to secure a therapist, considering how useful the services are, and how high the demand is. Part of the issue around this was the EA not announcing funding allocations to schools quickly enough - with most therapists (including myself) not starting back in schools after the summer break until October, and the announcement regarding extensions of the pilot not being announced until last minute, leaving schools (and therapists) unable to plan for the year ahead. Many therapists were unable to apply for the tender due to this uncertainty, and understandably were reluctant to leave other stable jobs in order to participate considering they had no guarantee of ongoing work as the HHM funding was only announced in 2-3-month increments.”*

5.3.3 Pilot Impact

Therapists/counsellors were asked in their opinion what extent they agreed / disagreed with the various statements in relation to the impact of the pilot. A breakdown of the responses to this question is included below.

Figure 22:- Providers: Impact of the pilot



77 out of 83 respondents answered this question.

As outlined in the chart above, the % of respondents that strongly agreed/agreed to the statements in relation to the impact of pilot are as follows:

- **97%** strongly agreed/agreed that the pilot enhanced the behaviour of the children who participated.
- **98%** strongly agreed/agreed that the pilot enhanced the emotional/mental wellbeing of children who participated.
- **82%** strongly agreed/agreed that the pilot enhanced the academic performance of the children who participated.
- **99%** strongly agreed/agreed that pilot positively impacted on the schools who participated.

Overall, the results demonstrates that all respondents strongly agreed/agreed that the pilot has had a positive impact on the children and schools. It is also very positive that none of the respondents answered strongly disagree/disagree that the pilot did not make an impact on the behaviour, emotional/wellbeing and the academic performance of the children who participated and the schools.

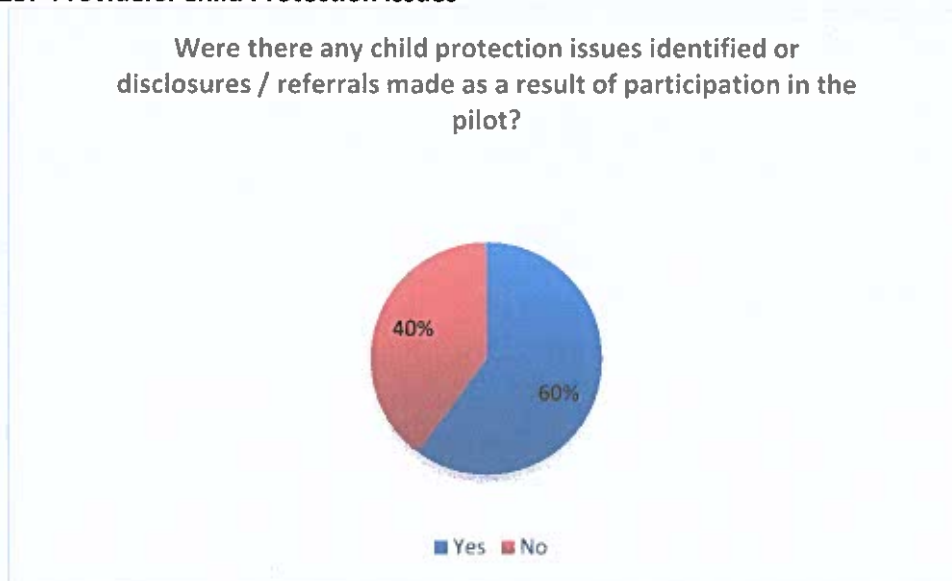
A sample of additional comments in relation to impact of the pilot are included:

Commentary

- *"When a child is referred to me sometimes the behaviour could be stemming from home. They could show signs of good behaviour in the school environment, so teachers do not see any issues or concerns, however it can be different from the home environment. I had children referred from teachers of behavioural issues and help the child to talk about they are feeling and implement coping strategies so the child can manage when they are triggered in their surrounding environment. I feel it has massively shown positive wellbeing in children as it has improved their attention span, concentration, the ability to grow in confidence and recognise their strengths and weaknesses. Increase of relationship with friends and family. We all know that a child can be impacted by the ACEs (Adverse Childhood Experiences). Child needs their voice to be heard when they are young as this can have a great impact in how they live their future."*
- *"Therapeutic interventions are a valuable investment to the lives of participating pupils & impacting/improving the lives of others around them."*
- *"Culturally in the school the impact of counselling benefited staff knowing that there was a trained counsellor on site to refer to when issues were arising knowing that they could refer their students."*
- *"I had one child who began to cry whenever I shared that I was unsure if the funding was going to be continued. This speaks volumes in itself to the value this child, and many others, place on therapy. The staff's general feedback was positive; many commented saying they felt relief knowing that the children were getting additional support in a way that they could not offer it."*
- *"Teachers and principals regularly commented on the change they were seeing in the children who accessed the counselling - describing them as brighter, a weight off their shoulders, engaging better socially, and so on."*
- *"The service has had a great impact on the children and families who were able to avail of it. In some cases, it has been the early intervention that has prevented future school avoidance and mental health deterioration."*
- *"My principal regularly reported how beneficial she felt it was to be able to offer this service in school. She had simply sent a text message to parents for anyone who might like to avail of the service, and we had 12 referrals in a couple of days. For a small school, this is remarkable, and she said previously they would have never been able to afford to offer therapeutic support to these children."*
- *"I do agree this has been a good intervention even though not many children can access. I see many children coping okay in school, holding it together and not at home and these children have missed out on this pilot, these are the perfect children for play therapy. I also felt that some teaching staff felt awkward about approaching parents in case they took offence."*
- *"It is hard to quantify and determine the academic impact along with other important factors. However, there has been improvement in practice transfer test scores for P7 children attending the service."*
- *"As a school's counsellor for [REDACTED] years I can see how therapeutic interventions have greatly enhanced all the areas mentioned above for the majority of children I have worked with. I cannot say how the pilot has impacted as I do not have any of the outcome's statistics."*
- *"Some schools needed socialised to what counselling/therapy is and what it isn't. More training required for primary schools regarding this is needed. Also, the pilot was too short to adequately assess the impact on schools who have just received the service during the pilot. From our experience of delivering counselling in schools over [REDACTED] years, counselling provision has strongly positively impacted these schools."*

Therapists/counsellors were asked if there were any child protection issues identified or disclosures / referrals made as a result of participation in the pilot. A breakdown of the responses to this question is included below.

Figure 23:- Providers: Child Protection Issues



The chart above outlines that 60% of therapists/counsellors were able to identify or forward disclosure/referrals as a result of the participation in the pilot.

Counsellors were also asked to confirm how many child protection issues were identified or disclosures / referrals made as a result of the pilot within the comments in this question.

Therapists/Counsellor identified 127 child protection issues or disclosure/referrals were made as a result of participation of the pilot³⁰.

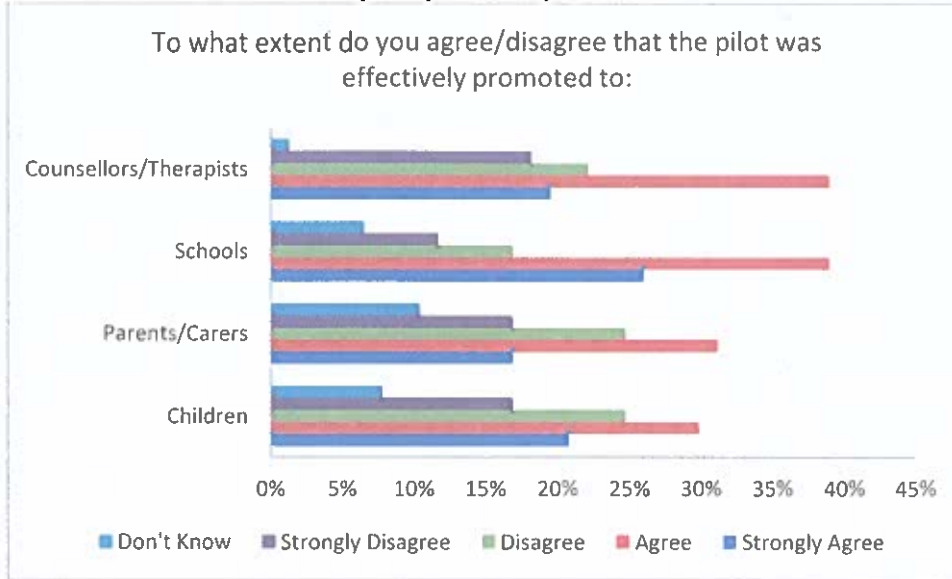
The results demonstrate that the pilot achieved a key outcome from the Business Case to identify child protection issues at an early stage.

5.3.4 Promotion of the Pilot

Therapists and counsellors were asked in their opinion to what extent they agreed/disagreed with how effectively the pilot was promoted to various stakeholder categories. A breakdown of the responses to this question is included below.

³⁰ Note: 204 no. child protection issues were recorded on the MMRs submitted during the evaluation period.

Figure 24:- Providers: How effectively the pilot was promoted



77 out of 83 respondents answered this question.

As outlined in the chart above, the % of respondents that strongly agreed/agreed that the pilot was effectively marketed/promoted to the various groups are as follows:

- 51% of therapists/counsellors strongly agreed/agreed that the pilot was effectively promoted to children.
- 48% of therapists/counsellors strongly agreed/agreed that the pilot was effectively promoted to parents/carers.
- 65% of therapists/counsellors strongly agreed/agreed that the pilot was effectively promoted to therapists/counsellors.
- 58% of therapists/counsellors strongly agreed/agreed that the pilot was effectively promoted to schools.

The results demonstrate that only half of the respondents agreed that the pilot was effectively promoted to children and parents by schools. Reasons for this included the short lead in time, the tight turnaround to use funding and the extensions to the pilot to market and promote the pilot effectively to children and parents.

Promotion for the pilot could be more effective with an appropriate lead in time and better understanding of therapeutic provisions being offered.

Two thirds of the respondents agreed that the pilot was effectively promoted to therapists/counsellors but there is an opportunity to make this more effective by improving the promotion campaign to attract more appropriate qualified therapists/counsellors to tender which will reduce the insufficient numbers of providers in the future.

A sample of additional comments in relation to effectiveness of the promotion of are pilot included:

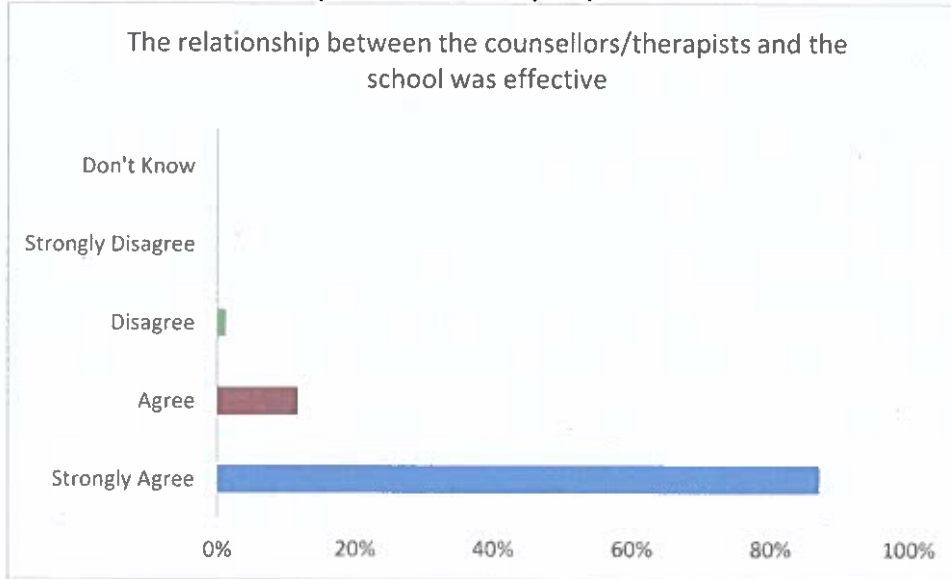
Comments – To what extent do you agree/disagree that the pilot was effectively marketed / promoted

- *“There were some delays in getting information to schools, but otherwise, once the information was released, it was excellent.”*
- *“The school and therapists promoted the pilot to the parents/carers and children as the referrals were being made. I feel this was done well, as no parents refused the service. Therapists of course are passionate about therapy and children's mental wellbeing, and this passion is reflected in the schools too, which feeds into the promotion and promotion towards parents and children.”*
- *“I feel that once the schools and Therapeutic practitioners engaged and discussed best way forward and got a better sense to what the pilot was offering then parents/carers were given well informed information to reassure them that their children were being offered a great opportunity to explore, be supported in a safe therapeutic environment.”*
- *“It would have been beneficial to have an online information session prior to the pilot being set up.”*
- *“The pilot was not marketed to the schools by the EA or the DE. Within the school setting it was promoted by the counsellor and the designated officer to staff, parents and children.”*
- *“There wasn't a lot of time given at the beginning of the pilot for agencies to produce HHM specific promotional/information materials to parents and schools before the programme went live and services were in high demand with a tight turnaround for schools to use their funding.”*
- *“I felt the school, parents had very little knowledge of other areas of therapeutic fields, such as art therapy, play therapy etc. The HHM booklet didn't include other professional bodies, only the BACP body for counsellors only. Art therapy is bound to BAAT (British Association of Art Therapists), if this was clearly stated in the HHM booklet of the BAAT website, I think this would have saved time and cost.”*
- *“Once schools and therapists were aware of the funding, children/clients were prioritised appropriately within the HHM specifications and parents, and children were effectively marketed. However, communication from EA regarding the HHM pilot was short notice and many schools had too little time to find a therapist in time to use the funding. Therapists were also not given enough information and enough time to register with the tender.”*
- *“It was not marketed or promoted to children and/or the parents/carers as schools would often highlight children suitable and make a referral that way for the programme. The parents were not made aware of the services and due to the roll out of the programme and not knowing if it would be extended, schools could not put out a newsletter to inform parents of this or they would be inundated with lists of children put forward by parents to start therapy, as there was such a need. HHM was never given a clear 'we have funding, and it will be in place for the full school year' which gives the school and therapist the knowledge that it is more permanent and therefore could look at creating a waiting list. However, HHM seems to be set to a couple of months at a time with last minute notice that it is being extended but the funding would also be late, so it made it difficult for schools to offer or promote this openly to all.”*
- *“My sense from schools is that they felt they received the promotional materials with too short notice and they felt rushed into making referrals.”*

5.3.5 Relationships between Therapists/Counsellors and the Schools

Therapists/Counsellors were asked to what extent they agreed / disagreed in relation to the relationship between the therapists/counsellors was effective. A breakdown of the responses to this question is included below.

Figure 25:- Providers: Relationships between therapists/counsellor and schools



77 out of 83 respondents answered this question.

As shown in the chart above 99% of respondents strongly agreed/agreed that the relationship between therapists/counsellors and schools were very effective.

A sample of additional comments in relation to the effectiveness of the relationship between therapists/counsellors and schools within the pilot are included:

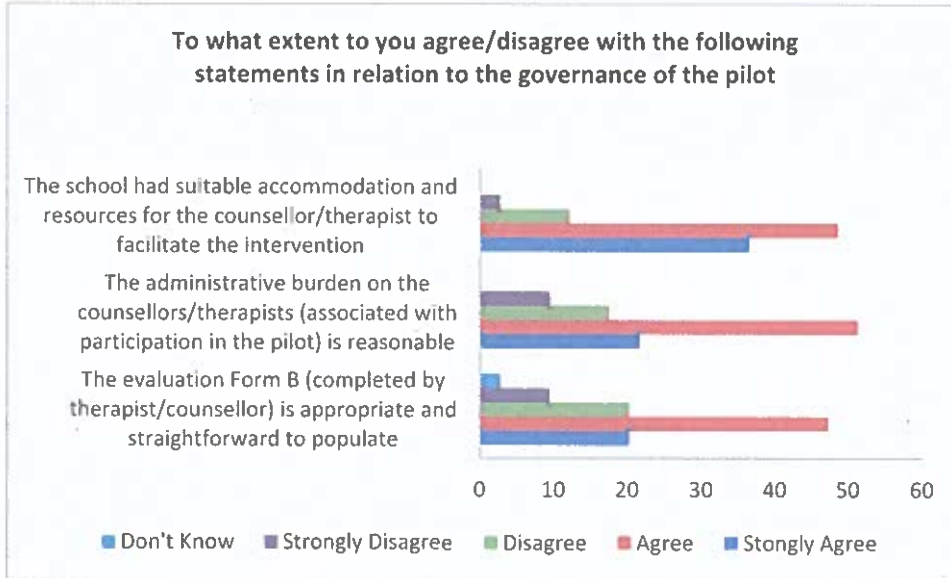
Comments – The relationship between the counsellors/therapists and the school was effective

- *"It is imperative that there is a good honest working relationship between both parties with an understanding of roles and responsibilities on both sides."*
- *"Engaging schools' relationship was valued, developed & maintained."*
- *"I felt schools listened to me and especially the secretaries [redacted]. I had to have meetings with principals and teachers to educate them on what play therapy was as the EA had given them no idea at all. I have found schools very open to the idea of more creative therapies and are beginning to see the benefits. However, they need to be assured of money for an academic year in order to plan for children to have sessions as a minimum of 12 sessions is essential in order to see any progress at all. The EA seem oblivious to this fact and therefore, children were not able to have as many sessions as they required."*
- *"I have never had better relationships with schools and their staff. The pilot released the financial pressures and allowed therapists and school senior staff to work together as they are supposed to."*
- *"Good working relationships are the corner stone for best practice within schools. I make this a priority in my practice."*
- *"In my experience, all schools I have worked in under HHM have been great. They have supported me and been very thankful for the work I came in to do. Even with uncertainty around HHM continuing or what the future may look like, I have gotten through it with the help of the schools. We have supported each other from the beginning."*
- *"Again, I can only answer on my own experience, but this element is crucial to the effectiveness of the work and in my opinion takes some time to develop - therefore consistency in provider is of utmost importance."*
- *"The working relationship is due to the individual counsellor. Those with relevant experience of working in school understand that system work is key. [redacted] Guidelines and best practice need to be clear and understood by all involved."*

5.3.6 Governance of the pilot

Therapists/Counsellors were asked to what extent they agreed / disagreed with the various statements in relation to the governance of the pilot. A breakdown of the responses to this question is included below.

Figure 26:- Providers: Governance of the Pilot



74 out of 83 respondents answered this question.

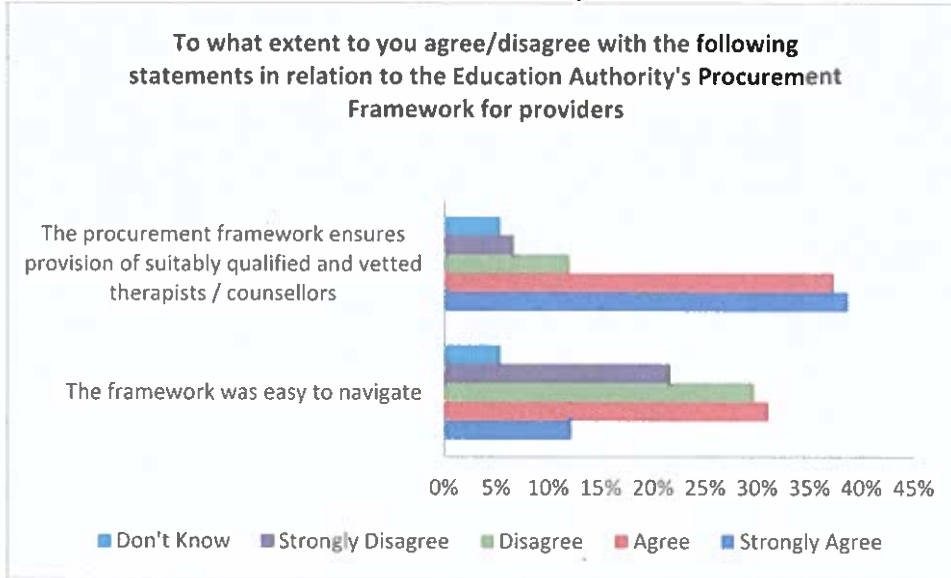
As outlined in the chart above, the % of respondents that strongly agreed/agreed to the statements in relation to the governance of pilot are as follows:

- **68%** of respondents strongly agreed/agreed that the evaluation Form B (completed by therapist/counsellor) is appropriate and straightforward to populate.
- **73%** of respondents strongly agreed/agreed that the administrative burden on the counsellors/therapists (associated with participation in the pilot) is reasonable.
- **85%** of respondents strongly agreed/agreed that the school had suitable accommodation and resources for the counsellor/therapist to facilitate the intervention.

The results demonstrate that the therapists/counsellors had a positive response relating to the governance of the pilot.

Therapists/counsellors were asked to what extent they agreed/disagreed with the various statements in relation to the EA’s Procurement framework for providers. A breakdown of the responses to this question is included below.

Figure 27:- Providers: Governance -Education Authority's Procurement Framework



75 out of 83 respondents answered this question.

As outlined in the chart above, the % of respondents that strongly agreed/agreed to the statements in relation to the EA's procurement framework for providers are as follows:

- **76%** of respondents strongly agreed/agreed the procurement framework ensures provision of suitably qualified and vetted therapists / counsellors.
- **43%** of respondents strongly agreed/agreed the framework was easy to navigate.

The results demonstrate that three quarters of therapists/counsellors agree that the EA's framework is appropriate to ensure that therapists/counsellors are suitably qualified and vetted. However, over half of therapists/counsellors found the framework difficult to navigate as they were not fluent with the process. This suggests that there are opportunities to improve the e-tendering process by giving more guidance and advice on completing tenders to providers.

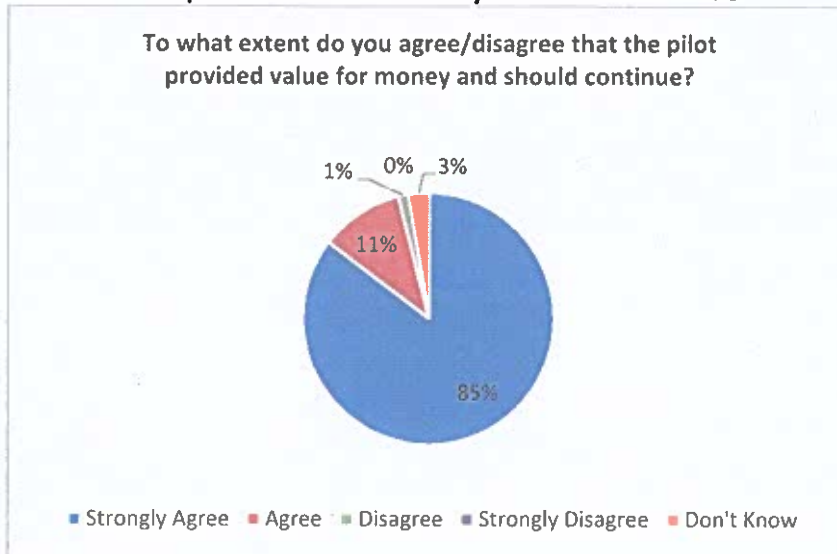
A sample of additional comments in relation to EA's procurement framework are included:

Comments – To what extent to you agree/disagree with the following statements in relation to the Education Authority's Procurement Framework for providers

- *"The administrative burden for the actual pilot was reasonable, but the procurement process (applying for the tender) was extremely difficult for a lot of therapists. The online portal was tricky and temperamental and was not intuitive. For example [REDACTED] [REDACTED] Other therapists who were highly qualified and experienced were excluded because of their membership body, e.g., UKCP. I also think it was very confusing because while the framework was designated as a pilot, it did say on it that it was estimated to be £40 million pounds over 4 years. However, the dates kept being changed so there was no certainty as to when we were actually employed until. There was also very little guidance or even templates as to how things were meant to be written, what was essential or non-essential. Hopefully this will be better this time around."*
- *"There has been no direct contact with counsellors. Form B may be useful for evaluation but as counsellors we could also benefit from being able to use this with parents/carers and teachers. Uncertainty around longevity of the pilot means we are constantly considering having to end or balancing what type of counselling we can offer should it be ending soon."*
- *"I felt the SDQ sometimes did not fully reflect each child's overall performance. The pre-score and post-score could be the same scores, however observation of the child during therapy and feedback from teacher/parent in the school or home environment shows improvement in their mental wellbeing."*
- *"The tendering process was badly communicated and seemed designed for larger agencies who were able to employ experts to complete. As private practitioners it was extremely complicated and very difficult to know what we had to do. About 30 of us got together to support one another. Many tears and much stress were experienced."*
- *"I would like to apply to work in the schools again, however I am also hoping it is not as complicated and difficult to do this time as it was the first time round."*
- *"Initially found the procurement framework overwhelming, very intimidating and full of unfamiliar jargon and the original timescale to be unrealistic. However, having gone through the process successfully I feel I would be much more confident doing it a second time. The guidance videos provided, and the helpline were essential to my completion of the process. I did feel that the process was quite comprehensive, told you upfront what the professional requirements were going to be and had good quality control measures and therefore probably managed to weed out inappropriate applications quite early on."*
- *"Collaboration with the appropriate governing bodies such as BACP, BAAT, PTUK etc would be beneficial for the DE when thinking about procuring services for a primary school therapy service. This could aid a more robust awareness of how to source suitable therapists. Having a diploma in counselling and experience of working with children (regardless of what field of experience) does not necessarily mean that the therapist is suitable to work therapeutically with children. Likewise, Art therapists with a master's in art therapy does not mean they have experience of working with children using Art Therapeutic techniques. The Competency of therapists must be better scrutinised. Agencies who specialise in employment and recruitment of staff are probably better placed to govern practice and vet appropriate candidates to work with children. Schools are not equipped to. Appropriate policies and procedures pertaining to therapies must exist to protect children, who are the most vulnerable."*
- *"I believe the need to re-tender is a waste of time and is unfair given the timeframe and the fact we are in schools delivering a service that we may not be successful for in January - haven given so much space therapeutically to build relationships and strong safe spaces for our clients to explore their lives."*
- *"Form B was basic and then changed and doesn't capture enough, I had good rooms to use but provide all my own equipment Framework was very stressful indeed."*

Therapists/counsellors were asked to what extent they agreed/disagreed that the pilot provided value for money and should continue. A breakdown of the responses to this question is included below.

Figure 28:- Providers: Pilot provide value for money and should continue



75 out of 83 respondents answered this question.

The chart above shows that, in their opinion, 96% of respondents strongly agreed/agreed that the pilot provided value for money and should continue. 1% of respondents disagreed that the pilot provided value for and should continue and 3% of respondents didn't know.

The results demonstrate a very positive response to the overall pilot from therapists/counsellors and suggests that therapists/counsellors believe the pilot was successful and improved the health and well-being of children in primary schools.

A sample of additional comments in relation to if the pilot was value for money and should continue are included below:

Comments – To what extent do you agree/disagree that the pilot provided value for money and should continue?

- *“A clear yearly programme with allocation of budgets from the start of the school year is crucial in order to help planning and procurement of appropriate staff.”*
- *“I do think project should continue and of course it benefited children but I also seen wider impact on the teacher being supported and class peers. I do strongly feel however that we should be looking upstream to stop some of this, early intervention and changing the education system to match with children's development as when we push too early it causes emotional difficulties. I know our communities have a lot of adverse childhood experiences but when we harness the power of child led play especially in KS1 we wouldn't have the same issues rising.”*
- *“From a small service perspective, I believe the pilot worked well and it was fair to the smaller providers who offered a dedicate service to their local primary schools.”*
- *“I think the money is at good value. Following our governing bodies, it covers our costs. However, this term's budget only covered 6–8-week sessions in schools this term instead of the normal 12 weeks. It isn't always ideal as the children only begin to make progress and become familiar with me around week 6. Therapy is a long-term service. But it has allowed me to go to schools that have not been able to avail of the service at all.”*
- *“I feel it is a natural partnership and provides a holistic approach to wellbeing.”*
- *“This programme is a GREAT asset to the schools; the children need it!”*
- *“It has benefited so many children in so many ways and this is not being captured in the current format. More forward planning required and a more straightforward framework.”*
- *“I agree, because I strongly believe that every primary school child should have access to counselling, in the same way that all post-primary pupils do. However, I think it needs to be organised in a much more efficient way. Counsellors and organisations providing counselling should have been consulted beforehand. It was clear that those rolling it out had little understanding or experience of therapy and made it difficult for those on the ground already delivering. More regulated approach needed. More accountability Clearer guidance for schools.”*
- *“It would be more stable as in running for a 2- or 3-year period, rather than a few months at a time.”*
- *“It was value for money when schools requested as many children as possible to access the therapy in groups, however this wasn't always most beneficial for each child, and some required individual therapy. The provision of funding for an academic year rather than by term would allow schools to better plan and refer children in most need and to have their needs met in the most effective manner, whether groups or individuals.”*
- *“The programme should be in place for the full calendar year as it is important to: Preparation and planning for a September start to run continuously through the school year. This would ensure that the service is not interrupted and provide confidence in the programme.”*

5.3.7 Provider Interview Findings

In addition to the provider survey, BCS conducted qualitative data gathering with a range of providers within the framework via virtual one-to-one interviews. See schedule of consultees at [Appendix 4](#).

The responses are summarised in the following sections.

5.3.8 What are your views on the delivery model?

Overall providers were generally excited for this pilot and one provider in particular indicated that they have been lobbying for a counselling intervention for primary schools for over 15 years. However, they felt that there were issues with delivery, and they found the speed of the launch to be very challenging. They felt that the delivery of the pilot could have been better with more time to consult with schools and providers to ensure there was an appropriate workforce, processes, procedures and training and support established to improve the efficiency and effectiveness of this pilot.

Larger providers, already delivering school services before the pilot, found the delivery ran smoothly as these schools were already aware of the different types of interventions, procedures and the process. A number of less experienced schools were not aware of the different types of therapy, and some providers felt that this made the delivery of the pilot complex. Providers believe more awareness and information is required so schools can gain a better understanding of the different therapies and providers felt EA support for schools was limited.

Larger providers generally believed the procurement framework was not the best model for this programme as it was inflexible for the limited NI workforce of therapists/counsellors. The procurement model used for the pilot is known as a Fixed Framework Agreement and the term “fixed” refers to the fact that no additional providers can be added during the life of the framework. Providers felt that a dynamic framework model might be more appropriate where additional providers can be added on an annual basis.

Larger providers felt that any future provision would benefit from a contract similar to the ICSS model to offer more flexibility and better governance.

Sole traders believed the framework was flexible and gave them a unique opportunity to compete rather than being employed through larger providers. They appreciated the opportunity to choose local schools to provide appropriate counselling/therapy to instead of being sent to any school in the region. Sole traders found the tender process challenging, especially if it was their first tender application. Smaller providers suggested that EA tender guidance was insufficient and discouraged providers applying, indeed smaller providers gained help and support from each other.

Generally, all providers felt that the delivery of the pilot was adversely impacted by the low number of available qualified counsellors/providers. Despite funding being available throughout the pilot, providers suggested that some schools were not aware of funding until confirmation that the pilot was being extended. This brought uncertainty to schools and providers and made forward planning challenging. Due to high demand and low availability of therapist/counsellor’s providers feel more work is required to increase the workforce. Suggestions included development plans for college students, where, within a year, students become qualified

therapists/counsellors through appropriate training, qualifications and supervised sessions or the programme includes university and BACP etc. placement opportunities within their workforce.

5.3.9 What are your views on how the pilot was governed?

The larger providers believed there was little to no governance within this pilot and were concerned there were limited quality assurance processes and complaints processes in place. These providers highlighted the difference in high quality governance of the ICSS and this pilot and were not sure if this was due to ICSS being a contract rather than a framework. They believe HHM governance processes should mirror ICSS to ensure children and young people are receiving a good quality service.

ICSS contract stipulates that there are operational agreements in place between schools and providers including key information, key contacts, number of sessions, delivery mechanisms, guidelines for safeguarding and contacts for referrals etc. These agreements ensure high quality governance which providers feel is missing from the pilot. It is noted however that EA stated in the specification that the ICSS handbook should be followed.

Larger providers raised concerns regarding safeguarding training for providers. Larger providers deliver safeguarding training for their staff and raised concerns that smaller providers may have not received any safeguarding training or be aware of safeguarding signs, processes and procedures. This is an important outcome of this intervention as it provides early disclosures. Note: EA have advised that they provided safeguarding training to providers.

Smaller providers/sole traders had no issues with the monitoring information but did suggest that there should be better guidance and set templates to complete the forms.

Larger providers were not so sure about the pilot monitoring information and stated that they had to provide support to principals to complete the monitoring forms and payments as the schools found this complicated. They suggested that this put unnecessary administrative burden on schools and providers felt there was an easier way to monitor this information. The larger providers suggested that EA didn't provide much support to schools completing this paperwork.

Some providers believed monitoring forms lacked consistency in how they were completed by schools and noted that Form B was changed during the pilot. They suggested that EA guidance was limited and consequently there was no consistency completing forms. They questioned the validity of monitoring data. They also felt providers should not be completing Form B's and that the school, child and parent should be completing the SDQs. All providers consulted used CORS (Child Outcomes Rating Scale, for measuring overall wellbeing and is validated for children 6 – 12 years) and BAC (Brief Assessment of Cognition) evaluation tools to monitor progress in addition to Form B's.

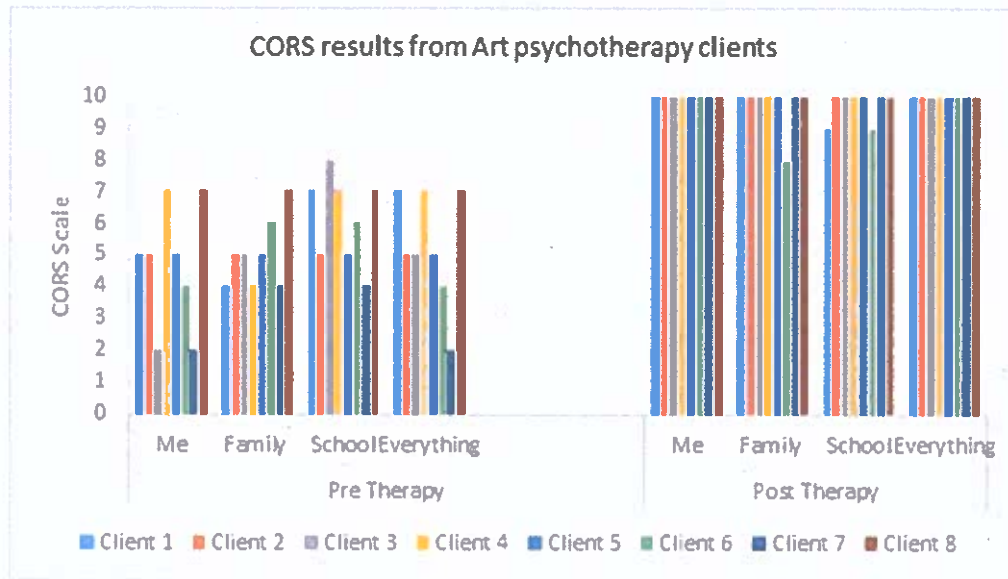
5.3.10 What are your views on the impact of the pilot?

Providers believe that the pilot had a positive impact on children. All provider's noticed the stigma of mental health was reduced and awareness of help was increased. This filtered out to communities outside the school.

They also believed the pilot had a positive impact in the wider school community especially with teaching staff, who become more aware of children's issues, see therapy as a positive intervention and are becoming trauma informed with the ability to recognise when a child needs help and put in place the appropriate referrals.

One of the larger providers provided evidence in relation to impact sourced from their child-completed CORS results, captured in the academic year 2021-22, from 450 children who received counselling. It was completed at each intervention session. These results indicated that 81% of children whose baseline CORS score was within the 'clinical distress' range moved to 'normal range' at intervention endpoint. Further evidence of HHM positive impact was provided by an art psychotherapist, operating as a sole trader, from eight clients which demonstrates CORS scores were greatly improved after an 8-week block of Art psychotherapy (10- highest and 1- lowest, things are not good) in the figure below:

Figure 29: Art Psychotherapy CORS scores



Overall, providers highlighted concerns of the children/school staff/providers regarding the long-term uncertainty of the pilot in case it ceases with children who are mid-intervention which could cause more anxiety and stress. They suggested that this had a negative impact on children, schools and families as they have built trusting relationships with their therapists/counsellors and are worried the pilot will stop.

5.3.11 What are your views on Value for Money associated with the pilot?

Larger providers felt the pilot was value for money but to gain a better assessment would need to see the pilot's effects over a longer term. They suggested there is a need to assess how the pilot has affected other departments such as health to assess if early intervention has reduced the number of mental health referrals in the future and adult life. The need to assess if early intervention in primary schools has reduced referrals in ICSS was also suggested. Providers suggested that the pilot has also helped children who need more help quickly access resources e.g., children who had have special needs have had early identification through the pilot and gained the appropriate help.

Larger providers feel that to make the pilot more efficient DE/EA would need to re-visit the number of sessions provided per day in schools and if unused sessions can be re-used by other schools. Providers highlighted concerns that some providers could offer up 10 sessions a day in some schools and were concerned of the quality of these sessions as the Code of Conduct states no more 5 sessions per day. They believe that DE/EA should set a number of sessions a day on

the framework to ensure that the quality of sessions is appropriate, and counsellors/therapists have efficient time to provide an effective service.

Smaller providers felt that the pilot was value for money as they will provide reasonable rates to schools as larger providers have bigger overheads for administration etc.

5.3.12 What are your views on Relationships during the pilot?

All providers felt that the relationships with schools were generally good especially with Key Contacts, teaching staff and principals. Key Contacts and principals were very hands on and would meet regularly with the therapists/counsellors to discuss progress including if there were any safeguarding issues etc. Larger providers felt there were tensions with schools at times when providers couldn't provide counsellors/therapists to schools due to resource issues.

5.3.13 What are your views on promotion during the pilot?

Generally, providers felt that they had promoted services effectively in schools as there was a high demand for therapy/counselling.

Sole providers would like the opportunity to present and engage with more schools and promote the particular type of therapy they provide to make schools more aware of how this intervention could benefit children.

All the providers felt that the tender was not effectively promoted by DE/EA. Providers heard about the tender competition through word of mouth or their accreditation body. They believe that a number of suitable providers missed the tender or where not aware there was a tender which also reduced the pool of therapists/counsellors.

5.3.14 What are your views on the ongoing need for a primary school counselling service?

Providers believe there is a continued need to deliver primary school therapies / counselling however, there is a need for DE/EA to work to increase the workforce, upskill schools with information and knowledge and ensure the correct data is being captured to monitor the progress of the intervention.

5.4 EA Views

5.4.1 Introduction and Background

In addition to conducting the schools and counsellors' surveys, BCS conducted qualitative data gathering with the Education Authority via a virtual interview. The responses are summarised in the following sections.

5.4.2 Was the pilot a good strategic fit?

The EA considered the HHM to be a good strategic fit in alignment with the Children and Young People's Strategy, the Framework for Children and Young People's Emotional Health and Wellbeing in Education (including the early identification aspect) and that it sits alongside the EA's Nurture service among other things. Primary schools counselling was lobbied for some time and the EA support the provision of therapeutic services to children in the form of a pilot.

5.4.3 What are EA views on the delivery model?

EA felt that it is important to set some context in relation to the delivery model. Indeed, the lead in time was a contributory factor to challenges faced throughout the pilot. The lead in time between funding being allocated and the pilot becoming operational was insufficient.

In addition, NI procurement law³¹ requires funding in excess of £5k to be allocated via a procurement exercise and the average time to develop such an exercise is usually in the region of a year³². More importantly, a procurement framework supported safeguarding in that service providers would have to meet criteria in relation to vetting and qualifications. In addition to this the EA did not have the necessary capacity within their in-house procurement service to procure the broad range of therapeutic and counselling services offered by the pilot within the required timescales, therefore it was necessary for them to engage procurement consultants (Ernst and Young known as EY) to develop an appropriate procurement exercise. Consequently, the development of a specification had to be turned around in a 4/5-week period. Overall, this procurement exercise was done in 3 months, a process that normally take one year. Operationally this delivery model was unsatisfactory to the EA and schools and overall, EA found it very challenging to deliver.

The timing of the funding becoming available to schools was also problematic in that it coincided with other funding streams (the Wellbeing Fund and Children Looked After funding) becoming available around the same time. It is however noted that due to the nature of the funding (Covid-19 funding provided via DoF) that the timing was not an issue that could be managed by either DE or EA. This caused difficulty for schools as they needed to source a range of therapeutic and counselling services in a short period of time to align with the pilot timeframe. This proved impossible in some areas where a lack of availability meant some schools were unable to participate in the pilot. (Feedback in the schools and counsellor /therapist surveys indicate provision was lacking, especially in rural areas).

To mitigate in delays starting the pilot schools could initially continue with any counselling services they were already using until the pilot framework was in place. Schools were asked to quality assure (QA) any existing providers, however, not all did. Some existing providers were rejected by the framework as they failed to meet the criteria.

The lead in time impacted on EA's ability to appoint an AAO however that did not impact on the delivery of the pilot as senior officers stepped in to complete all necessary actions.

This coincided with EA receiving many queries from schools and complaints about the lead in time, responding to these in tandem with developing a framework and appointing a dedicated resource created challenges for those officers leading on the pilot.

Providers found the e-procurement process challenging, in particular sole traders or small organisations who were not fluent in the process. EA's procurement team are developing some training/advice to mitigate against this reoccurring in future. Also, despite advertising, pre-notification and schools encouraging existing providers to apply there was a lack of applicants and only 84 providers were successful. This proved to be an insufficient supply to meet demands for services. Another drawback of the framework was that no additional organisations could be added after the application closing date. EA consider the model of framework used in this instance and have taken on board lessons learned for future provisions.

³¹ <https://www.finance-ni.gov.uk/sites/default/files/publications/dfp/PPN%2004%2021%20Procurement%20Control%20Limits%20pdf%20%283%20May%202022%29.PDF>

³² Source: EA procurement team

EA also believe that the name of the pilot may have played a part in the lack of applications and suggest changing it from “Healthy Happy Minds” to “Primary Schools Counselling & Therapeutic Service” to avoid any future ambiguity therefore attracting more applicants.

Schools complained to EA in relation to the administrative burden associated with the population and submission of Monthly Monitoring Returns. EA believe that a model similar to the ICSS approach could mitigate this i.e., where the therapist/counsellor role includes responsibility for populating and submitting Monthly Monitoring Returns.

5.4.4 What are your views on communications?

While working relationships between DE and EA are excellent, communications could have been stronger, for example, EA felt caught off guard in relation to queries from schools following the extension announcements.

5.4.5 What are your views on how the pilot was governed?

EA believe more discussion could have taken place regarding guidance, in relation to the design of the pilot reporting mechanisms for example:

- the first draft of the Strengths and Difficulties questionnaire (Form B) had categories missing.

EA ran awareness raising sessions for school principals and Key Contacts, but these often became complaints sessions for schools regarding the tight lead in time and administrative burdens. Schools also asked to use the funding for other needs.

As previously noted, schools could source their own therapeutic and counselling services initially while the framework was developed and in some areas no provision existed therefore not all schools had provision. To mitigate this in future EA suggested provision of services to mirror the approach adopted by the ICSS. EA recommend merging any future primary schools counselling and therapeutic services with post primary school service to improve efficiencies.

EA believe that shifting responsibility for population and submission of the Monthly Monitoring Returns to providers would allow for tighter processes and result in better oversight. Governance was very difficult as some schools used providers not on the framework which was in contradiction to the DE guidance and EA advice.

Governance arrangements between EA and DE were informal with ad hoc meetings on a semi regular basis.

Recommendation 8 – Conduct routine DE/EA meetings until any future programme is embedded

Routine meetings should take place between DE and EA until any future programme is embedded.

5.4.6 What are your views on the impact of the pilot?

EA believes the pilot was very effective in a lot of schools, however the short-term funding arrangements did make forward planning difficult in relation to pilot extensions.

5.4.7 What are your views on duplication and complementarity with the ICSS?

As no other primary school counselling programme is in place there is no duplication in relation to the Healthy Happy Minds pilot. In relation to complementarity EA recognise that aspects of the ICSS contract and its management would be beneficial to any future primary provision.

5.4.8 What are your views on Value for Money associated with the pilot?

Value for money was impacted by issues around the timing of the pilot. Due to the broad range of therapeutic and counselling services offered by the pilot there was variation in session rates.

5.4.9 What are your views on the ongoing need for a primary school counselling service?

Demand definitely exists for provision of primary schools counselling and therapeutic services; however, any future provision should incorporate suggested improvements. It is critical to go forward utilising a framework to ensure a quality provision to children. In this instance, schools saw the framework as a barrier but if done differently it offers critical protection for everyone.

5.5 DE Views

5.5.1 Introduction and Background

In addition to conducting the schools and counsellors' surveys, BCS conducted qualitative data gathering with the DE Pupil Support team. The responses are summarised in the following sections.

5.5.2 Was the pilot a good strategic fit?

DE considered the pilot to be a good strategic fit in alignment with strategies and policies outlined in the business case.

5.5.3 What are your views on the delivery model?

The use of a procurement framework was a good model and made it easier for schools to select providers once it was introduced. It also improved the quality of therapeutic/counselling provision as it regulated the quality of provision. However, timing was an issue, it would have been optimal had the procurement framework been in place in advance of the pilot. In practice, however, a shortened tender timeline was issued during the lifetime of the pilot and was only introduced in February 2022.

DE acknowledge the timing aspect of this particular framework was not ideal and that providers experienced difficulties during the e-procurement phase. Providers set up a WhatsApp group to help each other as they felt they could not obtain enough procurement assistance from EA through Ernst Young (EY) however, it should be noted that the procurement exercise was a competitive and commercial process, and it is not possible to provide individual support. Queries were addressed through e-tenders and each applicant had access to queries and responses.

DE prefer a framework model for this type of programme over a contract (used in ICSS) as the framework offers more flexibility for schools and providers. For example, providers can increase the number of schools supported and in turn can increase the number of practitioners they engage. It is important to acknowledge, however, the number of organisations included in the

framework could not be increased after this competition closed so a regular refresh of the framework would also be helpful.

5.5.4 What are your views on communications?

DE directly supported providers at the initial phase of the pilot until EA had a dedicated resource in place to administer the pilot and this was very time consuming for DE. Since the EA resource has been established, communications have been very responsive.

5.5.5 What are your views on how the pilot was governed?

A pilot Programme Board was established, with a Terms of Reference and was chaired by the DE's Director of Inclusion and Wellbeing. Membership included representatives from key stakeholders. Risk was managed in alignment with the business case and discussed at Programme Board meetings accordingly.

DE worked closely with EA although there was some confusion regarding issuing communications to schools and consequently some duplication occurred.

5.5.6 What are your views on the impact of the pilot?

DE believe the pilot was very effective in meeting its objectives in areas where providers were available. The diversity of therapeutic interventions offered by the pilot was a programme strength.

5.5.7 What are your views on Value for Money associated with the pilot?

DE had concerns around anecdotal reports from some providers regarding increases in session rates pre and post the development of the framework. There is generally a range in session rates for therapy/counselling however, the framework was a means to control this.

5.5.8 What are your views on the ongoing need for a primary school counselling service?

DE believe there is a continued need to deliver primary school therapies/counselling and would like to see the ICSS and HHM merged into a single programme delivering a range of therapeutic interventions. However, this will be subject to funding availability.

5.6 Parent views

The Review Team planned to gather feedback directly from a sample of parents of children who participated in the pilot, from a North Belfast primary school, however, on the day of the virtual workshop, none of the parents who had agreed to participate actually attended.

However, an art therapist provided additional qualitative feedback gathered after HHM provision to ■ schools in ■. The table below shows evaluation survey results from parents. The results are very positive and illustrate that the majority believed the overall delivery of the intervention to be satisfactory and could see benefits for their children. All parents agreed that funding should be made available in primary schools to offer this therapy for all children who need it.

Table 16 - Summary of Parents feedback following HHM art therapy sessions

Question	Response Rate	Comments
How satisfied were you with the referral process?	100% 'Very Satisfied'	<ul style="list-style-type: none"> • "My child was helped due to a need for some support. He has made progress." • "Happened very quickly which was great."
How satisfied were you with the assessment process?	100% 'Very Satisfied'	<ul style="list-style-type: none"> • "Very satisfied – relaxed environment – child has felt comfortable sharing his feelings." • "It was very organised and arranged quickly which was helpful." • "Very professional from the start and explained everything and felt comfortable."
How satisfied were you with the communication of the therapist during the programme of art therapy?	94% 'Very Satisfied' & 6 % "Satisfied"	<ul style="list-style-type: none"> • "Communication pre and post has been brilliant. As a parent I felt at ease with the therapist." • "Gave good information for helping my child at home. I could tell she was good with children and her heart was in her job."
Do you think your child has benefited from art therapy?	94% 'Very Satisfied' & 6 % "Satisfied"	<ul style="list-style-type: none"> • My child has made progress and is trying to consider what fears are real/not real." • "My son has gained so much confidence. He is able to be open about his emotions and handle them better. He is more able to cope and process his emotions." • "He is a lot more settled now and not as anxious. He is happy and back to his bubbly self"
Overall, how satisfied were you with the art therapy service?	93% 'Very Satisfied' & 6 % "Satisfied"	<ul style="list-style-type: none"> • "My child was able to figure out what was worrying for her and be given the autonomy in the process. It has been great and been a really good service." • "Excellent service to provide for the children and support me as a parent"
Do you think that having counselling/creative therapies within primary schools is something that will benefit children?	100% 'Very Satisfied'	<ul style="list-style-type: none"> • "100% it is going to help a lot of children and they need support." • "There needs to be more for all children. It needs to be normalised and the stigma decreased." • "I think every school should have this and it would be so beneficial for all children. There are so many issues affecting young children."

Source: Provided by an Art Therapist provider.

5.7 Children's Views

In addition to qualitative parental feedback gathered by the art therapist, feedback was also gathered from the children who participated in the intervention. This represents a small sample of children who participated; however, it provides a valuable insight into the views of those children.

The children were given a feedback sheet '**What I thought about art therapy**' figure outline, with two thought bubbles. Each child had the opportunity to use art materials to colour, draw and write on this autonomously. Below are some of the thoughts gathered from the children.

Figure 30: Summary of Children’s feedback following HHM art therapy sessions

“I liked the art” “I liked the setting where the art therapy took place”
 “I loved the game” “It was so fun” “Therapist was really kind”
 “It helped me get rid of my fright” “I get to colour in”
 “Fun, nice and some time off class” “It helped with my feelings”
 “Art therapy made me have fun” “Art therapy helped control my anger”
 “I liked how we did art and played games” “I think it helped” “Really happy”
 “It did help and I was happy about being listened to”
 “It helped me talk about my dad more” “It was fun and artistic” “I liked it”
 “I just really didn’t like when my mum came in” “More confident”
 “I was a bit scared at the start” “It was good in the end”
 “This has helped me so much” “I’d have been much more sad if I hadn’t come here”
 “I liked playing with you” “I’m not scared”
 “Smiley emoji” “happy”

Further testimonials from children participating in art psychotherapy sessions included the following:

- *“In Art psychotherapy sessions I don’t know why, but I paint with my heart not my head”.*
- *“I have drawn a washing machine spinning – because my head is always spinning but when I go to Art therapy the spinning stops.”*
- *“I can breathe here...”*
- *“For 30 minutes a week in Art therapy I get to go back home [redacted] – I get to draw my home and I’m there!”*
- *“I’ve made a telescope because I can zoom in on me when I’m here”.*
- *“I have made a remote control with a pause button, because you always help me hit pause”.*
- *“You’re like an occupational therapist but for feelings and friendships – you stick hearts back together and make pictures to help me make friends.*
- *“I don’t know why, but this works, I feel so much better ...thank you!”*

A sample of artwork by children participating in art psychotherapy is included in [Appendix 9](#).

Children’s feedback indicates their participation in art therapy and art psychotherapy were positive and beneficial experiences.

5.7.1 Case Study

The following case study provides a further insight to the views of children and parents and demonstrates how valued the intervention was to this family.

[redacted] Primary School: A mother, and single parent, and her daughter moved here [redacted] to study and believe they both benefited greatly from the support of the HHM pilot.

Due to unforeseen circumstances, they both suffered a traumatic event 




The mother referred her daughter for counselling through the pilot and believed it was extremely helpful and made a big difference to both their lives. She found the counsellor very compassionate and appreciated her approach and interaction as a parent. This included a detailed session without the child prior to the intervention to understand her daughters' circumstances and current challenges. The counsellor updated the mother regularly regarding her daughter's stressors and discussed and guided her regarding possible solutions, which the mother states gave her *"the opportunity to be mindful of my own behaviour and responses toward my daughter especially in situations where I needed to respond to her stressors"*.

Her daughter looked forward to counselling sessions and said it was her safe "space to talk about emotions".

The mother believed a benefit of participating in the pilot was that her and her daughter were able to spend better quality time together and as an adult, she felt more equipped to deal with her daughter's stressors.

The mother also quotes that *"I didn't feel alone myself and knew that I had a layer of support I could reach out to in a situation of distress"*. The mother also described how the pilot has helped both her and her daughter to understand each other's limitations and what is realistically possible under their circumstances.

The pilot had a great impact on this family and if they had been  they would have not received any mental health services especially for post-traumatic stress.

5.8 SWOT Analysis from stakeholder views

5.8.1 Pilot Strengths

HHM strengths include, among other things:

- Broad range of therapeutic services being offered.
- HHM is the only regional primary school therapeutic provision.
- Actively preventing and reducing mental health issues amongst primary school children.
- Reducing the stigma of mental health issues and raising awareness of available help.
- Identifying needs and making referrals to other services.
- Teaching staff becoming more trauma informed.

5.8.2 Pilot Challenges / Weaknesses

HHM challenges / weaknesses include, among other things:

- Insufficient lead in time to funding becoming available and extensions to the pilot.
- Lack of provision and particularly in rural areas.
- Low monitoring responses from schools.
- Inconsistent completion of monitoring data.
- Promotion was impacted due to lead in time issues.
- Administrative burden for schools was significant.
- Support for schools was insufficient.
- Inflexible procurement model.
- Insufficient understanding in schools of therapeutic services on offer.

5.8.3 Opportunities

HMM opportunities include, among other things:

- Improve lead in times for future provision.
- Improve promotion to schools and providers as well as to parents and children.
- Reduce administrative burden for schools by shifting this responsibility to providers.
- Increase consistency in monitoring data.
- Concentrate efforts to secure provision in rural areas to meet statutory rural proofing requirements.
- Develop workforce availability.
- Potential to merge with post primary provision.

5.8.4 Threats

HMM threats include, among other things:

- Availability of future funding in current economic climate.
- Lack of providers especially in rural areas.
- Supply outweighing demand.

5.9 Primary research findings – Summary and conclusions

The following table provides a summary and conclusions from the primary research overall.

Table 17: Primary Research Summary

Summary of Primary Research	
Strategic Fit	Schools surveyed and DE/EA consultations indicate the pilot is a good strategic fit with the relevant strategies and policies.
Delivery	Findings indicate pilot delivery was positive in relation to the quality of services and the range of interventions used, indeed 95% of schools and 99% of counsellor/therapist surveyed agreed. Nearly 90% of schools and therapists/counsellors agreed that not all children were able to avail of services and demand outweighed supply due to the limited supply caused in part to insufficient lead times etc., DE/EA agreed. Less than half of therapists/counsellors agreed that procurement framework was easy to navigate however, the model did regulate the quality of provision. EA felt the framework was not dynamic enough and found it challenging to deliver due to tight lead in times. Providers believed HMM was not widely known about among potential providers which impacted application numbers. Supply issues were more apparent in rural areas.
Communications	DE and EA had a good working relationship however, EA advised communications to schools were sometimes duplicated as DE did not notify them that they had written to

Summary of Primary Research	
	<p>schools separately on one occasion regarding a particular therapeutic approach (equine therapy), this caught EA off guard as the letter to schools was not shared with them. Communications could be improved with timely /in advance updates.</p> <p>61% of schools surveyed agreed schools' guidance and support from DE/EA was effective. Schools felt the pilot was rushed with little preparation and limited communication which affected their working relationships with EA/DE.</p>
Promotion:	<p>50% of therapists/counsellors surveyed agreed the pilot was effectively promoted to children and parents/carers and 58% of schools agreed. 65% of therapists/counsellors surveyed agreed the pilot was effectively marketed to therapists/counsellors while 59% of schools agreed. Going forward, improved promotion for tendering could increase supply, however due to short lead times to use funding planning and promotion was limited for therapists/ schools and parents/carers. Schools and providers would like to see an increase of collaboration and consultation with DE/EA so they can plan for any future provision.</p>
Governance:	<p>The pilot was governed by the Wellbeing Framework Programme Board with routine assurance processes and reporting of risk management etc., reasonable for a pilot of this scale.</p> <p>In relation to monitoring, 68% of therapist/counsellor surveyed agreed the Form B was appropriate and straightforward to populate while less than half of the schools agreed that Forms A & B were appropriate and straightforward. If the programme is to continue EA, schools and therapists/counsellors believe that reporting needs to be reviewed with more key stakeholder engagement. Schools felt reporting was an administration burden in their already pressured environment, indeed 55% of schools surveyed disagreed that the administrative burden was reasonable. Provider consultations questioned reporting data due to inconsistency in how schools completed returns and suggested that schools needed more guidance. EA believe reporting should be the responsibility of providers going forward, similar to the ICSS model.</p>
Impact	<p>DE and EA believe the pilot was very effective in a lot of schools and met its objectives in areas where providers were available. 90% of schools and therapists/counsellors surveyed agreed the pilot had a positive impact on the behaviour, emotional/mental and wellbeing of the children and has had a very positive impact on the school as a whole.</p> <p>25% of schools and 60% of therapists/counsellors surveyed believed child protection issues were identified, or disclosure/referrals were forwarded as a result of participation in the pilot. This is a positive impact of the pilot as child protections issues were identified at an early stage.</p>
Displacement / Duplication	<p>None of the consultees felt there was any other programmes available that would suggest displacement or duplication. It was suggested better alignment with ICSS post primary counselling programme could bring benefits to any future phases.</p>
Value for Money	<p>DE had concerns around anecdotal reports from providers regarding increases in session rates pre and post the development of the framework. There is generally a range in session rates for therapy/counselling however, the framework was a means to control this. EA also highlighted the variation in rates, but this was due to the broad range of therapeutic and counselling services. Schools surveyed also commented on the excessive and variation in session rates especially with play and art therapies and believe these sessions should be capped. EA and some providers suggested tighter monitoring arrangements and merging with the ICSS to enhance value for money.</p>
Continuing Need for the Programme	<p>DE and EA believe there is a demand to delivery primary school therapies / counselling and over 90% of schools and therapist/counsellors surveyed agreed.</p>

Summary of Primary Research	
Strength, Weakness, Opportunities and Threats	<p>Strengths</p> <ul style="list-style-type: none"> • Broad range of therapeutic services being offered. • HHM is the only regional primary school therapeutic provision in the region. • Actively preventing and reducing mental health issues amongst primary school children. • Reducing the stigma of mental health issues and raising awareness of available help. • Identifying needs and making referrals to other services. • Teaching staff becoming more trauma informed. <p>Weakness</p> <ul style="list-style-type: none"> • Insufficient lead in time to funding becoming available and extensions to pilot. • Lack of provision and particularly in rural areas. • Low / inconsistent monitoring responses from schools. • PR were impacted due to lead in time issues. • Administrative burden for schools. • Communications / support to schools. • Inflexible procurement model. <p>Opportunities</p> <ul style="list-style-type: none"> • Improve lead in times for future provision. • Improve promotion and PR to schools and providers as well as to parents and children. • Reduce administrative burden for schools by shifting this responsibility to providers. • Increase consistency in monitoring data from schools. • Concentrate efforts to secure provision in rural areas to meet statutory rural proofing requirements. • Develop workforce availability. • Potential to merge with post primary provision. <p>Threats</p> <ul style="list-style-type: none"> • Availability of future funding in current economic climate. • Lack of providers especially in rural areas. • Supply outweighing demand.

6. VALUE FOR MONEY ASSESSMENT

6.1 Introduction

In line with NIGEAE and Magenta Book evaluation guidance, this section considers the Value for Money associated with the Healthy Happy Minds pilot programme, including an assessment of the level of economy, efficiency, cost-effectiveness associated with the pilot during the evaluation period.

6.2 Overview the Healthy Happy Minds Business Cases

The original Business Case (dated 21 June 21) related to a pilot for Primary School Counselling across all primary schools and primary cohort of Special Schools.

The pilot was one of a range of measures proposed to support the Wellbeing Framework's implementation. It was a universal / whole school support for primary school pupils with a focus on preventing / reducing mental health issues.

Delivery of the pilot as set out in the Business Case would address *the issue of emotional health and wellbeing of children as a significant concern and the issue of whether a primary school counselling service will be provided by the Department as this has been the subject of a significant number of AQs/CORs/Education Committee Cases, reflecting the increasing demand for a service at primary school level.*

The Business Case noted that *as yet, there is no counselling service at primary school level... and 22.9%³³ of schools are providing a counselling service through their own resources whether through their Common Funding Formula funding or the Extended Schools Programme. The imperative is to have a model with a variety of counselling delivery models given the age and range of ability/competence of the children concerned.*

Four options were considered within the Business Case. The preferred option involved schools purchasing counselling support directly. It was noted in the Business Case that the preferred option would provide *more flexibility by enabling the schools to choose a service provider with the most appropriate counselling offering to meet their needs – as these are very young children the benefit of choice cannot be overstated with options ranging from art and music therapies through to support incorporating the family as well as the traditional ICSS face-to-face talking therapy approach.*

It was anticipated that the pilot programme would inform the Department's strategic approach focusing on the emotional health and wellbeing challenges facing children and young people and how the education system can effectively support them through a primary school counselling programme.

In the period since approval by DE Finance in June 2021, the pilot was extended, initially for April - June 2022 at a cost of £1.82m (at which point DE Finance confirmed an addendum was not required as a result of the underspend in 2021/22) and as a result of Ministerial Directions to further extend it between September – December 2022, and again from January to March 2023. Addendums sought approval for these further extensions as the cost exceeded the conditions of

³³ Source: <https://www.education-ni.gov.uk/sites/default/files/publications/de/school-omnibus-survey-2015.pdf>

approval outlined by DE Finance. The revised total cost of the pilot was estimated at £6.15m. It should be noted this evaluation covers only the period November 2021 to October 2022.

6.3 Overview of Healthy Happy Minds Procurement Framework

The HHM framework was developed to align with NI procurement law which requires funding in excess of £5k is to be allocated via a procurement exercise. On the basis of the approved Business Case, schools could initially continue to fund providers they had already engaged with until the EA's framework was in place. This was scheduled for January 22 however; it was delayed until mid-February which led to further delays in HHM provision as a number of schools had waited for the framework instead of securing their own support directly in advance.

Once in place the framework became the only mechanism for schools to secure providers to be funded under the HHM pilot. This did not preclude schools from using other funding to secure their own providers or from continuing provision already in place.

As the framework agreement was for 1 year it was developed on a fixed model i.e., once the competition was closed no further providers could be added. It included all primary settings split into 11 geographical areas aligned to local councils. The framework included criteria for accreditation with professional bodies, experience working with young people, minimum clinically supervised practice hours, qualifications, appropriate supervision, CPD and Access NI certification. Further requirements included, among other things, administration arrangements, monitoring and record keeping, induction information, service delivery plans, contingency arrangements, complaints policies/procedures, insurance and GDPR.

109 applications were received and 84 were awarded.

Aspects of the framework worked well while others proved more challenging, as follows:

The framework worked well in relation to:

- Meeting requirements for procurement law.
- Quality assuring service provision.
- Providing flexibility for schools choosing providers.
- Sole traders had an opportunity to compete with larger providers.

The framework challenges included:

- Lead in time to funding being formally allocated was challenging for EA to develop any procurement exercise.
- EA required external assistance to procure a provision due to the time pressure and limited procurement resource within EA.
- The e-tender application was a complicated process which larger providers were familiar with however, sole traders struggled mainly through a lack of clarity in the documentation and support in completing it. This resulted in some being rejected for minor issues. It should be noted that this is a competitive and commercial process, and it is not possible to provide individual support. Queries were addressed through e-tenders and each applicant had access to queries and responses.
- The external procurement consultants were unfamiliar with EA procurement processes consequently there was a significant number of queries from applicants.
- DE received high volume of queries as providers felt they could not get the required support from EA or the procurement consultant.

- Not enough providers applied, and some that did were rejected for minor issues due to the complexity and inexperience among sole traders, consequently, demand outweighed supply. See above re procurement processes.
- The framework was a fixed model i.e., once the competition was closed additional suppliers could not be added to meet demands. EA worked to increase the numbers of counsellors/therapists approved for providers already on the framework to increase capacity so whilst the numbers of providers did not increase their capacity did. This was not helpful for sole traders some of whom had previously worked for larger providers and left that arrangement to work for themselves providing HHM services.
- Providers had to apply initially and each time the pilot was extended as reported by providers, however, EA advise that they remained on the list.
- Providers experienced difficulty receiving timely payments for their service from schools. Sole traders were significantly impacted by this as some waited several months on payments.
- Schools complained that rates increased through the framework compared to what they had been formerly charged when directly engaging with providers.

Other feedback from providers suggested professional bodies should be consulted in the development tendering processes for any future provision with many in support of a more dynamic model.

Recommendation 9 – Procurement framework should be more dynamic and include provider support at tender stage

A more dynamic framework arrangement is used for any future provision i.e., with entry points to add providers during the contract duration and include support for providers at tendering stage in line with procurement rules and process.

6.4 Economy

6.4.1 Notes on Financial Data

In relation to the cost information provided in this section the following is noted:

- The financial information contained within this section, relating to the HHM pilot, has been provided by DE.
- DE provided BCS with a business case and an addendum pertaining to the programme:
 1. BCS was provided with a Business Case dated 21 June 2021, to the value of £4,944,064 for the 1 September 2021 to 31 March 2022 period. An initial extension for the period 1 April 2022 – 30 June 2022 was granted and dated 25 March 2022 at a cost of £1.82m without an addendum as it was within the OBC tolerance due to an underspend – see [Appendix 3](#).
 2. BCS was provided with a Business Case Addendum dated August 2021 for an extension to the pilot, as a result of a Ministerial Direction, for the period 1 September 2022 to 31 December 2022 at an additional cost of £2.25m. The total cost of the pilot was estimated at £6.15m. - see [Appendix 3](#)
- The pilot has been evaluated on a total cost basis, as per NIGEAE guidance.
- The addendum approval stated that the pilot evaluation should be submitted by June 2023, which will be the case.

6.4.2 Original Healthy Happy Minds Pilot Anticipated Expenditure

The table below provides a breakdown of the original budgeted HHM costs, as per the original Business Case (June 2021).

The pilot budgeted costs totalled £5m, with DE funding all aspects of the pilot for the 1 September 2021 to 31 March 2022 period.

Table 18:- Original Programme Budget (as per Original Business Case)

Item	£
Counselling / Therapy	4,846,596
EA oversight costs	47,468
Evaluation costs	100,000
TOTAL	4,994,064

Source OBC June 21. Note: No in-house costs for DE to manage the programme were included in the Business Case.

6.4.3 Revised Healthy Happy Minds Pilot Anticipated Expenditure

After the original Business Case was approved, there was an underspend due to *delays and procurement restrictions*.

The following table reflects the expenditure covered by further addendums to the business case, following Ministerial Directions up to 31 March 2023. As set out below, the total expenditure increased from £5m to £6.5m on the basis of changes to the timings as set out above.

Note: DE had commenced work to commission BCS to conduct the evaluation prior to the approval of further extensions to the pilot up to March 2023, the evaluation was conducted on data available up to 31 October 2022. Table 19 reflects additional financial data subsequently provided by DE in June 2023.

Table 19:- Revised Pilot Budget (as per Addendums)

Item	£
OBC actual expenditure up to 31 October 2022	2,083,000
Initial extension within 10% tolerance	1,820,000
Addendum extension to 31 December 2022*	2,250,000
Reduced Requirement identified December 2022 and returned to DE so not lost to education as used to manage other pressures in year	(1,400,000)
Addendum extension to 31 March 2023	1,750,000
TOTAL BUDGET	6,503,000
Total Expenditure to 31 March 2023	6,384,000

Source: Addendum for HHM (DE).

6.4.4 Actual HHM Programme Spend for the period of the evaluation (November 2021 to October 2022)

The following table provides an overview of DE's actual expenditure on the pilot which totalled £3,204,490 up to 31 October 2022.

Table 20:- Healthy Happy Minds Pilot Actual Spend

Actual expenditure up to 31 October 2022	£
OBC	
Counselling / Therapy	2,012,184
EA oversight costs (<i>Assistant Advisory Officer</i>)	█
Evaluation costs	█
Sub TOTAL	2,089,982
Addendum	
Counselling	811,597
EA oversight costs (<i>Assistant Advisory Officer</i>)	█
Evaluation costs	█
Sub TOTAL	827,205
Other Costs	
DE In-house Costs	█
EA In-house Costs (excluding Assistant Advisory Officer)	█
Procurement Costs	█
Sub TOTAL	287,303
Expenditure TOTAL	3,204,490

Actual Expenditure provided by DE; Evaluation Costs: BCS evaluation costs;
DE & EA In-house Costs: See Section 6.6 Efficiency, Table 23.

DE actual expenditure on the pilot up to 31 October was £3,204,490 this would suggest a projectory towards further underspend against budget.

Explanation provided by DE for the variance against the original business case, stated that there were unforeseen delays in establishing the procurement framework in 2021/22 and limited numbers of providers tendered for the procurement framework, resulting in limited availability of counsellors / therapists during the pilot period and causing demand to outweigh supply.

Note: DE have confirmed, as at May 2023, provisional expenditure figures are £6,384,000 for the duration of the pilot from inception to 31 March 2023. This is based on £2,083,000 spend in 2021/22 and £4,301,000 in 2022/23 and does not include DE or EA in-house costs.

Whilst DE spend was considerably below what was anticipated in the initial period of the pilot, due to delays in the procurement framework and less providers tendering for the framework, HHM did largely achieve the objectives and outcomes it sought to. Therefore, it may be concluded that the programme was delivered economically vis-a-vis the estimated expenditure. However, outcomes i.e., more children receiving interventions especially in rural areas, could improve.

6.4.5 Session Rates

Business Case counselling costs were based on a rate per session and the basis for this was calculated at the average being charged across the sector at that time, which was £█. However, the actual average cost, indicated by data contained in the Form A returns, was higher, at £█ per session. Schools complained that rates increased through the framework compared to what they had formerly been charged when directly engaging with providers.

One larger provider's feedback indicated that their rates were higher than usual due to complexities in calculating distances between schools in a particular rural area. A further comment was provided stating that inequitable funding had an impact on larger providers, with sole traders able to demand a much higher fee, as opposed to agencies (i.e., larger providers) who have a payment structure and supply services to post primary schools. The impact of this has made it more difficult for agencies to recruit.

Others stated concerns around increasing petrol costs and the cost-of-living crisis and one sole trader said they were working at a loss as the schools weren't willing to pay rates that would cover their full costs, including resources. This provider is also working on an agency basis to supplement their income.

6.5 Effectiveness

6.5.1 Notes on Performance Data

In relation to the performance/activity information provided in this section the following is noted:

- The information contained within this section, relating to the HHM pilot, has been provided by DE and the EA, gathered via the Monthly Monitoring Form A and Form B returns from providers and schools - see Section 4.4 Data Gathering and Data Sources for further details and [Appendix 6](#) for forms.
- Not all schools submitted MMRs therefore, the actual number of children receiving therapeutic sessions may be greater.
- How 'sessions' are defined may vary between the original business case and the information returned, given that schools/providers may have reported differently.
- Analysis of data DE provided to the Review Team from schools indicated that some forms were incomplete and there may have been variance in how those completing the form interpreted the questions, therefore, not all data sets corroborated with each other. In addition to this, the forms were updated after the first few months of use therefore, early data contains slightly less information compared to later data.
- Some providers believed monitoring forms lacked consistency in how forms were completed, and Form B was changed during the pilot and EA guidance was limited consequently there was no consistency completing forms. They questioned the credibility of monitoring data. They also felt providers should not be completing Form B's and that the school, child and parent should be completing this together. All providers consulted used CORS and BAC (Brief Assessment of Cognition) evaluation tools to monitor progress in addition to Form B's.

6.5.2 Achievement of Qualitative Objectives

Effectiveness reviews the extent to which the objectives defined for the intervention at the outset have been realised in practice, taking account of the counterfactual.

Qualitative objectives for the pilot were set out in the Business Case. For the purpose of this evaluation programme effectiveness is assessed against the objectives as identified in the original Business Case.

The qualitative objectives are detailed in the following table together with an assessment of the extent to which these have been achieved.

Table 21:- Assessment of extent to which objectives were achieved

Objective	Target	Analysis
<p>1. To ensure that primary pupils (including those in Special Schools) will have access to a 100% of primary pupils wishing to consistent, high quality counselling provision.</p>	<p>1. All primary pupils (including those in Special Schools) will have access to counselling provision. 100% of primary pupils wishing to avail of it (where it is clinically appropriate).</p>	<p>Partially Achieved 24% of the total number of primary settings did not avail of HHM services and schools surveyed believe this was due to a lack of provision. This was corroborated by other evaluation evidence. It should be noted that a number of schools already provided similar provision and therefore did not avail of the HHM services. In total the pilot was made available to 795 mainstream primary schools, 35 special schools and 6 EOTAS settings. The findings from the school's survey undertaken as part of the BCS evaluation indicated: of the 267 schools settings responding to a question asking if their school availed of services 15% (or 41 no.) indicated they did not and reasons for this suggests this was mainly due to a lack of provision regarding insufficient providers. Provision was a particular issue in some rural areas including (cited in feedback): Newcastle, Tyrone and Fermanagh, as schools reported that if framework providers had availability, they were unwilling to travel to these locations, making the service Belfast centric. Generally, feedback indicated that availability of providers was also an issue. The survey also asked schools if they agreed that not all children requiring services were able to avail of them and that demand outweighed supply: (of the 219 responses) 89% "strongly agreed" and "agreed". Therefore, counselling was not accessible to 100% of primary schools wishing to avail of it.</p>
<p>2. A variety of counselling delivery models given the age and range of ability/competence of the children concerned. This will include at a minimum talking, art, music and play-based therapies.</p>	<p>2. A variety of counselling models were delivered via the Healthy Happy Minds pilot.</p>	<p>Achieved Data from the MMRs indicated 12,309 children received therapeutic sessions as follows: talking 36% (or 4401 no.), play 23% (or 2827 no.), music 7% (or 805 no.), art 17% (or 2083 no.), drama 2% (or 192 no.), group 7% (or 848 no.), equine therapy 2% (or 208 no.) and other 8% (or 945 no.) - including creative therapy and Cognitive Behavioural Therapy.</p>
<p>3. An independent evaluation of the quality of counselling sessions will be undertaken (by June 23).</p>	<p>3. An independent evaluation of the quality of counselling sessions will be undertaken (by June 23).</p>	<p>Achieved This report is the output of an independent Post Project Evaluation of the HHM pilot commissioned by DE and it was completed prior to June 2023 as planned. In terms of the quality of sessions, this was considered as part of the evaluation and was based on information as reported by schools and therapists / counsellors.</p>
<p>4. Measure the impact on both the children and the school staff as a result of this intervention being available</p>	<p>4. Measure the impact on both the children and the wider school community via data captured in the MMRs (Form A and Form B). Schools were asked to "indicate the extent you believe the counselling intervention is having a positive impact on: individuals involved; and the wider school community".</p>	<p>Achieved MMR data for the 12,309 sessions delivered indicated (differing categories) of positive impact for: <ul style="list-style-type: none"> individuals involved as follows: Negligible 2% (or 31 no.), Moderate 21% (or 306 no.), Significant 71% (or 1010 no.), Unsure 7% or (33 no.) and 6 schools didn't submit data regarding impact. wider school community data indicated: Negligible 4% (or 56 no.), Moderate 26% (or 354 no.), Significant 59% (or 790 no.), Unsure 10% or (140 no.) and 6 schools didn't submit data regarding impact. </p>

Objective	Target	Analysis
<p>2. To reduce underachievement and improve the chances of young people enhancing their educational development and fostering their health, wellbeing and social inclusion.</p>	<p>5. Measurable data will be collated to confirm achievement levels and compared not only to peers but to themselves based on earlier life performance.</p>	<p>Not Measurable No measurable data is available to evidence achievement levels. Due to the many factors impacting underachievement, it was not possible to identify evidence to determine if the specific HHM intervention reduced underachievement and improved the life chances of young people, and stakeholders unanimously agreed that evidencing a difference in achievement levels as a consequence of the therapeutic services was not possible due to the many factors impacting underachievement.</p>
<p>6. Guidance is provided to schools to assist them in securing appropriate and quality provision for their needs, informed by the ICSS Post Primary Handbook</p>		<p>Achieved DE produced a guidance document with input from EA, which was issued to schools and available on the EA website. In addition EA provided a suite of online guidance, see Section 4.6, on Monitoring and Reporting to assist schools including: completion of Monthly Monitoring Returns, completion of Whole School Evaluation forms and a more general "Key Actions for Schools" guide. Other supporting online information included: FAQ's, links to ICSS Handbook, information videos etc. However, the HHM guide had to be updated after initial use as some information was missing regarding reasons for children presenting for services. Analysis of data returned from schools indicated that some forms were incomplete and there may have been variance in how those completing the form interpreted the questions, as not all data sets corroborated each other, and some providers questioned the credibility of this data. Return rates for data were low throughout the pilot as guidance stated it would either be returned monthly or in bulk at the end of the pilot.</p>
<p>3. To identify child protection issues at an identified, early stage.</p>	<p>7. Collation of measurable data from schools to confirm that child protection issues have been identified, progressed and resolved.</p>	<p>Achieved Measurable data was collated via the monitoring reports, relating to the number of referrals raising "Safeguarding Concerns", however no data was captured on how these issues were "progressed and resolved". <i>*Note: Whilst the objective 'To identify child protection issues at an early stage' was met in full, once a safeguarding / child protection issue is identified the existing processes in place across school settings and within the Education Authority would be the appropriate route for addressing such matters. It would not be appropriate to collect information regarding the resolution of safeguarding/child protection matters and to do so may be unethical. This is known only to the relevant agencies and the family. Wording in future business cases should consider the appropriateness of gathering any safeguarding / child protection information. All child protection issues were addressed as per the DE guidance³⁴.</i> Returns from school's data indicates that of the 8421 "referrals resulting in therapy", 204 safeguarding concerns were raised. The Review team consulted with EA's Child Protection Support Service (CPSS) team who reported no obvious increase in the number of calls to their service as a result of the HHM pilot. They did see an increase of 28% more calls in 21/22 compared to 20/21 (increase from 19/20 was 5%) however, they believe the increase is likely related to a return to the classroom after lockdown and increased need regarding Covid issues³⁵. However, as an early intervention (EI) initiative, the CPSS team feel this is a positive sign</p>

³⁴ Safeguarding and Child Protection in Schools - A Guide for Schools | Department of Education (education-ni.gov.uk)

³⁵ Source: EA's DRAFT Child Protection Support Service Annual Report September 2021 – August 2022

Objective	Target	Analysis
		<p>that HHM is working as intended and in tandem with a range of other child protection EI programmes e.g., Operation Encompass³⁶ i.e., if early intervention was not working as intended CPSS could expect to see an increase in calls to their service.</p> <p>Of the 214 schools responding to a question in the school's survey 25% (or 53 no.) indicated they identified or disclosed child protection issues as a result of participation in the pilot. The vast majority of these identified 1 – 3 child protection issues per school – this is a very significant finding and demonstrates the key role the pilot has played in identifying child protection issues at an early stage. Of the 77 providers responding to a question in the Counsellor / therapist survey 60% (or 46 no.) indicated they identified or disclosed child protection issues. Some counsellors felt there was a need for training on EA specific safeguarding policy and procedures. Examples were provided where children who disclosed self-harming behaviours as well as emotional and potentially physical abuse were safeguarded as a result of the pilot.</p>

³⁶ Operation Encompass aims to ensure all children experiencing domestic abuse receive timely support in their school. See <https://www.operationencompass.org/>

The findings in the table above confirm the HHM pilot has been largely effective in achieving the over-arching pilot objectives set out in the original business case. Indeed 3 of the 4 targets set to measure objective 1 have been achieved and the 4th partially achieved due to the lack of provision, especially in rural areas. One of 2 targets set to measure objective 2 has been achieved with the other regarded as too difficult to evidence. Whilst the objective 'To identify child protection issues at an early stage' was met in full, once a safeguarding / child protection issue is identified the existing processes in place across school settings and within the Education Authority would be the appropriate route for addressing such matters. It would not be appropriate to collect information regarding the resolution of safeguarding/child protection matters and to do so may be unethical.

The purpose of the HHM pilot, as a feasibility study, was to help DE learn how a larger scale project might work in practice and by highlighting areas for improvement the pilot has been successful in achieving that aim.

Recommendation 10 – Explore workforce expansion

DE should continue their work with universities, professional associations and other relevant stakeholders to explore expansion of this profession / workforce to meet the needs of any future provision.

Recommendation 11 – Consider if the impact on achievement is a key objective for any future programme and if so, develop a mechanism to measure the impact of therapeutic services on achievement.

DE should consider the feasibility and value of including the impact of therapeutic services on achievement as a measurable objective, and if necessary, develop a mechanism to measure the impact of therapeutic services on achievement.

Recommendation 12 – Training for providers on EA specific safeguarding policy and procedures

EA should train providers in EA specific safeguarding policy and procedures. (It is noted that at the time of reporting EA were planning for this to commence).

6.5.3 Achievement of Quantitative Objectives

The quantitative objectives for the programme were set out in the Business Case, initial extension, and Addendum.

The following table provides a summary of the outputs which were actually delivered, vis-à-vis those anticipated:

Table 22:- Assessment of extent to which outputs were achieved

	Anticipated no of sessions	Actual Sessions Achieved during Pilot
OBC (1 Sep 21 – 31 Mar 22: 27 term time weeks)	4549	Achieved: 15,976*
Initial extension within OBC tolerance (1 Apr 22 – 30 Jun 22: 11 term time weeks)	1853	
Addendum: further extension (1 Sep 22 – 31 Dec 22: 8 term time weeks [to 31 Oct 22 cut-off date for submission of data for inclusion in PPE])	1348	

	Anticipated no of sessions	Actual Sessions Achieved during Pilot
	7,750	15,976

*Actual start date was November 2021 rather than September as stated in the Business Case. 15,976 represents the total number of therapeutic sessions (9,720 individual sessions and 6,076 group sessions) from MMRs (Form As) submitted, therefore the actual figure is likely to be greater. See section 4.5 for further details.

As shown above the number of actual sessions delivered was greater than the anticipated number. The anticipated figure of 7,750 sessions was based on the size, split into ranges, of pupil enrolment in primary schools multiplied by the number of estimated sessions required for a school in that category and multiplying this by the number of schools within that category. These were based on the original pilot period in the Business Case of 27 term time weeks and pro-rated for the extension periods as follows:

Table 23:-Total Number of Sessions

	Dates	Session numbers	No of term time weeks
OBC	1 Sept 21 - 31 Mar 22	4549	27
Initial extension within tolerance	1 Apr 22 - 30 Jun 22	1853	11
Addendum	1 Sept 22 - 21 Dec 22	1348	8
		7,750	

The pilot was largely successful in delivering most objectives as set out in the original business case. Evidence from this evaluation suggests that it largely achieved its original qualitative and quantitative objectives. Overall, it is therefore concluded that the pilot was effective. However, there were some challenges encountered e.g., establishment of the procurement framework, demand outweighed supply and providers were unwilling to travel to rural areas.

6.5.4 Counterfactual

As part of the BCS schools survey, respondents were asked if in the absence of the pilot would the school have been able to provide therapy / counselling services to children and of the 215 respondents 87% said no. Findings from further stakeholder consultations also support this view that the therapy / counselling services would not have been available to primary school children without the pilot programme funding.

Overall, BCS evaluation findings, on balance, support the view that implementation of the pilot delivered impacts that would not have been achieved to the same extent in the absence of the pilot.

6.6 Efficiency

A means of assessing how efficiently the programme has been delivered is to consider the percentage of total costs that equate to management overheads. This provides an indication of the delivery costs vis-à-vis the total programme delivery costs. The following table sets out the management overheads associated with the HHM pilot from November 2021 - October 2022.

During the pilot period, DE estimated that the HHM pilot was staffed by 20% Grade 7 and 5% Staff Officer. The following table provides a summary of HHM staffing and management overheads.

Table 24:- Healthy Happy Minds Staffing and Management In-house Costs

In-house Costs	Salary + 30% for pensions etc.	In-house Management costs	% of expenditure on in-house costs
DE			
Principal x 20% of time	█	█	
Staff Officer x 5% of time	█	█	
	DE sub TOTAL	█	
EA			
Head of Pupil Wellbeing Services x 30% of time	█	█	
Head of Critical Incident/Emotional Health & Wellbeing x 50% of time	█	█	
Senior Clerical Officer x 60% of time	█	█	
Senior Category Manager, Procurement x 30% of time	█	█	
Category Manager, Procurement x 30% of time	█	█	
Category Manager, Procurement x 10% of time	█	█	
	EA sub TOTAL	█	
	TOTAL	138,303	
Actual Expenditure		3,204,490	4.3%

Source: DE salaries based on average salary costs from pay NICS pay scales 2021/22. EA provided their salary costs.

From the analysis above, it is apparent that the management overheads associated with the HHM pilot over the 1-year evaluation period were £138,303, this represents 4.3% of the total pilot costs. It represents a small proportion of overall programme costs and as a result could be considered as an efficient delivery of the pilot.

Going forward, EA and some larger providers believe HHM could be aligned with the ICSS provision as a single point of access providing tailored primary and post primary support, to reduce running costs, ensuring greater joined up provision, including aligned professional standards and would complement the draft PfG around strategic planning for joined up action across Departments while also contributing to the longer term aims of the Mental Health Strategy (2021-2031).

Recommendation 13 – Include in-house management costs in Business Case for any future provision

DE should include in-house management costs in the Business Case for any future provision to reflect the total costs to department.

Recommendation 14 - Consider merging primary and post primary counselling/therapeutic provisions

DE should give consideration to aligning primary provision with the post-primary ICSS provision as a single point of access providing tailored primary and post primary support, with the view to reduce running costs and ensure greater joined up provision, complementing the draft PfG around strategic planning for joined up action.

6.7 VFM – Summary and Conclusions

The VFM assessment indicates that the HHM pilot was delivered effectively and successfully achieved most of the original objectives. However, demand outweighed supply especially in rural areas and no evidence exists to determine if the pilot made an impact on the academic achievement of participating children.

Counselling and therapy overall ran successfully and resulted in positive impacts for the children involved as well as their wider school communities that would not have been achieved in the absence of the pilot.

On the basis of the totality of the evidence gathered over the course of the evaluation it is concluded the delivery of HHM pilot represented good value for money as, in terms of effectiveness it achieved most objectives, in relation to economy it was within budget and management costs were within 20% indicating it was efficient.

7. CONCLUSIONS AND RECOMMENDATIONS

7.1 Introduction

This section sets out the conclusions of this evaluation and summarises the recommendations.

7.2 Conclusions

The following table provides a summary of conclusions aligned with the key evaluation sections.

Table 25:- Summary Findings

Section	Summary Conclusions												
Strategic context and landscape	<p>It is concluded that the HHM pilot was well aligned with a number of relevant strategies and policies in NI and provides a good strategic fit.</p> <p>Having conducted a high-level landscape review it is concluded that the HHM, as a regional primary school counselling provision, is unique to NI and ahead of the other UK regions and the ROI.</p>												
Programme activity	<p>In terms of outputs, the programme did achieve the numbers of sessions as set out in the business case and addendum, however, demand outweighed supply and not all children wishing to avail of services received them due to supply issues.</p> <table border="1"> <thead> <tr> <th></th> <th>Target Session numbers (Business Case)</th> <th>Actual Session numbers (Data submitted to DE)</th> </tr> </thead> <tbody> <tr> <td>OBC</td> <td>4,549</td> <td rowspan="4">15,976</td> </tr> <tr> <td>Extension within OBC tolerance</td> <td>1,853</td> </tr> <tr> <td>Addendum</td> <td>1,348</td> </tr> <tr> <td>TOTAL</td> <td>7,750</td> </tr> </tbody> </table>		Target Session numbers (Business Case)	Actual Session numbers (Data submitted to DE)	OBC	4,549	15,976	Extension within OBC tolerance	1,853	Addendum	1,348	TOTAL	7,750
	Target Session numbers (Business Case)	Actual Session numbers (Data submitted to DE)											
OBC	4,549	15,976											
Extension within OBC tolerance	1,853												
Addendum	1,348												
TOTAL	7,750												
Objectives	<p>It is concluded that HHM has been somewhat effective in achieving the over-arching pilot objectives set in business case. Indeed, responses indicate 60% of practitioners confirmed identification and appropriately referred child protection issues. A lack of provision on the procurement framework (especially in rural areas), difficulty evidencing impact on pupil achievement and data not being captured to measure the identification, progress and resolution of safeguarding / child protection issues* were challenges in fully achieving objectives.</p> <p>The purpose of the HHM pilot, as a feasibility study, was to help DE learn how a larger scale project might work in practice and by highlighting areas for improvement the pilot has been successful in achieving that aim. See Section 4.3 Programme Objectives for full details. It has also been noted that the business case and procurement process were undertaken at pace due to the Covid-19 funding becoming available at short notice.</p> <p><i>*Note: Whilst the objective 'To identify child protection issues at an early stage' was met in full, once a safeguarding / child protection issue is identified the existing processes in place across school settings and within the Education Authority would be the appropriate route for addressing such matters. It would not be appropriate for the HHM pilot to collect information regarding the resolution of safeguarding/child protection matters and to do so may be unethical. This is known only to the relevant agencies and the family. Wording in future business cases should consider the appropriateness of gathering any safeguarding / child protection information.</i></p>												
Governance	<p>The Wellbeing Framework Programme Board oversaw the implementation of the pilot and received progress updates based on monitoring returns data. Formal assurance was also sought in relation to appropriate governance arrangements. Overall, this level of governance is considered reasonable for a pilot of this nature and scale. See Section 4.7 Governance & Management/Staffing for full details.</p>												

Section	Summary Conclusions								
Staffing	Staffing arrangements, once in place, appear to be appropriate, however, stakeholder feedback indicated demand for support especially at tendering stage was a challenge. The short lead in time for funding left no opportunity to recruit the Assistant Advisory Officer in time for the pilot commencing. See Section 4.7 Governance and Management/Staffing for full details.								
Monitoring and reporting	Having reviewed the monitoring and reporting, it is concluded that reporting mechanisms were reasonable however issues arose including: slow reporting filtering in from schools; schools indicated reporting was an administrative burden; forms had to be amended as some data categories were missing; there were issues at the design phase regarding monitoring of data; monitoring forms had to be refined and there were issues with getting these forms appropriately completed and returned. Therefore, some data was incomplete, some data sets submitted from schools did not corroborate with others. Issues with monitoring returns are likely to have been impacted by ongoing industrial action. See Section 4.8 Monitoring & Reporting for full details.								
Risk	Throughout the implementation of the programme risk was managed via the production and updating of the Wellbeing Framework specific risk register, in line with good practice. The original business case contained a risk assessment; however, this did not identify the risk or appropriate mitigation measures associated with lack of provision on the framework in some rural areas. See Section 4.9 Risk Management for full details.								
Promotion	It is concluded that promotion to children and parents by schools was constrained to an extent due to short lead in times relating to the availability of initial funding and pilot extensions. Therapist feedback indicated a lack of understanding in schools of interventions being offered beyond counselling. Promotion to providers was impacted by the short lead in time to funding becoming available. See Section 4.7 Promotion for full details.								
Primary research findings	The primary research process for the evaluation captured the views of key stakeholders, including schools, providers and other stakeholders. Primary research findings indicate that 85% of schools surveyed availed of pilot services and from EA data we know 24% of all primary settings did not avail of services; impact was believed to be positive for children and the wider school community; most schools would be unable to provide counselling without the pilot, provision was an issue for 52% of schools surveyed, particularly in rural areas. Despite the availability of sub cover, monitoring was an administrative burden for schools and promotion was somewhat restrained due to lead in time issues. Importantly, child protection issues were being identified through participation in the pilot. Significantly, 204 child protection issues or disclosure/referrals were made as a result of participation of the pilot (according to monitoring data). See Section 5 Primary Research Findings for full details.								
Stakeholder views	<p>The primary research process for the evaluation captured the views of key stakeholders, including schools, providers and other stakeholders including DE and EA – See Appendix 4 for full list. Primary research findings indicate that 85% of schools surveyed availed of pilot services and from EA data we know 24% of the total number of primary settings could not avail of services. Impact was believed to be positive for children and the wider school community, indeed:</p> <table border="1" data-bbox="469 1693 1401 2018"> <thead> <tr> <th colspan="2" data-bbox="469 1693 1401 1738">Primary Research: Key Impact Stats</th> </tr> <tr> <th data-bbox="469 1738 932 1774">Schools</th> <th data-bbox="932 1738 1401 1774">Practitioners (Therapists/Counsellors)</th> </tr> </thead> <tbody> <tr> <td data-bbox="469 1774 932 1899">96% of respondents strongly agreed/agreed that the pilot enhanced the emotional/mental wellbeing of children who participated.</td> <td data-bbox="932 1774 1401 1899">97% of respondents strongly agreed/agreed that the pilot enhanced the behaviour of the children who participated.</td> </tr> <tr> <td data-bbox="469 1899 932 2018">96% of respondents strongly agreed/agreed that the pilot enhanced the wellbeing of children who participated,</td> <td data-bbox="932 1899 1401 2018">98% of respondents strongly agreed/agreed that the pilot enhanced the emotional/mental wellbeing of children who participated.</td> </tr> </tbody> </table>	Primary Research: Key Impact Stats		Schools	Practitioners (Therapists/Counsellors)	96% of respondents strongly agreed/agreed that the pilot enhanced the emotional/mental wellbeing of children who participated.	97% of respondents strongly agreed/agreed that the pilot enhanced the behaviour of the children who participated.	96% of respondents strongly agreed/agreed that the pilot enhanced the wellbeing of children who participated,	98% of respondents strongly agreed/agreed that the pilot enhanced the emotional/mental wellbeing of children who participated.
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Section	Summary Conclusions	
	93% of respondents strongly agreed/agreed that pilot positively impacted on the schools who participated.	99% of respondents strongly agreed/agreed that pilot positively impacted on the schools who participated.
	<p>87% of schools who responded would be unable to provide counselling without the pilot, provision was an issue for 52% of schools surveyed, particularly in rural areas. Importantly, 60% (50 practitioners) of therapists/counsellors surveyed believed child protection issues were identified, or disclosure/referrals were forwarded because of participation in the pilot. This is a positive impact of the pilot as child protection issues were identified at an early stage.</p> <p>Monitoring was an administrative burden and for schools and promotion was somewhat restrained due to lead in time issues. See Section 5 Primary Research Findings for full details.</p>	
Economy	Whilst DE spend was considerably below what was anticipated (with a variance of -48%) due to less providers tendering for the framework, HHM did largely achieve the objectives and outcomes it sought to as set out in the original business case. However, there were challenges with children receiving interventions in rural areas. See Section 6.4 Economy for full details.	
Effectiveness	Overall, the pilot was successfully delivered in line with most of its objectives. Evaluation evidence suggests that it largely achieved its original qualitative and quantitative objectives however demand outweighed supply (providers did not tender for all areas). The broad BCS evaluation findings support the view that implementation of the programme by schools has had positive impacts that would not have been achieved in the absence of the pilot. It is therefore concluded that the programme has been somewhat effective. See Section 6.5 Effectiveness for full details.	
Efficiency	It is concluded the delivery of HHM represented reasonable efficiency, from a programme implementation perspective. See Section 6.6 Efficiency for full details.	

7.3 Recommendations

Based on the findings of this evaluation, the following recommendations are made:

Table 26:- Recommendations

Heading	Recommendations
Monitoring and Reporting	Recommendation 1 – Monitoring Design to include key stakeholders. All key stakeholders should be involved in the design of monitoring processes for any future provision.
	Recommendation 2 – Monitoring responsibilities to sit with providers. Service providers should be responsible for submitting monthly monitoring returns to EA, similar to roles and responsibilities within the ICSS provision, to ensure robust monitoring information is available throughout any future provision and to reduce the administrative burden for schools. The Review Team also recommend that future provider contracts include targets in relation to monitoring data to improve Management Information evaluation robustness.
	Recommendation 3 – Maintain electronic monitoring records only. Monitoring returns should be submitted to EA in online format only. Hardcopy returns should only be accepted in exceptional circumstances and transferred to electronic format.
Risk Management	Recommendation 4 – Greater focus on risk at Business Case stage. The risk associated with the lack of provision on the framework in some areas for this broad range of counselling and therapeutic approaches at primary school level should be included in the Business Case risk assessment for any future provision.
	Recommendation 5 – Rural Proofing. A rural proofing exercise should be conducted in alignment with the statutory requirement to rural proof any future primary school counselling provision.
PR	Recommendation 6 – Promote any future provision in advance of commencement.

Heading	Recommendations
	<p>Any future provision is promoted to providers with as much advance notice as possible prior to tendering to attract a greater response with the view to securing more providers.</p> <p>Recommendation 7 – Build understanding in schools settings. EA should build understanding in school settings of therapeutic provisions being offered, beyond talking therapies.</p>
Governance	<p>Recommendation 8 – Conduct routine DE/EA meetings until any future programme is embedded. Routine meetings should take place between DE and EA until any future programme is embedded.</p>
VFM	<p>Recommendation 9 – Procurement framework should be more dynamic and include provider support at tender stage. A more dynamic framework arrangement is used for any future provision i.e., with entry points to add providers during the contract duration and include support for providers at tendering stage in line with procurement rules and process.</p> <p>Recommendation 10 – Explore workforce expansion. DE should continue their work with universities, professional associations and other relevant stakeholders to explore expansion of this profession / workforce to meet the needs of any future provision.</p> <p>Recommendation 11 – Consider if the impact on achievement is a key objective for any future programme and if so, develop a mechanism to measure the impact of therapeutic services on achievement. DE should consider the feasibility and value of including the impact of therapeutic services on achievement as a measurable objective, and if necessary, develop a mechanism to measure the impact of therapeutic services on achievement.</p> <p>Recommendation 12 – Training for providers on EA specific safeguarding policy and procedures. EA should train providers in EA specific safeguarding policy and procedures. (It is noted that at the time of reporting EA were planning for this to commence).</p> <p>Recommendation 13 – Include in-house management costs in Business Case for any future provision. DE should include in-house management costs in the Business Case for any future provision to reflect the total costs to department.</p> <p>Recommendation 14 - Consider merging primary and post primary counselling/therapeutic provisions. DE should give consideration to aligning primary provision with the post-primary ICSS provision as a single point of access providing tailored primary and post primary support, with the view to reduce running costs and ensure greater joined up provision, complementing the draft PFG around strategic planning for joined up action.</p>