

Adapting a 'screening-to-intervention' pathway for child anxiety problems for delivery in routine practice

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Abstract

Objective

An integrated screening-to-intervention pathway has been shown to reduce child anxiety problems in a large trial in primary schools in England. Mental Health Support Teams (MHSTs) provide a clear route to future implementation in England. We set-out to identify what adaptations need to be made to the pathway to maximise fit with a routine practice context where MHSTs work with schools to deliver the pathway. This paper summarises key findings from the adaptation process and shows how we used learnings from qualitative interviews with key actors (MHST staff, school staff, parents), follow-up discussions with a subset of interview participants and wider consultations to adapt pathway procedures and produce guidance and materials for future implementation.

Results

Adaptations are presented using the Model for Adaptation Design and Impact (MADI) domains and include: pre-implementation activities to raise the profile of MHSTs in schools, procedural adjustments to accommodate local variation in MHST communication channels and systems for collecting screening data, and removal of activities included in the research trial. Our adaptation process is applicable for other research that aims to transfer intervention delivery from research to routine practice contexts and the pathway could be expanded to other mental health problems and age groups.

Introduction

We used a co-design approach to develop a screening-to-intervention pathway for child anxiety problems in primary schools in England (1). As part of the pathway, all parents and carers (hereafter referred to as parents) of children in participating classes are invited to complete a short child anxiety screening questionnaire (2) and receive feedback on whether their child screened 'positive' or 'negative' for anxiety problems. Where a child screens positive, they are offered a brief CBT intervention delivered via online (Online Support and Intervention for child anxiety: OSI) and telephone support for parents. As some children who screen negative may be experiencing anxiety problems, these parents can also request the intervention. A recent large randomised controlled trial found that the pathway alongside usual primary school practice increased remission from anxiety problems at 1 and 2 year follow-ups, compared to usual school practice only (3). These findings indicate that routine delivery of the pathway in primary schools could provide an effective way to increase access to evidence-based intervention for child anxiety problems. However, successful transfer of innovations or interventions to routine practice requires a systematic approach to fit the real-world context, whilst preserving core intervention functions (4).

In parallel with the definitive trial to evaluate the screening-to-intervention pathway outcomes, we set out to prepare for routine delivery outside the research trial. The pathway was co-designed (with teachers, parents and children) (1) to fit in primary schools and has been evaluated in a real-world primary school context, with school staff facilitating key activities in the trial (e.g. distributing screening questionnaires). However, other aspects of the trial and the pathway did not resemble practice contexts, and so require adaptation for routine practice implementation. In the trial, psychological practitioners in the research team delivered the intervention and the pathway was delivered alongside other research-related activities that will not be needed outside of research (e.g. parents completed a wider set of measures alongside screening questionnaire).

By 2029 every school in England will have a partner Mental Health Support Team (MHST) (5) that offer a suitable context for implementation of our screening-to-intervention pathway. These teams provide targeted evidence-based interventions for common mental health problems in schools and support universal approaches to mental wellbeing (6). However, MHSTs present new contextual considerations. Although the MHSTs are a national initiative, there is considerable local-variation in the type and extent of support offered (7) which required exploration. To gain insight into factors expected to influence delivery of the pathway in this new context, we conducted qualitative interviews with MHST staff, school staff and parents (8). Some anticipated barriers to implementation overlapped with those considered in the original pathway co-design (1) (e.g., privacy concerns among parents), while others were specific to the MHST context. It was clear that the extent to which MHSTs were visible and integrated in school communities varied, and stronger working relationships were identified as a potential facilitator. Participants highlighted potential challenges with the organisation and procedures of some MHSTs, including referral routes that do not yet allow for self-referral from parents, and data collection and storage facilities which do not accommodate individual child data for whole classes (as required for screening) (8). As such, the screening-to-intervention pathway needs to be adapted to fit with the MHST context and implementation plans will need to allow for sufficient flexibility to accommodate local contextual considerations (9, 10). Before making any changes however, it is important to carefully consider any positive or unintended negative consequences of these changes on how the pathway functions (4, 11).

Our aim was to adapt the screening-to-intervention pathway for routine practice delivery through MHSTs. Specifically, we set out to develop 1) adapted pathway procedures for delivery through MHSTs that maximise intervention-context fit and are consistent with pathway functions, and 2) materials needed for future implementation (implementation guidance and accompanying materials). We used findings from qualitative interviews with MHST staff, school staff and parents (8), follow-up discussions with a subset of these participants and additional consultations to iteratively develop and refine adaptations and implementation materials. The Model for Adaptation Design and Impact Framework (MADI) (4) guided all discussions and decisions about adaptations to pathway procedures. The purpose of this paper is to present a summary of the key findings from the adaptation process and illustrate how we used these findings to develop adapted pathway procedures and materials to support implementation.

Main text

Adaptation process

Ethical approval

was obtained from the University of Oxford Medical Sciences Interdivisional Research Ethics Committee (Reference: R86975) and research participants provided written informed consent to participate.

1. Qualitative interview insights

First, we used findings from in-depth qualitative analysis of interviews with 16 MHST staff, 6 school staff and 6 parents of primary-school-aged children (8) (see Additional File 1 for interview guides). We identified barriers to delivery and possible solutions/adaptations to these, as well as other areas where there was still uncertainty which required further exploration. Through a whole research team meeting, and follow-up smaller group discussions with parent and school staff representatives (RM and HE), we agreed adaptations/solutions, and areas that warranted further feedback through follow-up discussions.

2. Follow-up discussions with qualitative interview participants

We then invited a subset of qualitative interview participants who expressed an interest in further involvement to take part in two follow-up discussions. These meetings (60–90 minutes) were conducted via video-call and were audio-recorded, with recordings used to make detailed notes of each discussion. Discussions were conducted individually or in small groups, to suit participant preferences. Participants received a £20 gift voucher as a thank you after each meeting.

Seven interview participants took part in follow-up discussions; 4 psychological practitioners from 3 MHSTs, and 2 members of school staff in leadership roles and 1 parent from 3 schools, with all but one participating in two meetings (see Additional File 2 for participant characteristics).

In the first meeting we presented and discussed possible adaptations to the pathway and areas of uncertainty. In line with the MADi framework, we asked participants for thoughts and reflections on possible adaptations, and probed for potential positive and unintended negative consequences of adaptations. Following these discussions, the research team discussed participant feedback, agreed adaptations, and began to draft implementation guidance and accompanying materials.

In the second meeting, we sought feedback on sections of draft materials and key information to include in implementation guidance and accompanying materials.

3. Additional consultations

Alongside follow-up meetings with qualitative interview participants, we facilitated additional consultations with parents. This included a 60-minute group discussion via video-call with 5 parents to explore experiences of schools communicating information with parents and views on key content to include in parent-facing materials. Later, two parents provided feedback via email and/or video-call discussion on draft text and the overall design of parent-facing materials.

Parents who participated in consultation activities had a child within the intervention's target age range. The group represented a mix of those with and without lived experience of parenting a child with mental health difficulties and/or special educational needs, as well as those with and without prior experience of parent-led CBT.

A senior member of MHST staff and a primary school Assistant Head reviewed draft implementation guidance and accompanying materials for MHSTs and schools respectively. We asked for feedback on the clarity and completeness of text, layout and structure and expected confidence in using the guide. Feedback was provided either via email or during a video-call.

Consultation activities were reimbursed at a rate of £20-£25 per/hour.

Results

We provide a summary of potential ways to respond to barriers derived from analysis of qualitative interviews in Additional File 3 and areas requiring further consideration in the follow-up discussions in Additional File 4. Areas for further consideration included considering how best to raise awareness of MHSTs across school communities and how to integrate the pathway into existing structures in ways that sufficiently consider parents' preferences.

The agreed adaptations to pathway procedures included: (1) additional pre-implementation activities to raise awareness of MHSTs with parents and school staff; (2) adjustments to procedures to allow screening data collection to be managed locally by MHSTs and to accommodate different parent-to- MHST contact routes; (3) removal of routine sharing of individual screening outcomes with schools and research consent procedures. Table 1 details the adaptations using the MADi framework domains (adaptation characteristics, potential mediating or moderating factors, expected outcomes and potential unintended consequences).

Table 1

Adaptations to the identification-to-intervention pathway procedures for delivery through Mental Health Support Teams (MHSTs)

Adaptation	Adaptation characteristics	Potential mediating or moderating factors (why, how and what circumstances)	Intervention and implementation outcomes (including unintended consequences)
Raise parent awareness of the MHST before implementation	What is modified: New pre-implementation activities to raise awareness of the MHST among parents Nature of adaptation: Additional pre-implementation activities (e.g. display 'who's who' posters with photos of MHST staff, MHST staff attend regular schools events and activities such as drop-off/pick-up times) Associated guidance and materials for MHSTs and schools Who participated in adaptation decision making: Qualitative interview participants reported variation in the extent to which MHSTs are known to families; parents and MHSTs viewed the closeness of this relationship as important for parent engagement and suggested ways to enhance this relationship. The research team (including school and parent representatives) used interview findings and further feedback from follow-up discussions with participants to draft and refine guidance and materials. For whom / what is the adaptation made: For MHSTs and parents	Alignment with core functions: Aligns with aim to maximise participation in screening and increase access to evidence-based interventions for child anxiety problems Goal/reason for adaptation: To maximise participation in screening and subsequent engagement in OSI To maximise potential benefits of ongoing relationship between MHSTs and the school community that was not available in the research context	Intended to improve implementation outcomes (acceptability and reach) Potential unintended consequences: Increased workload for MHST staff and school staff delivering/facilitating additional pre-implementation activities
Raise school staff awareness and understanding of the MHST and the pathway before implementation	What is modified: New pre-implementation activities to raise awareness and understanding of the MHST and the pathway among school staff Nature of adaptation: Additional pre-implementation activities, including joint MHST and school staff planning meetings and MHST staff being visible in schools (e.g. host drop-ins for school staff, organise regular meetings, have a presence in the 'staff room') Associated guidance and materials for MHSTs and schools Who participated in adaptation decision making: Qualitative interview participants emphasised the key role of school staff in facilitating pathway activities. Given this, it was identified that the MHST and school staff would need to work closely together and that the MHST should be well-known and familiar to school staff The research team (including school and parent representatives) used interview findings and further feedback from follow-up discussions with participants to develop and refine guidance and resources for MHSTs on raising awareness of the MHST, facilitating pre-implementation planning meetings with relevant school staff, and supporting school staff to manage and respond to parents' queries and concerns. For whom / what is the adaptation made: For MHSTs, school staff, and parents	Alignment with core functions: Aligns with aim to maximise acceptability and positive experiences of the pathway procedures among school staff and parents Goal/reason for adaptation: To maximise acceptability and positive experiences of the procedures across the school community To maximise the ability of school staff to manage and respond to parents' concerns and by doing so maximise participation in screening and subsequent engagement in OSI To maximise potential benefits of an ongoing relationship between MHSTs and the school community that was not available in the research context	Intended to improve implementation outcomes (acceptability and reach) Potential unintended consequences: Increased workload for MHST staff and school staff delivering/facilitating additional pre-implementation activities
The MHST manages screening data collection and storage locally	What is modified: Change to process and platform for collecting and storing screening data Nature of adaptation: In the research context, screening data across all schools was collected and stored on a central system managed by the research team. The system was used to collect screening questionnaires via an online survey, manually enter paper	Alignment with core functions: Aligns with aim to maximise rapid implementation Goal/reason for adaptation: Essential for implementation outside a	Intended to provide interim solution to maximise early adoption Potential unintended consequences: Lack of centrally managed screening system could present a barrier to adoption by MHSTs and variation in delivery of screening processes

Adaptation	Adaptation characteristics	Potential mediating or moderating factors (why, how and what circumstances)	Intervention and implementation outcomes (including unintended consequences)
	questionnaire responses, and score screening responses across all schools. For delivery through MHSTs, the collection and storage of screening data will need to be managed locally and MHSTs will need to follow local data protection and information governance requirements. Who participated in adaptation decision making: Qualitative interviews with MHST staff revealed variation in data collection practices across MHSTs and confirmed that many MHSTs do not collect individual-level identifiable data for whole classes. The need for a centrally managed data platform for screening was identified. The research team will explore avenues to develop a data platform for screening in the future and initially provide guidance on using locally managed systems. For whom / what is the adaptation made: For MHSTs	research context Interim solution to maximise early adoption by MHSTs	
Process to request OSI where child does not screen positive for anxiety problems	What is modified: Change in how parents can request OSI if their child does not screen positive for anxiety problems Nature of adaptation: In the research context, all parents were able to contact the research team to request OSI. Parents of children who screened negative for anxiety problems and parents who did not complete screening were able to contact the research team to arrange a call with a Children's Wellbeing Practitioner to discuss and explore whether OSI may be helpful. For delivery through MHSTs, parents of children who screen negative for anxiety problems or do not complete the screening questionnaire will need to contact the designated member of school staff to request contact with the MHST. MHSTs are encouraged to also include a mechanism for parents to contact them directly. Parent materials will be editable to allow for tailoring/variation in the exact contact procedure across MHSTs. The guidance and resources on helping school staff manage and respond to parent queries will include post-screening queries. Who participated in adaptation decision making: Qualitative interviews with MHST staff illustrated that only some MHSTs have routes for direct communication from parents and many MHST staff raised concerns about whether this would be possible in their service. The research team (including school and parent representatives) developed guidance for MHSTs to encourage them to consider including a mechanism for direct contact from all parents following screening, and developed resources to support school staff to manage and respond to parents' concerns/queries following screening. For whom / what is the adaptation made: For MHSTs, schools, and parents	Alignment with core functions: Uncertain. Potential to create a barrier to accessing support for some children. Will need monitoring. Goal/reason for adaptation: To maximise fit with and adoption across MHSTs, including those without direct contact routes for parents. Mandatory direct contact routes for parents to MHSTs may reduce adoption across MHSTs.	Intended to maximise adoption and fidelity across MHSTs Potential unintended consequences: Parents of children who screen negative but may benefit from OSI could be deterred from requesting support.
Sharing of screening outcomes with schools	What is modified: Change to the procedure for sharing screening outcomes with schools. Nature of adaptation: In the research context, parents had the option to consent at the outset to the research team sharing their child's screening outcome with the school. Before OSI delivery, the research team shared the names of children who screened positive for anxiety problems with the school, where parents had agreed for this information to be shared. Parents were also encouraged to tell the school if they were participating in OSI or could opt for their clinician to inform the school. For delivery through MHSTs, the routine sharing of names of children who screened positive with schools is removed. MHSTs will discuss and seek parental permission for information sharing on a case-by-case basis during the	Alignment with core functions: Aligns with aim to maximise acceptability among parents and minimise avoidable workload for school staff and MHSTs. Goal/reason for adaptation: Maximise acceptability among parents Opportunity to simplify process / remove element	Intended to maximise acceptability and minimise potentially unnecessary workload for MHSTs/schools. Potential unintended consequences: Removes an opportunity for school staff to be aware of children who may benefit from support and do not go on to receive OSI (e.g. parent does not proceed with 'feedback call')

Adaptation	Adaptation characteristics	Potential mediating or moderating factors (why, how and what circumstances)	Intervention and implementation outcomes (including unintended consequences)
	'feedback call' or OSI delivery. MHST will also provide schools with a class or school level summary of screening outcomes (number of screening questionnaires completed, and the number and percentage of screen positives and screen negatives). Who participated in adaptation decision making: Qualitative interviews and consultations with additional parents were consistent with findings from the original co-design work that views related to information sharing vary and some parents feel it is very important to have the option to choose what information is shared with the school. Findings indicated that seeking parent consent for information sharing with schools aligned with usual practice for MHSTs. It was agreed an overall summary of screening outcomes could help MHSTs with assessing level of need and planning wider support. In follow-up discussions, participants raised doubts about the usefulness of the list of names for schools which confirmed experiences in the research trial. On the basis of these findings, the Research team (including school and parent representatives) decided to remove the routine sharing of the list of children who screened positive, and instead provide an aggregated summary. For whom / what is the adaptation made: For MHSTs, schools and parents	that is likely to have minimal benefit. Opportunity to provide schools with aggregated class-wide information that could be discussed together with the MHST and guide plans for wider mental health and wellbeing provision.	
Embedded research trial procedures removed	What is modified: Remove elements that were integrated only for the purpose of the trial Nature of adaptation: In the research context, parents had the opportunity to opt their child out of all activities (including the workshop), (opt-in) research consent was obtained from parents at the outset, and baseline trial measures were collected alongside screening questionnaires. For the new delivery context, the opt-out and research consent process is removed and MHSTs are advised to follow their local consent procedures. Revisions were made to the school and parent-facing resources and materials from the research trial were revised to reflect delivery through MHSTs (e.g. research elements were removed). Who participated in adaptation decision making: Qualitative interview participants confirmed that the opt-out process was not needed and the consent process would need to follow local information governance requirements. The research team (including school and parent representatives) revised original participant-facing resources and materials. For whom / what is the adaptation made: For MHSTs, schools, parents and children	Alignment with core functions: Aligns with aim to maximise acceptability across all groups Goal/reason for adaptation: To maximise fit with new delivery context Opportunity to simplify the process / remove elements that are not required outside a research trial	Intended to maximise acceptability and minimise unnecessary workload for schools and MHSTs Potential unintended consequences: Potential for local consent procedures to have a negative impact on acceptability

[Insert Table 1]

Additional File 5 documents how we used key insights throughout the adaptation process to inform the development of materials needed to support implementation by MHSTs. This included: 1) an implementation guide for MHSTs providing information on delivery and how to support school staff, together with accompanying materials (e.g., a template to populate with assigned roles/tasks in the team, a pre-implementation checklist to work through with schools); 2) a separate implementation guide for schools to provide tailored information and accompanying materials for school staff (e.g., a written summary of the pathway to share with all staff, a template with answers to common questions from parents); and 3) adapted parent-facing materials in written and video formats that can be edited locally, screening pack materials, post-screening template feedback letters and parent call script.

Discussion

This study produced adapted procedures and materials needed to enable the screening-to-intervention pathway to be quickly integrated into routine practice following a definitive trial. It will be important for early implementation efforts to integrate an assessment of how the pathway is implemented in practice to

further inform decisions about what is or is not working and additional refinements that are needed (9). Indeed, possible negative consequences were identified for each of the adaptations so these will need to be actively assessed in implementation evaluations. In particular, the feasibility of delivering pre-implementation activities to raise awareness of MHSTs in advance of the pathway and time spent on these activities will need to be established. Similarly, the impact of adjustments that represent marked departures from the original pathway should be closely monitored. For example, in the research trial all parents in participating classes were able to contact the intervention delivery team and school staff based on feedback that was received in the original co-design that some parents may be reluctant to discuss their involvement with school staff(1). We have now made adjustments to allow for the fact that not all MHSTs have systems in place for parents to contact them directly during and after screening so it will be particularly important to evaluate experiences and outcomes of these changes. Collecting identifiable data from parents for whole classes of children was the aspect of the pathway that seemed to be the most marked departure from usual practice for MHSTs. To enable rapid implementation across varied MHSTs, the adapted procedures provide teams with some flexibility to determine how best to integrate this within the constraints of their existing local systems and processes. However, the integration of a digital platform for all MHSTs to use to collect and score screening questionnaires and share screening outcomes with families would optimise large-scale implementation (8)

The process we used to adapt the pathway had important benefits that improve the likelihood of successful implementation going forward. We worked with a broad range of individuals who would be directly involved in delivering and receiving the pathway procedures to carefully consider and agree adaptations and develop implementation materials and resources. Participants' voices feature throughout practitioner and parent-facing materials (e.g., through quotes and suggested ideas and activities) which will help ensure materials resonate with these audiences. Using an established implementation framework and constructs that have been shown to influence implementation to guide qualitative data collection and analysis allowed us to pre-emptively consider likely obstacles (12). Our application of the MADI framework, and comprehensive advance consideration of the possible positive and negative impact of adaptations also reduces the risk of unexpected consequences emerging at later stages (4). These methods, and use of different data sources, could be applicable for others who are scaling or transferring interventions from research to routine practice contexts for other mental health difficulties and age groups.

Limitations

This study has some limitations. We explored anticipated barriers and expected consequences of adaptations, rather than direct experiences of the pathway in an MHST context. Although participants represented a range of MHST, school and parent characteristics, findings may not generalise across other MHSTs and primary schools. The views of MHST and school staff who are most reluctant to implement the screening-to-intervention pathway and parents who are most likely to experience barriers to accessing the pathway may not have been captured, so it will be important for future evaluations of routine practice delivery to consider experiences among a broad range of individuals. We focused on barriers related to MHST and school systems, but there may be wider contextual factors (e.g. external pressures, political conditions) that will need to be considered when scaling-up. In the research trial context, participation rates varied across schools with fewer participating families in schools with higher compared to lower numbers of economically disadvantaged families (3). It will therefore be particularly important to evaluate experiences of routine delivery in schools with varied pupil populations and specifically consider further adaptations that may be needed in the context of socioeconomic disadvantage.

Abbreviations

MADI – Model for Adaptation Design and Impact; MHSTs – Mental Health Support Teams; OSI – Online Support and Intervention.

Declarations

Ethics approval and consent to participate

The study was conducted in accordance with the Declaration of Helsinki. Ethical approval was obtained from the University of Oxford Medical Sciences Interdivisional Research Ethics Committee (Reference:R86975) and research participants provided written informed consent to participate.

Consent for publication

Not applicable

Availability of data and materials

The datasets generated and analysed during the current study are not publicly available because the data are qualitative and it is not possible to sufficiently anonymise them, but the data are available from the corresponding author on reasonable request.

Competing interests

CC is a developer of the OSI platform. The University of Oxford receives consultancy and royalty payments linked to the distribution of the intervention outside of research; CC does not receive any personal payments. All other authors declare no conflicts of interest.

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Authors' contributions:

TR took overall responsibility for all aspects of the study. TR, CC, ML, CG, and FS contributed to funding acquisition and conceptualisation. All authors contributed to methodology and formal analysis. AP, RU, RM, TR contributed to investigation. RU, AP, and TR contributed to the original draft preparation and all authors contributed to reviewing and editing. TR has full access to all the data in the study and takes responsibility for responsibility for the integrity of the data in the study and the accuracy of the data analysis.

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Supplementary Files

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- [AdditionalFile2Participantcharacteristicstables.docx](#)
- [AdditionalFile3Summaryofbarrierstodeliveryandpotentialwaystorespond.docx](#)
- [AdditionalFile4Areasofuncertaintyrequiringfurtherconsiderationinfollowupdiscussions.docx](#)
- [AdditionalFile5Developmentofimplementationguidanceandmaterials.docx](#)