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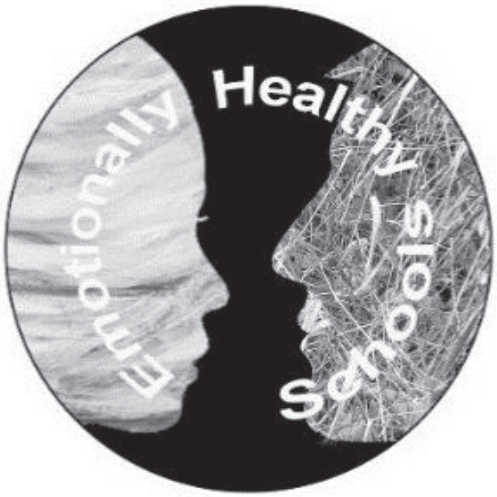
Evaluating the impact of the Cheshire East Emotionally Healthy Schools Pilot Project

Research Report

April 2017



Cheshire East Council

This study was carried out by the University of Salford CYP@Salford research group on behalf of Cheshire East Council. The study was funded by Cheshire East Council. The purpose of the study was to identify the outcomes for pupils and staff following the delivery of the Emotional Healthy Schools pilot project into six secondary schools.

The research team acknowledges the support and time given by the staff and pupils of the pilot schools and the EHS project team to make this research possible.

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Our research spans health, social care and education, and focuses on enhancing services, improving outcomes and evidencing impacts on children and families. The research group works closely with colleagues in the NHS, Local Authorities, the Third Sector, and national networks. We have research links with international partners in the Nordic countries, the Middle East, the Far East, Europe and Australia.

Celeste Foster Principal Investigator

Dr Gillian Rayner

Dr Shelly Allen

CYP@Salford
School of Nursing, Midwifery, Social Work and Social Sciences
Mary Seacole Building
University of Salford
SALFORD
M6 6PU

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Research project focus and objectives

The focus of the research study was to evaluate the impact of the Emotionally Healthy Schools (EHS) Project against its intended outcomes as set out within Cheshire East Council's contract specification for the EHS project.

The emotionally healthy schools project (EHS) was developed by Cheshire East Children's Service in order to address priority outcomes in its Children and Young People's Plan, 2015-2018.

http://www.cheshireeast.gov.uk/children_and_families/childrens_trust/childrens_trust.aspx

The EHS project is a local partnership approach between schools, statutory and non-statutory emotional health and wellbeing services; providing a mixture of whole school and targeted interventions for pupils, underpinned by access to mental health and wellbeing training and consultation to school staff. The EHS pilot project was designed in accordance with the principles outlined with the Department of Education's (2015) white paper: "Promoting children and young people's emotional health and wellbeing – A whole school and college approach". The project was piloted in six secondary schools between December 2015 and December 2016. Details of the EHS project can be found in the Emotionally Healthy Schools Service Specification (Kehoe, 2015).

Objectives

To undertake a 12 month mixed methods evaluation of the impact of the EHS project against its intended end of project implementation outcomes:

School staff specific:

1. To measure pre and post project rates of appropriate and inappropriate referrals to Tier 3 Child and Adolescent Mental Health Services (CAMHS), from participating schools
2. To measure staff knowledge of local service provision available in addition to CAMHS, that can support pupil emotional health and wellbeing
3. To measure confidence of staff to talk to pupils about and help with emotional health and wellbeing issues pre and post project

School staff and pupils:

4. To measure pre and post levels of stigma in relation to emotional health and wellbeing
5. To measure pre and post levels of awareness and knowledge of emotional mental health and wellbeing

Pupil specific

6. To measure pre and post levels of knowledge that young people have about maintaining their emotional wellbeing
7. To measure pre and post whether young people can identify where to go for help if they need it
8. To measure pre and post confidence, school-focused measures self-esteem and resilience levels in young people who have participated in targeted group or participatory activities

Whole school:

9. To provide evidence of a school environment which aims to promote and support the development of self-esteem, confidence and resilience in its pupils

2. Research Method

A multi methods approach was utilised to evaluate the success of the EHS project in achieving the above objectives. This involved qualitative and quantitative approaches matched to particular elements of the project and their intended outcomes.

Wherever possible data collection instruments were selected from the suite of nationally agreed and validated outcome measures developed by Child Outcome Research Consortium (CORC: http://www.corc.uk.net/resources/measures/) which are now approved to use in universal (e.g. school) and primary care children's services.

Method 1:

(Outcome 1)

Quantitative comparative analysis of aggregated CAMHS service referral data for the six participating schools for a 6-month period prior to implementation of the EHS project and in the final 6-month period of the 12-month project (using existing aggregated and anonymised data set, routinely collected by CWP CAMHS service). Data for referral rates and Tier 3 CAMHS response was analysed using descriptive statistical analysis. The data set for this component was not large enough to warrant inferential statistical analysis.

Method 2

(Outcomes 3, 4, 5 8 and 9)

Online survey design. All staff and all young people in schools participating in the EHS pilot project were invited to participate in an anonymous online survey, administered using Bristol Online Survey system. This system allows for

administration to a cohort that is spread across six geographical locations, full anonymity and in-programme collation of data for analysis.

Data collection tool design

There was a separate survey for staff and for young people. Both instruments were adapted from a method that has been tested and validated in two randomised control trials. This focused on, evaluating the effects of Mental Health First Aid interventions on levels of understanding of common emotional health difficulties, perceived stigma, and confidence to talk about and help with emotional health needs, in both staff and young people (Svensson and Hansson, 2014; Jorm et al., 2010; Graham, Phelps et al., 2011).

This method is centred around a short vignette and a series of related questions that concern the participant's ability to identify the emotional health issues within the vignette, levels of personally held stigma and perceptions of other's people's levels of stigma. For staff, questions assessed confidence and intention to help. For pupils, questions assessed confidence in the helpfulness of school staff and knowledge of where they could seek help if they or a friend needed it. For each question participants chose from a series of responses that most applied to them, ranked across a Likert scale.

A series of additional questions were added to this basic method, that relate directly to the specific intended project outcomes.

For the staff survey these were:

- To understand local care pathways, sources of help and how to signpost young people
- To identify perceived training needs

For the young people's survey these were survey items that provided a

- A measure of self-esteem
- A measure of resilience

The questions relating to self-esteem and resilience were developed from a review of four validated outcome scales for young people that specifically measure resilience and self-esteem as separate domains from clinical symptomatology in order to be appropriate to the non-clinical population in this study (NPC Wellbeing Measure, http://www.thinknpc.org/our-work/our-services/npcs-well-being-measure-2/; BASC-2, Reynolds and Kamphaus, 2004; Resiliency Scales for Children and Adolescents, Prince-Embury, 2006; Child and Youth Resilience Measure (CYRM) Ungar and Leibenberg, 2009).

Analysis of these validated measures indicated that core domains of resilience are: sense of mastery (optimism, self-efficacy, adaptability) and sense of relatedness. Items selected, assessed self-perception of positive constructs of resilience, rather than questions relating to potential problems associated with resilience and self-esteem. This was to manage the ethical issues that can arise from asking young people to self-report difficulties in an anonymous questionnaire, which does not allow

for follow-up of individuals. In particular, 'relatedness' questions connecting to sub-domains of trust, availability of support and tolerance of diversity within the school environment (Reynolds and Kamphaus, 2004), were specifically selected as these provide a concurrent measure of school's provision of a relational environment that supports development of resilience (intended outcome 9). Language, question construction and survey size was informed by the National Children's Bureau Research Centre Guidelines for undertaking research with children and young people (Shaw, Brady and Davey, 2011).

Both surveys were piloted to ensure readability, understanding and usability for the participant, to check that questions elicit the intended scope of response, and whether sufficient categories of response were available for closed questions (Kelley et al., 2003). For the staff survey, school teacher members of the project steering group were invited to pilot the survey. For the pupil survey, members of the Young Advisor Group (a group of young people who participated in the implementation of the EHS project and who received training and support to take part in the project development alongside professional stakeholders), piloted the study and advised the research team on age/developmentally appropriate use of language and question construction.

Data analysis

Descriptive statistics were calculated within Bristol Online Survey Software. Degree of change over time was analysed by comparison of proportion of responses, in accordance with calculated margin of error for the sample size at a confidence level of 95%. Where appropriate significance of relationship between variables was analysed using Pearson Chi Squared.

Survey questions that generated free text (qualitative) data were analysed using a content analysis method (Elo and Kyngas, 2007), to code and organise content into ordinal and sub-ordinal categories.

Due to lower than anticipated numbers of participants in the staff survey, the data analysis strategy was amended. Changes in pre and post data were reported as whole numbers or percentage change, and cross-tabulation was used to explore relationships between factors. In addition, a small number (n=5) of anonymised matched pairs were included in the analysis to corroborate emerging trends from comparison of the whole sample group over time.

Method 3

(Outcomes 1, 5 and 6)

Quantitative analysis of the impact of targeted interventions, using validated age-appropriate self-report outcome measures pre, mid and post completion of pupil or parent participation.

Data collection

Data was routinely collected as part of EHS project implementation at the beginning, middle and end of each targeted intervention, using a repeated measures design.

Measures were administered and anonymised by the provider organisations, then forwarded to the research team for collation and analysis.

Measures used:

- For targeted group approaches for young people:
    - Measure of impact of intervention upon pupil's wellbeing: Young Person Outcome Rating Scale (ORS)
    - Measure of pupil's satisfaction with the intervention: Session Rating Scale (SRS) (Miller et al., 2003)
- For Parent engagement strategies:
    - Parent Session Feedback Questionnaire (Chorpita, 2003)

The ORS measures 4 dimensions of wellbeing and the combined score can be used to identify those young people who may warrant additional mental health assessment and intervention. Prior to data being anonymised for the Salford research team, the needs of any young person scoring below the combined score cut-off were discussed by the school's EHS project worker with the CAMHS project clinical lead in order to ensure referral to further services where required.

Data analysis

Responses were coded into SPSS (version 23). Scale scores were summed for Outcome Rating Score (ORS) and Satisfaction Rating Score (SRS) for each participant. Descriptive statistics were calculated. Frequency analysis and mean scores were calculated for both subscales and combined scores within each measure. Inferential statistical analysis to establish levels of statistical significance of change over time was undertaken. As data was not normally distributed, nonparametric tests were selected.

The degree of change between pre and post intervention measures was analysed using a non-parametric Mann Whitney U test to compare means. A nominal statistical significance level was established a priori: P value was set at <0.05.

Method 4

(Outcomes 1, 2, 3)

Qualitative data analysis generated from CAMHS Consultation Questionnaire (CAMHS Outcome and Research Consortium (CORC). This is an instrument designed to measure impact and effectiveness of access to mental health practitioner consultation for teaching and other non-mental health staff. This instrument was routinely administered as part of the EHS project implementation. Data was subject to frequency counts and thematic analysis of free text, in accordance with the method by Braun and Clarke (2006).

Ethical considerations

Approval, governance and monitoring.

Cheshire East Council retained responsibility for the implementation and governance of the EHS pilot project that the research study was evaluating. Ethical approval was secured from the University of Salford Research Ethical Approval Panel (HSCR15-136). Organisational agreement to undertake the study and the terms and conditions of the supply of services by the research team on behalf of the University of Salford was granted via the research contract; signed by University of Salford Research Contract department and by Cheshire East Council Governance and Legal departments c/o Jonathon Potter. The study was carried out in accordance with the research governance framework for social care research (ESRC 2015).

Information about the evaluation process was distributed to EHS School leads, head teachers and other stakeholders through the EHS pilot steering group, school lead's meeting and EHS newsletter/updates. An information leaflet was provided for all staff, pupils and their parents/carers outlining the overall study, its purpose and the different methods of data collection within it. All data was managed securely in accordance with the Data Protection Act (1998).

Strategy for recruitment and seeking informed consent

All staff and pupils in the participating schools were invited to take part in the survey. To gain informed consent potential participants were provided with age appropriate participant information and the opportunity to ask the research team questions about the study. Due to the need to seek consent from both young people and their carers in the case of those pupils under the age of 16, a 2-stage process of consent was implemented. As this was an evaluation of a project using a 'whole school' approach, an opt-out process was used for stage 1. The information for parents/carers made it clear that any parent who did not give their consent for their children to be invited to participate in the survey, could complete the withdrawal of consent form. Head teachers or a designated deputy collated withdrawal of consent forms and young people whose parents opted out were not invited to take part in the survey. At Stage 2 all young people were given their own age appropriate information sheet, and opportunity to answer any questions about the process. Pupils who had not been opted out by their parent's/carers were then invited to participate in the survey. The front page of the survey reiterated the principles of confidentiality, anonymity, voluntariness and the right to withdraw. This was supplemented by an audio file for pupils who prefer to listen rather than read, in order to maximise accessibility. Information was provided about sources of support, should pupils be affected by any of the issues raised in the survey. For students under the age of sixteen the survey was completed in school, in a timetabled classroom in order to ensure that pupils could seek clarification and support if needed.

Participant information clearly stated that participation was voluntary and that participants retained the right to withdraw at any point. Use of a nickname allowed

for data to be located and destroyed should any participant who completed the survey then decide to withdraw their consent later.

Confidentiality and anonymity was maintained with a participant selected nickname to enable anonymous matching of participant responses at baseline, mid and post project, for comparison purposes only. No other identifying information was collected.

3. Results

3a. Referral Data

At baseline, prior to the project's commencement, between January–June 2015 across all schools in the East Cheshire Locality there were a recorded 115 referrals to Tier 3 CAMHS. In terms of referrals made to CAMHS East by the six pilot schools, there was a total of 17 out of 115 (14.8%). Middlewich High School (which depending on pupil address refers to both East Cheshire and West Cheshire CAMHS services), made no referrals to Cheshire East CAMHS, but did make one referral to the neighbouring CAMHS West.

Poynton was the school most likely to refer based on this data. Poynton made over 50% of these (52.9%); Eaton Bank and Macclesfield High School made 17.6% each and Ruskin Sports College 11.8%. Referrals to CAMHS services are recorded according to the school in which the young person is enrolled, explaining why there are no recorded referrals from Oakfield.

Baseline audit data was compared with a further audit undertaken during the final 6 months of the EHS project implementation (ending December 2016). The results of both audit periods are presented in Table 1.

Table 1: Comparison of baseline and post referral data

School	**Eaton Bank**	**Macclesfield Academy**	**Poynton High School**	**Ruskin Sports College**	**Middlewich High School**	**Total**
Number of Referrals						
Pre	3	3	9	2	0 (CAMH East) 1(CAMH West)	18
Post	0	8	1	0	1	10
As a percentage of total CAMHS East referrals from secondary schools						
Pre (n=115)	2.6%	2.6%	7.9%	1.7%	Referral to west Cheshire CAMHS service not included	14.8%
Post (n=155)	0 %	5.2%	0.7%	0%	0.6%	6.5%
Referrals accepted						
Pre	1(33%)	3 (100%)	8 (88.8%)	2(100%)	1 (100%)	15 (83%)
Post	/	8 (100%)	1 (100)	/	0 (0%)	9 (90%)

***Benchmark acceptance rate across all schools in locality:** **Pre = 81%** *(n=93/115)*
Post = 81% *(n=126/155)*

During the post evaluation period, there were 10 referrals made to the CAMHS by the pilot schools. This is almost half the number referrals made by the pilot schools within the baseline audit period. The number of referrals represents an 8.3% reduction in the proportion of all school referrals to CAMHS that originated from the pilot schools. However, due the overall numbers of referrals being small, the degree to which this result may be to chance is relatively high, and would be best confirmed by re-running the audit at the end of the next sixth month period to see if the trend is sustained over time.

Poynton, which had previously made over 50% of referrals made 10% during the post period. Macclesfield Academy made the majority representing 80% of all referrals to CAMHS at that time. Interestingly, Macclesfield Academy had all referrals accepted at pre and post evaluation period indicating that of those young people identified as having a mental health need, all met the criteria for CAMHS. It can be inferred from this that where awareness of mental health needs and care pathways exists, appropriate action is taken to support the young person.

At the baseline evaluation period, Eaton Bank made three referrals of which one was accepted (33.3%). Eaton Bank's referred acceptance rate at pre-project implementation is considerably lower than the benchmark average for all schools (81%). However, it is not possible to say whether there have been any changes across the project timeframe given that no referrals were made during the post audit period by the school.

This also applies Ruskin Sports College where no referrals were made during the post audit period. Although in contrast to Eaton Bank, both referrals at baseline were accepted to CAMHS. As was the referral made by Middlewich High School, although interestingly this pattern reversed at post evaluation where the one referral was not accepted by CAMHS.As such, there is a mixed pattern of referral and acceptance between schools at pre and post evaluation period.

In summary, there was a clear decrease in referrals post period from 18-10 (-8.3% as a factor of the total number of school referrals received by Tier 3 CAMHS). At first glance, these figures look as though the snap shot audit suggests that the EHS project has produced almost a 50% reduction in referrals. However it must be remembered the reduction refers only to school high school initiated referrals, and so although it is evidence of good impact of the EHS project, it may only make a limited difference to the total number of referrals received by T3 CAMHS overall. At both time points across all pilot schools the acceptance rate of referral to CAMHS are above the benchmark of 81%. There was a small increase in the overall number of appropriate referrals from the pilot schools at the end of the project (+7%). Aside from Middlewich High School at post period, each individual school within the pilot study had their referrals accepted by CAMHS at a higher rate than the whole locality average. Caution is urged however in relation to making inferences with regard to Middlewich high school at the post period due to the single referral, which may not be representative of a more pervasive pattern.

Survey Data

3b. Survey Participation Data

Table 2: Staff and pupil participation by School

School	Teaching staff	Teaching assistants and support staff	No teaching staff participants			Pupils	Number opted out	Approx. No. eligible to take part	No. Pupil Participants		
			Pre	Mid	Post				Pre	Mid	Post
Middlewich High School:	51	53	27 (26%)	10 (9.6%)	10 (9.6%)	668	20	645	422 (65%)	98 (15%)	138 (21.4%)
Macclesfield Academy	43	18	23 (38%)	0	0	393	16	370	0 (0%)	0 (0%)	1 (<1%)
Oakfields, Cheshire East Pupil Referral Unit	10	8	0	0	0	max 30 places	2	25	0 (0%)	1 (4%)	1 (4%)
Eaton Bank Academy	approx. 50	?	21 (42)	0	0	approx. 750	16	730	284 (39%)	72 (9.9%)	1 (<1%)
Ruskin	40	36	6 (8%)	0	0	473	20	450	258 (57.3%)	2 (<1%)	0 (0%)
Not specified	-	-	-			-	-	-	23	0	0
Total	194	115	**77** (25%)	**10** (3.3%)	**10** (3.3%)	2315	74 (3.2%)	2220	**995** (45%)	**173** (7.8%)	**141** (6.4%)
	Combined staff total = 310										

Table 3: Breakdown by year group

Time point	Pre	Mid-point	Post	Total
Year 7	277	19	3	299
Year 8	213	8	25	246
Year 9	188	115	42	345
Year 10	186	29	29	244
Year 11 and 12	91	2	41	134
Unspecified	40	0	0	40

Implications for generalisability of the study findings

In the original design, the required minimum sample sizes were calculated using 95% confidence level and confidence interval of 5. This means that to be 95% sure that the results would be reflective of the answers picked by the whole population +/- 5%; we would need a sample size of:

- Staff: 172
- Pupil: 328

Pupil participation (995) at baseline far exceeded this minimum requirement and is a testament to the infrastructure support given to schools at the outset of the project. There was a significant level of drop off in participation of young people at the mid and endpoint survey within most schools. However, using a whole sample analysis (rather than school by school), still enables results to be reported at a 95% confidence level, with a margin of error (confidence interval) of +/- 7.5%. This means that results can confidently be assumed to reflect the whole population sampled. In addition, overall the participant rate for young people breaks down to provide even levels of representation across each year group (range 19-23%), allowing for reliable analysis between sub-groups at the mid and post project time points. Although it looks as though no young people from the pupil referral unit participated at the baseline survey, this cannot be assumed: 23 young people assigned informal terms for their school names. This may represent uncertainty for pupils in the PRU (as they remain on role in their original school, whilst attending the PRU), or may indicate residual nervousness regarding their anonymity. Although limited number of schools participated in the mid and endpoint survey, if engagement with all arms of the evaluation are taken as a whole there was representation from all schools. In addition, pupils from a range of the participating schools participated at baseline, midpoint, and endpoint. Therefore, in line with the initial intention of the commissioned evaluation and to maximise use of all data provided by pupils, a whole population approach was utilised across the whole project, rather than a school-by-school matched pair analysis.

The staff response rate at baseline of 77 represents a 25% return rate. This is in line with expected return rate for online survey methods, which are estimated between 21 and 30% (Sax et al., 2003), and comparable with the return rates in previous studies exploring teachers attitudes and beliefs regarding mental health education in school settings (Graham et al., 2011). However, the fall in participation to ten respondents at mid and endpoint, mean that changes reported must be interpreted with considerable caution. To address the challenges raised by having such a small mid and post sample group, an anonymised matched pair analysis of responses of five staff who completed at more than one time point was undertaken. Correlation between trends identified in the matched pair and the whole sample analysis increase the confidence with which results can be asserted as indicators of change,

3c. Pupil Survey Results

Data in the main summary tables (Tables 4 and 6) for both the pupil and staff surveys have been presented in the direction that is most likely to show change over the three time points of the evaluation period. Notable changes (those outside of the 7.5% percentage margin of error, or close to it) have been highlighted in green to depict a change in a positive direction and red to depict a change in a negative direction.

Question responses have been summarised in Table 4 and a narrative is provided in accordance with the intended EHS project outcome that it was designed to measure.

Table 4: Pupil survey outcomes Pre, Mid and Post EHS implementation

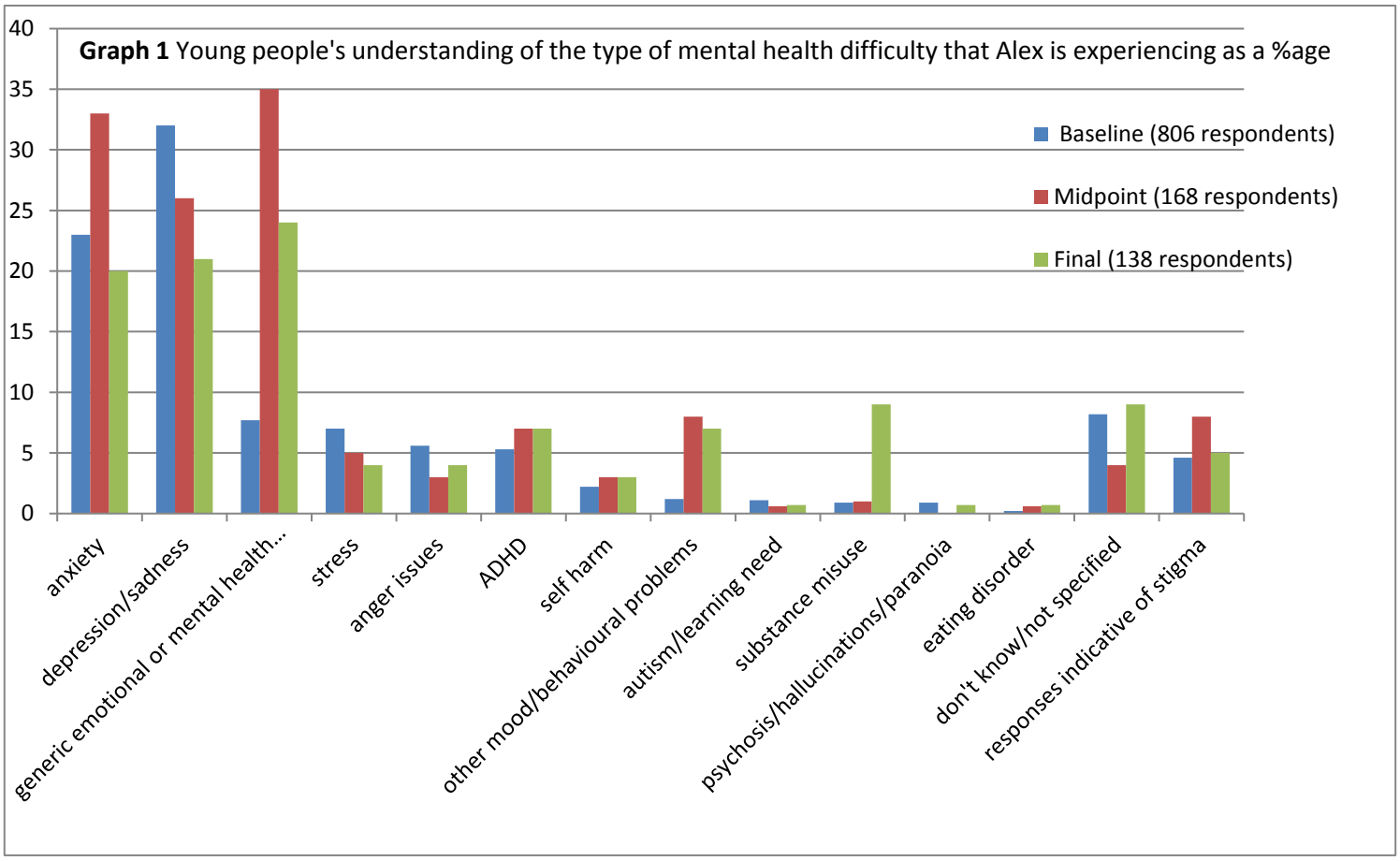
	Baseline	Mid-point	Post-project	% change
Mental health knowledge (%)				
Recognition of mental health issues in the vignette	**79**	**88**	**86**	**+7**
Knowledge of underlying causes	40	31	31.9	**-8.1**
Don't know/non-specific	**15.7**	**12.2**	**9.0**	**-6.7**
Stigmatising responses	4.6	8.0	5.0	+0.4
Personal stigma items: % ≥ *disagree*				
Personal weakness	57.2	74.1	56.5	-0.7
People with those problems are dangerous	47.8	52.9	44.5	-3.3
If they had a problem, they would not tell anyone	87.9	79.1	84.3	-3.6
Excuse for poor behaviour	48.2	57.4	48.6	+0.4
Should be taught alone	40.1	45.5	40	+0.1
Perceived stigma items: % ≥ *disagree*				
Other people believe a sign personal weakness	25.1	17	21.1	-4
Other people believe people with those problems are dangerous	22.4	15.1	18.8	-3.6
Other people would not tell anyone	88.2	83.8	86.3	-1.9
Other people believe it's an excuse for poor behaviour	29.5	26.5	31.5	+2
Other people believe Should be taught alone	23.2	17.0	24.5	+1.3
Confidence in own ability to stay emotionally healthy or help others: % ≥ Quite a bit				
Knowledge of places to get help	37.9	38.4	34.8	-3.1
Knowledge of sources of information	33.5	24	24.7	-8.8
Perception of own ability to generate ideas to stay well	36.9	29.6	31.7	-5.2
Beliefs and intentions about where to seek help: % Yes				
Belief in helpfulness of school staff	83.4	76.4	78.2	-5.2
Talked to a staff member about emotional health issue in the last month	**12.6**	**21.5**	**22**	**+9.4**
School-related indicators of resilience: % ≥ disagree				
I feel confident in school	17.5	22	21.1	+3.5
I feel hopeful that my school can help me achieve	10	11.7	17.8	+7.8
I feel I belong in my school	17.8	24	20.9	+3.1
In my school it feels safe to express difference or uniqueness	32	42.9	39.1	+7.1
Personal indicators of resilience: % ≥ disagree				
I can do things as well as most people	16.3	18.3	17.1	+0.8
When things go wrong I feel as though I can learn and bounce back	17.3	22.9	15.9	- 1.4
I am as good as most other people	18.7	18.2	22.3	+3.6

Pupil knowledge of mental health difficulties

This was a free text response to the question: 'What do you think is wrong with Alex?'

Pupil answers to this question broadly fell into two types: describing/naming the type of mental health problem and answers that reflected an attempt to consider the possible underlying causes.

TYPE OF MENTAL HEALTH DIFFICULTY



At the baseline 806 responses were given, with anxiety and depression the most common (55% of total responses).79% of responses of this type were appropriate to the symptoms being described. Combined with the range of possible mental health difficulties identified, this shows a very high baseline knowledge of mental health issues in the pupil participants prior to the implementation of the EHS project. 58% and 41% of respondents named anxiety and depression at midpoint and endpoint demonstrating stability in the level of student ability to identify mood related problems across the three time points of the survey. There was a small upward trend towards improved level of knowledge (+7%) in participant responses at the end of the project - see table 4.

Prior to EHS implementation 7.7% of pupil participants were only able to say that Alex had a generic mental health issue of some kind, 8% did not know what was wrong with Alex (though many of these responses indicated that they knew he needed help), and 4.6% gave responses that were indicative of stigma. Only 0.5% of the sample identified that there was nothing wrong with Alex. Given the high level of knowledge across the sample group before project implementation it was these results where we would hope to see a change as the project implementation progressed.

The number of responses indicative of a stigmatising attitude at baseline and end of project remained comparable (4.6% and 5%). However, at midpoint this peaked to 7.7%. Previous research by Jorm et al., (2010) evaluating the impact of mental health first aid training in school settings, found a specific effect impacting on stigma related responses: that students were biased towards giving more socially desirable responses at the baseline or pre-test time point, but that this bias decreased at later assessment points. As such, it is possible that the midpoint responses are a more accurate reflection of levels of stigma held by participants than the baseline survey the result possibly also highlights an opportunity for myth busting and stigma challenging to be concurrently implemented whilst endeavouring to support pupils to develop mental health awareness.

Examples of the kinds of stigmatizing statements given by pupils represented in text box 1.

Box 1: Examples of stigmatizing statements

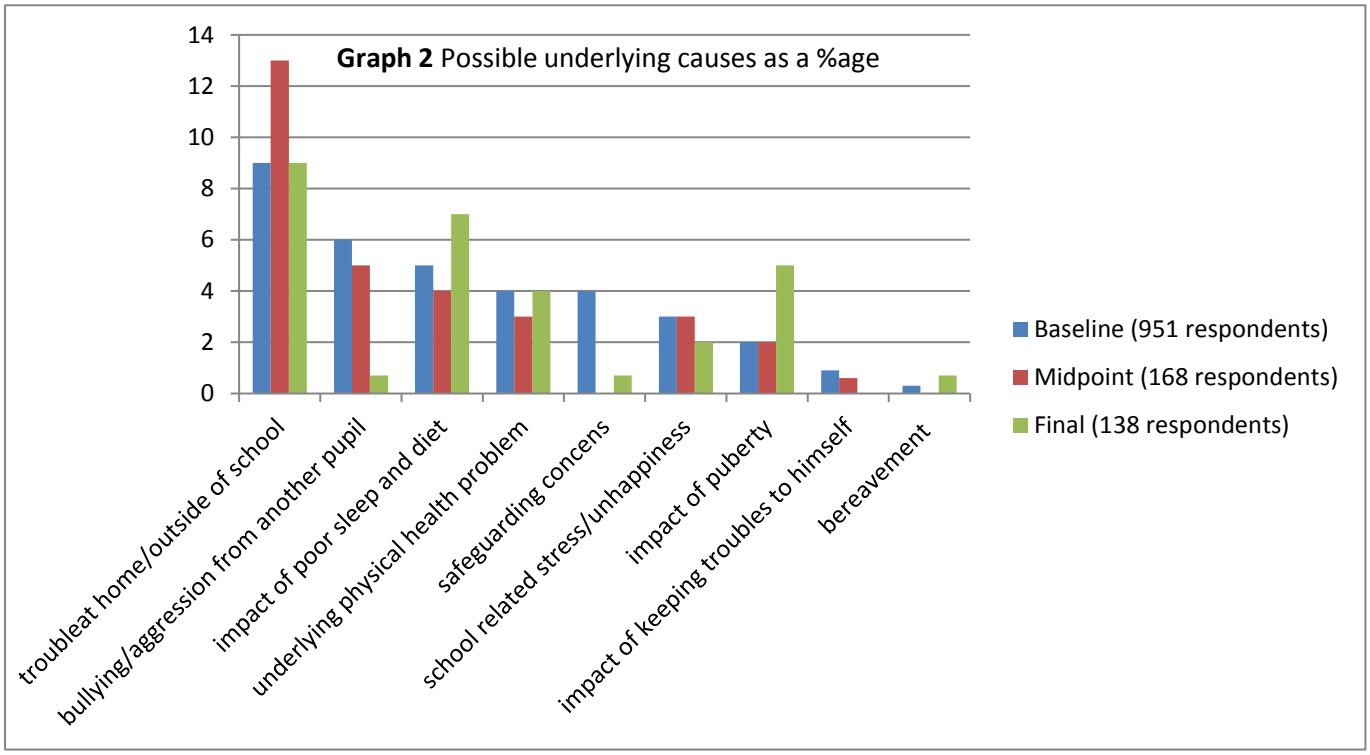
(S)He:

- Is weird
- Has a name like Alex
- Is bad
- Is scruffy
- Is a Schizo
- Is retarded
- Is attention seeking
- Is having a ‘giraffe’ (laugh)
- Is a wimp
- Is on a period
- Is not my problem
- needs to sort himself out

Recognition of the specific mental health difficulties associated with the vignette increased and the response of don’t know/non-specific reduced. This suggests there was an increased awareness relating to identification of mental health difficulties and development of accepted language to describe them. Knowledge of underlying causes decreased but this may be mitigated by answers being more closely associated with specific, named mental health problems such as anxiety and depression.

POSSIBLE UNDERLYING CAUSES

An average of 34% of all student responses at baseline, mid and end-point survey sought to offer a view on the possible underlying causes of Alex's difficulties. These responses are interesting on a number of counts. Firstly, they indicate an accurate understanding within the pupil population of the common statistically significant precipitants of mental distress. Secondly, they reflect an understanding of the relationship between physical and mental ill/health. This is particularly interesting when compared with staff responses, which comparatively do not offer the same attempt to understand 'why as well as 'what'.



These results also highlight that, after problems at home, bullying was the most significant cause for concern for the pupil population prior to the EHS project implementation, but that the number of student respondents who identified bullying as an underlying cause dropped from 6 % to 0.7 % at the project endpoint.

Indicators of personally held stigma and perceived stigma in other, in relation to mental health difficulties

Overall levels of personally owned/expressed stigma in the pupil sample were low. However, levels of perceived stigma in others are notably higher:

At baseline, only 26% agreed with the statement that emotional health issues are a sign of weakness but 48% believed that other people would think they were a sign of weakness. At the end of the project the number of pupils agreeing that emotional health issues were a sign of weakness had reduced to 16%, showing a further improvement in personally held attitudes, but perceived levels of stigma in others did not show significant change.

47.8% disagreed with the statement that Alex is dangerous, but only 22.4% felt that other people would also disagree, remaining stable across the 3 survey time points

At baseline, only 23.8% agreed that Alex's behaviour was an excuse for poor behaviour, but 44.1% believed that others would see it as poor behaviour indicating a significant expectation that others would judge. Although there was a 10% reduction in the number of pupils who believed that others would evaluate Alex's difficulties as an excuse for poor behaviour at the end point, the shift was from 'agree' to 'neither agree not disagree' rather than indicating confidant change in view of how other's perceive emotional health issues. A third of pupil respondents felt that Alex should be taught alone, but half of them thought that others would believe that they should be taught alone

Across all items relating to perception of stigma what can be said is that approximately twice as many students believe that others have stigmatising attitudes towards those with emotional health needs than report holding these views themselves. Whilst the results do point to some further improvement in the level of personally held stigmatising beliefs, the EHS interventions do not appear to have significantly reduced concerns about the views of others.

However, despite these concerns the likelihood that pupils would seek help if they had problems similar to Alex was high – 85% - with 32% initially agreeing that they would do so within a week of feeling this way, rising to 55% at the end of the project. This statistic can be understood in the context of the responses given regarding perception of staff responses to requests for help, which also shows an improvement over the duration of the project.

Perception of own capacity to stay emotionally health or contribute to emotional health of peers

Overall, pupil perceptions of their own knowledge about where to go to get help or information about mental health issues and of their own capacity to generate ideas about this was consistently rated as good in 75% or above of respondents at each time point. Though it should be noted that 16% of the participant group indicated that they did not think they could do this at all, which in fact rose to around 25% of participants at the end of project survey. Although the proportion of participants showing worsening results is relatively small, it does indicate that a small but

significant group continue to need access to mental health promotion strategies and information, or have struggled to make use of the information that has been provided.

Beliefs and intentions about where to seek help

At baseline, 83.4% of pupils felt confident that staff in their school would help them to help another young person about whom they were worried. This number remained stable at the mid and endpoint surveys (results show negligible reduction within the calculated margin of error)

There was a recorded reduction in the belief that staff could be helpful, however, there was an increase in pupils seeking out members of staff specifically to talk about an emotional issue. This suggests an increased level of confidence that this was acceptable and less of a concern that that such a request may be met unfavourably. As such, it may be reasonable to suggest that young people's knowledge regarding maintaining their emotional wellbeing and identifying where to go for help increased amongst those that staff have sustained and regular contact with.

In order of preference, pupils were likely to seek help from the following:

- 73.2% Parent or Carer
- 63% Pastoral support Team
- 62% School Nurse
- 54% Teacher
- 48.9% School Counsellor (although 10.3% thought this could be harmful)
- 35.8% Alex (27% thought this could be harmful)
- 41.1% Friends (21.5% thought this could be harmful)

The order of preference remained the same at each time point with only very narrow margin of difference in results between time points (<3%), indicating that results are very likely to be a good fit with the wider population.

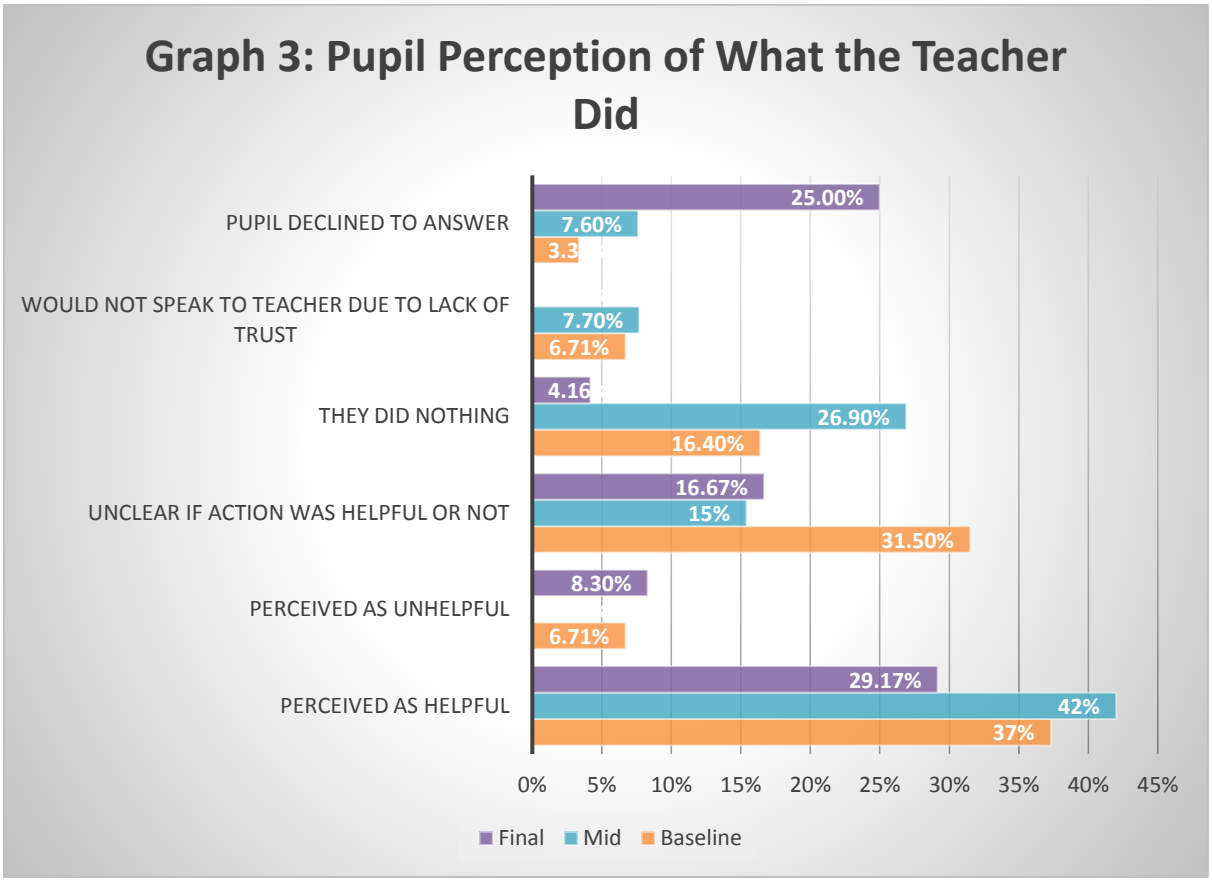
At the end of the project 86% participants identified that speaking to no one about their concerns would be harmful.

Actual help received from staff

The number of pupils seeking help for emotional health concerns in the month prior to completing the survey rose by almost 10% across the duration of the EHS project, from 12.6 to 22%. Although the number of young people approaching staff to talk about their emotional health looks relatively low, 12.6 (the baseline number) is actually in line with the expected point prevalence of mental health issues within the 11-17 population (Melzer et al. 2003). Therefore, the rise in numbers of young people seeking help within school is likely to reflect a positive impact of the EHS project on pupil's help-seeking behaviour.

What did the teacher do?

Graph 3 shows a comparison of pupil perceptions of teacher responses at each of the three time points.



Although it looks at first glance as though pupil perception of helpfulness has reduced at the end of project. In fact, this number is skewed by the high number of students declining to answer the question at this time point. If the figures are adjusted for this, then the proportion of respondents reporting helpful teacher responses at the endpoint rises to 39% in line with the other time points. It is also important to note that although the number proportion of respondents who evaluated teacher responses as helpful has reduced very slightly, it remains the most likely response.

Although overall there has not been an increase in the number of participants who appraised teacher responses as positive, there are a number of indicators of positive impact of the EHS project:

At baseline 17.6% of participants indicated that the staff member had done nothing. At the project midpoint the research team recommended work to ensure that staff members go back to young people to let them know what action has been taken. It is notable that only 4.2% of participants in the final survey reported that teachers had done nothing in response to their request for help.

Whilst the number of pupils reporting that they would never confide in a teacher about their mental health concerns due to lack of trust remained small but steady between the baseline and midpoint, the number of students reporting this concern at the end of the project had dropped to zero.

7.2% of responses reported actions that had been actively unhelpful or in the young person's view made things worse, this dipped to zero at midpoint, but then returned to a rate equivalent to the baseline.

Supportive measures included: being listened to, helped to feel safe, being helped to feel calmer, speaking to other people who could help with my problems, comforting me, suggesting ideas to help me get better, asking if I wanted to talk, being helped to consider strategies to help them cope such as problem solving and ideas on coping with anger. Referrals to counselling or CAMH's were seen to be useful with more generic considerations such as making sure they knew what was available that might be helpful.

Where it was unclear if it had been helpful or not, answers included indication that specific people had been involved such as parents, school nurses and specific teachers but it was not clear if this had been a positive or negative intervention, therefore further positive experiences could be hidden in this group. Actively unhelpful responses included being shouted at, being put in detention, breaches of confidence, being laughed at and being given information for which the young person could not see the relevance.

Though it was not directly asked about it is interesting to note, given the degree to which bullying was identified as a precipitant to mental distress in the earlier question, that 9.2% of all baseline responses implied within them that the cause of their distress was related to bullying or negative peer interaction. However, no responses at mid or endpoint carried the same implication.

Although the number of participant responses to this question are very different, at pre (268), mid (31) and final point (27), percentages are useful to seek any changes.

Table 5: Summary of changes in pupil perception of teacher responses to requests for help

Responses	Baseline	Midpoint	Final	Change
Helpful	37%	42%	39%	+5% - +2%
Unclear	31.5%	15%	16.7%	-14.8%
Unhelpful	6.7%	0.0%	8.3%	-6.7% - +1.6%
They did Nothing	16.4%	26.9%	4.16%	-12.24%
Would not speak to a teacher	6.7%	7.7%	0.0%	+1% - -6.7%

Chi Square test (X2) indicates that although results show a trend towards positive change in relation to perception of helpfulness and reduced perception of teachers doing nothing to help, results do meet test for statistical significance (p= 0.58).

School related indicators of resilience

60% of participants reported feeling confident within their school prior to project implementation and this remained stable at project end (-2%).

However, only 54.3% pupils agreed that they feel like they belong within their school, and although there was no change in this figure at the end of the project, the number of pupils who actively disagreed with the statement actually increased by nearly 8%.

Similarly, there was a small but notable reduction in the number of students who agreed with the statement “I feel safe to express things about me that are different” and overall approximately one third of pupil participants did not believe that their school was a safe place to express difference.

This is a domain in which it would be hoped that whole school approaches to building an inclusive culture, which are a constituent part of the EHS project philosophy, would positively impact. However, it is also important to note that these score may also reflect the developmental position of the participants; as adolescence is a time of normative anxieties relating to perceived personal difference from the norm and the impact this has upon inclusion/exclusion within social groups (Briggs, 2009).

Of note, the belief that the school could help pupils achieve actually declined modestly over time. This may relate to specific school activities that tend to increase performance anxiety for pupils taking place during the final survey period (December-January), for example exams. It may prove fruitful for individual schools to explore this as a timeline, to consider targeted support at timely periods where the demands placed upon pupils mean they may require additional input.

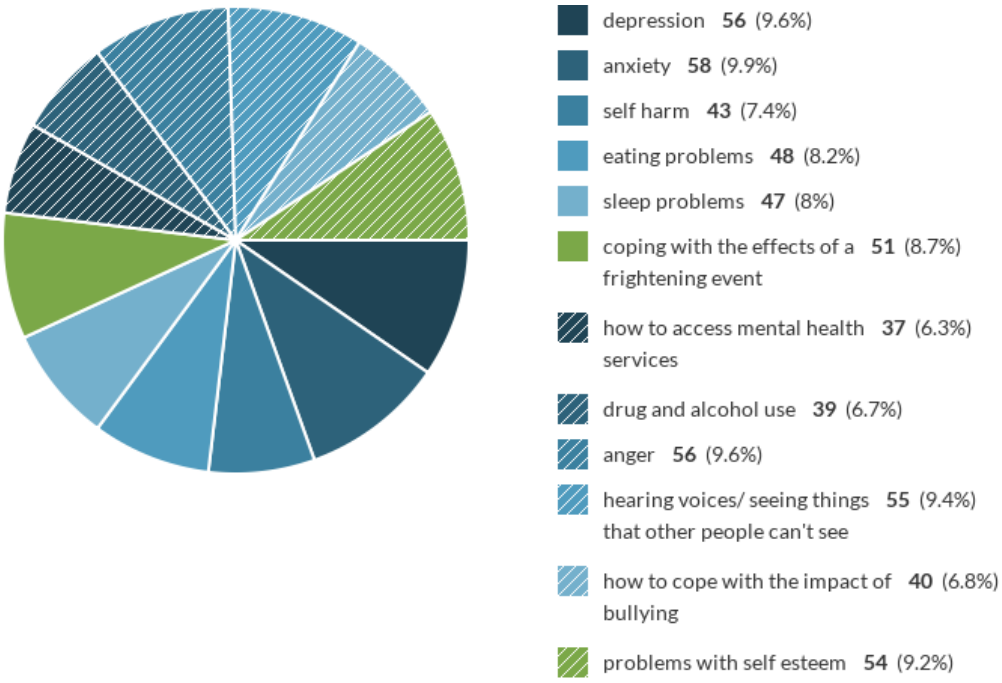
Personal indicators of resilience

It is demonstrated in table 4 that across the questions asking about personal sense of resilience, although overall most pupil responses indicated good levels of personal resilience, a consistent subgroup reported poor indicators of personal resilience (16-18%), which was not impacted upon by the EHS project. This figure is in line with what might typically be expected within the general population of 11-18 year olds, where rates of mental health distress are typically found to be within the range of 15-25%.

Further mental health information that pupils would like:

Students were given a choice of 10 aspects of mental health about which they might want further information at the end of the EHS pilot project. The results are presented in graph 4

Graph 4: Mental health topics about which pupils at the end of the project would like more information



At baseline depression self-harm, anxiety and coping with anger were the most frequently selected topics. At end of project it is possible to see that these are still topics of interest but do not stand out amongst other areas of mental health knowledge. This may reflect pupils feeling more knowledgeable about these topics, and/or becoming more aware as the project has progressed of the wider range of emotional health issues they can face. How to cope with bullying was added as a choice to the mid and endpoint surveys, in response to the high priority that bullying was given by participants in the baseline survey.

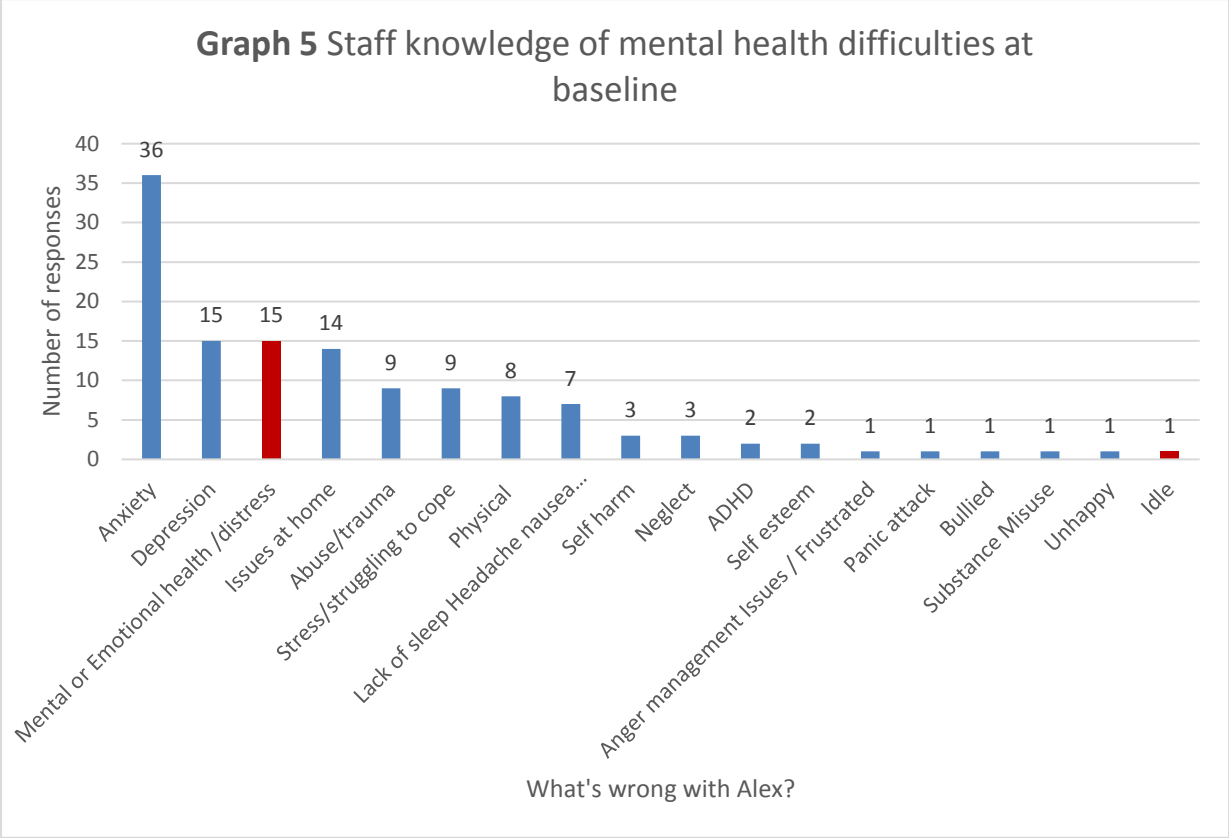
3d. Staff Survey

77 staff members completed the baseline, 10 completed the midpoint and 10 completed the endpoint. (Comprised of 16 different staff members across the last two time points). Results reported as percentages are summarised in table 6, to allow comparison between time points. However low uptake of the survey by staff members means that changes presented need to be interpreted with caution. Results of five anonymised matched pairs have been presented alongside the whole sample data to help confirm reliability of emerging trends.

However, even when the two forms of data analysis corroborate each other's findings, due to low participant numbers, it can still only be asserted that any changes are accurate for those who participated in the evaluation, rather than for the whole population.

Changes in knowledge of mental health difficulties

The baseline survey indicated a good level of knowledge of mental health issues in staff overall (81%).



This level of knowledge remained stable over the three time points, with a small increase (+6.5%) in proportion that recognised the mental health issues within the vignette. There was a concurrent small decrease (-5.5%) in the proportion of participants who could not specify the particular kind of emotional health difficulties present in the vignette. It was notable that bullying was almost absent in the staff group as a possible underlying cause at baseline, as compared to the pupil responses. It is also noted that staff members tended to express their understanding of the health difficulties as symptoms of illness, compared to pupils who were much more likely to express their understanding in terms of possible underlying drivers to Alex's distress. No responses indicative of a stigmatising attitude were given by participants at mid and end point.

Table 6: Staff outcomes at pre, mid and post EHS project implementation

	Baseline (n=77)	Mid-point (n=10)	Post-project (n=10)
Mental health knowledge (%)			
Recognition of mental health issues in the vignette	81	77	**87.5**
Knowledge of underlying causes	32	15.4	25
Don't know/non-specific	18	23	**12.5**
Stigmatising responses	<1	0	0
Personal stigma items: % ≥ *disagree*			
Personal weakness	92	90	**100**
People with those problems are dangerous	70	80	60
If they had a problem, they would not tell anyone	95	100	100
Excuse for poor behaviour	72	100	90
Should be taught alone	83	90	**100**
Perceived stigma items: % ≥ *Disagree*			
Other people believe a sign personal weakness	73	44	40
Other people believe People with those problems are dangerous	54	40	20
Other people would not tell anyone	93	100	**100**
Other people believe it's an excuse for poor behaviour	41	55	30
Other people believe Should be taught alone	46	60	**60**
Help given to students: %			
Never	29	40	40
Once	11	0	0
Occasionally	37	40	30
Frequently	24	20	**30**
Confidence level to help: % ≥Quite a bit			
Personally	37	44	40
Perception in others	45	60	40
Confidence in the support of colleagues to support the staff member	60	90	50

Table 7: Summary of change in anonymised matched pairs

Pair No.	Demonstrated level of knowledge	Personally held stigma	Stigma in others	Help seeking	Confidence in colleagues	Self-reported knowledge/ confidence	Actions to help	Signposting
1	↑	↓	↑	↑	↑	--	↑	↑
2	↑	--	↑	↑	--	↑	--	↑
3	--	--	↑	--	--	--	--	↑
4	↑	--	↑	↑	↑	↑	--	↑
5	--	↓	↑	--	↑	↑	↑	↑

Key

↑ = increase ↓ = decrease -- = no change

Questions relating to stigma

Staff results parallel pupil findings, in that levels of personally held stigma were reported as low at baseline (<10% in relation to emotional health difficulties indicative of personal weakness), with some questions showing that staff who participated in the final survey have even lower levels of personally held stigma. In the five matched pairs, two participants showed a reduction in personally held beliefs of a stigmatising nature and three participants, whose original score indicated very low levels of personally held stigma, remained the same (Table 7).

In contrast, both the comparison of overall survey results at baseline and endpoint, and analysis of the individual matched pairs, show a marked increase in perception of stigmatising beliefs and attitudes in others. As nearly all mental health awareness training includes increasing awareness of stigma and its impact upon those in mental distress, it is possible that engaging with training and talking more explicitly about emotional health issues within in the school environment may have actually increased individual's awareness of and sensitivity towards negative attitudes.

A notable positive change sustained at mid and endpoint is an increase in the speed within which staff respondents reported that they would seek help for an emotional health problem. By the end of the project all participants stated they would seek help, with the majority indicating they would seek help immediately and the rest doing so within a week of onset

Questions relating to confidence

Proportion of participants who felt not at all confident or only a little bit was reduced (-9.3%) at mid and endpoint.

Whole survey comparison shows marked improvement in all three questions relating to perceived confidence at mid-point, with a return to baseline levels at end of project. However, in the matched pair analysis there was a clear increase in self-reported levels of confidence and knowledge as well as in confidence in their colleague's abilities.

Intention to help

Staff were asked to rank which three actions they were most likely to take, if they were to be approached by pupils experiencing emotional health issues:

Rank	Actions	Responses		
		Baseline	Mid	End
1	Discuss with school based health professional	67	10	10
2	Have a conversation with the pupil	55	8	9
3	Discuss with another teacher	39	7	5
4	Referral to CAMHs	23	4	4
5	Contact the family	20	1	2
6	Discuss with a member of the admin team	5	0	0
7	Talk to other students	2	0	0
7	Do nothing	2	0	0

Responses marked in red indicates the baseline responses that we expected to be markers of change at the mid and post-project time points. As can be seen from table there was a positive trend away from discussing student's emotional health issues with their peers, administrative staff, or from doing nothing.

Actual help given to students

At baseline 71% of staff reported speaking to a pupil about their emotional health at least once in the month prior to completing the survey, with 23% indicating that they had done this frequently. Whilst the number of participants who had never spoken with a pupil in the last month increased modestly, there was also an increase in the frequency with which participants spoke with young people about emotional wellbeing issues.

TYPE OF HELP GIVEN:

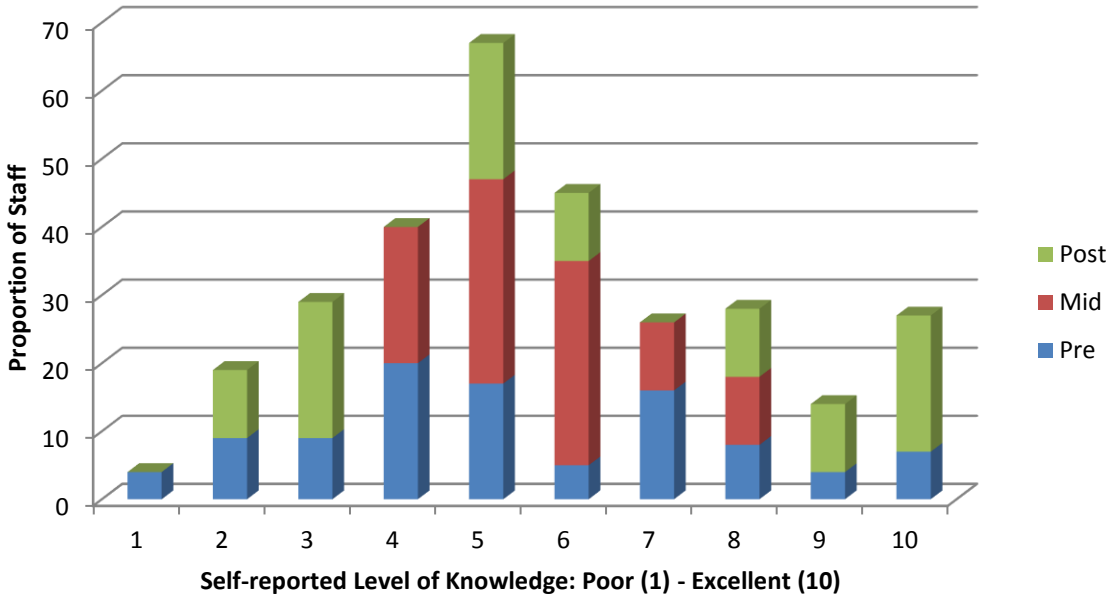
Intervention	**Number of responses**		
	Baseline (n=46	Mid (n=)	End (n=5)
Interpersonal interaction:			
Discussion	17	2	1
Listening	11	1	1
Reassurance	6	1	0
Time	3	0	1
Supported	2	1	1
Empathised	1	0	0
Mindfulness			1
Total	40	5	5
Discussed/referred with safeguard lead, pastoral support/line manager/SENCO	24	3	3
Advice, Sleep, Attend class, strategies	12	1	2
Contacted parents	4	0	2
PHSE sessions	1	0	0
Offered to mediate with parents	1	0	0
Opened a Common Assessment Framework or Individual action plan	1	0	2

It is noteworthy that the responses that relate to personal interaction with the young person correlates highly to the types of response that the pupil respondents have identified as helpful. The matched pair analysis revealed a positive shift over time with participants reporting use of more specific, intentional actions to help at the endpoint,

Perceived knowledge of sources of help and referral pathways within the locality

Graph 6 displays the distribution of how participants ranked their level of knowledge of sources of help at each time point.

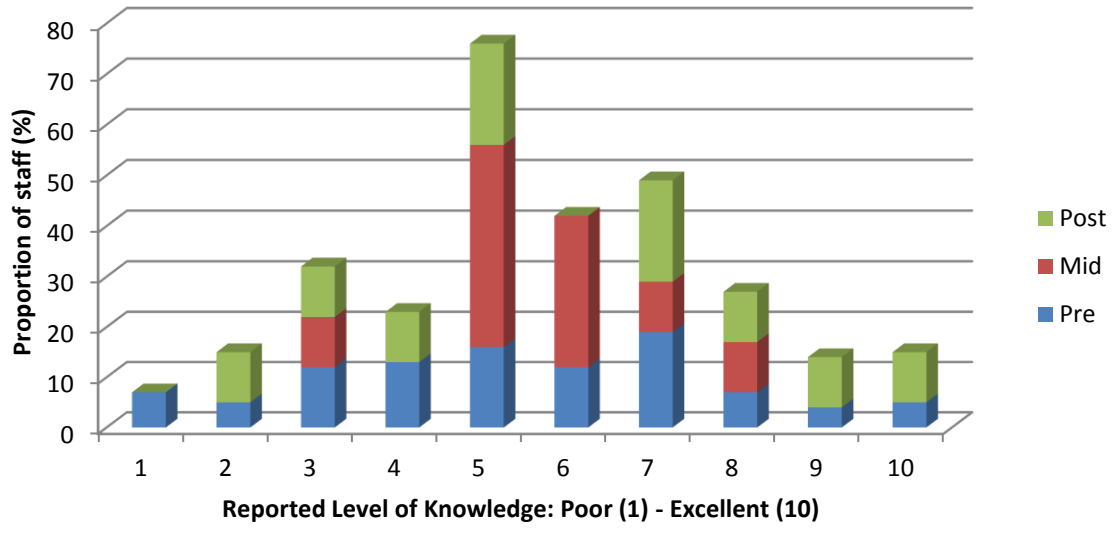
Graph 6: Staff knowledge of sources of help and referral pathways



Staff perception of knowledge of sources of information and advice for young people

Graph 7 presents the distribution of individual's knowledge and awareness of sources of information and advice, to which pupils could be signposted.

Graph 7: Staff knowledge of sources of information and advice to which to direct pupils

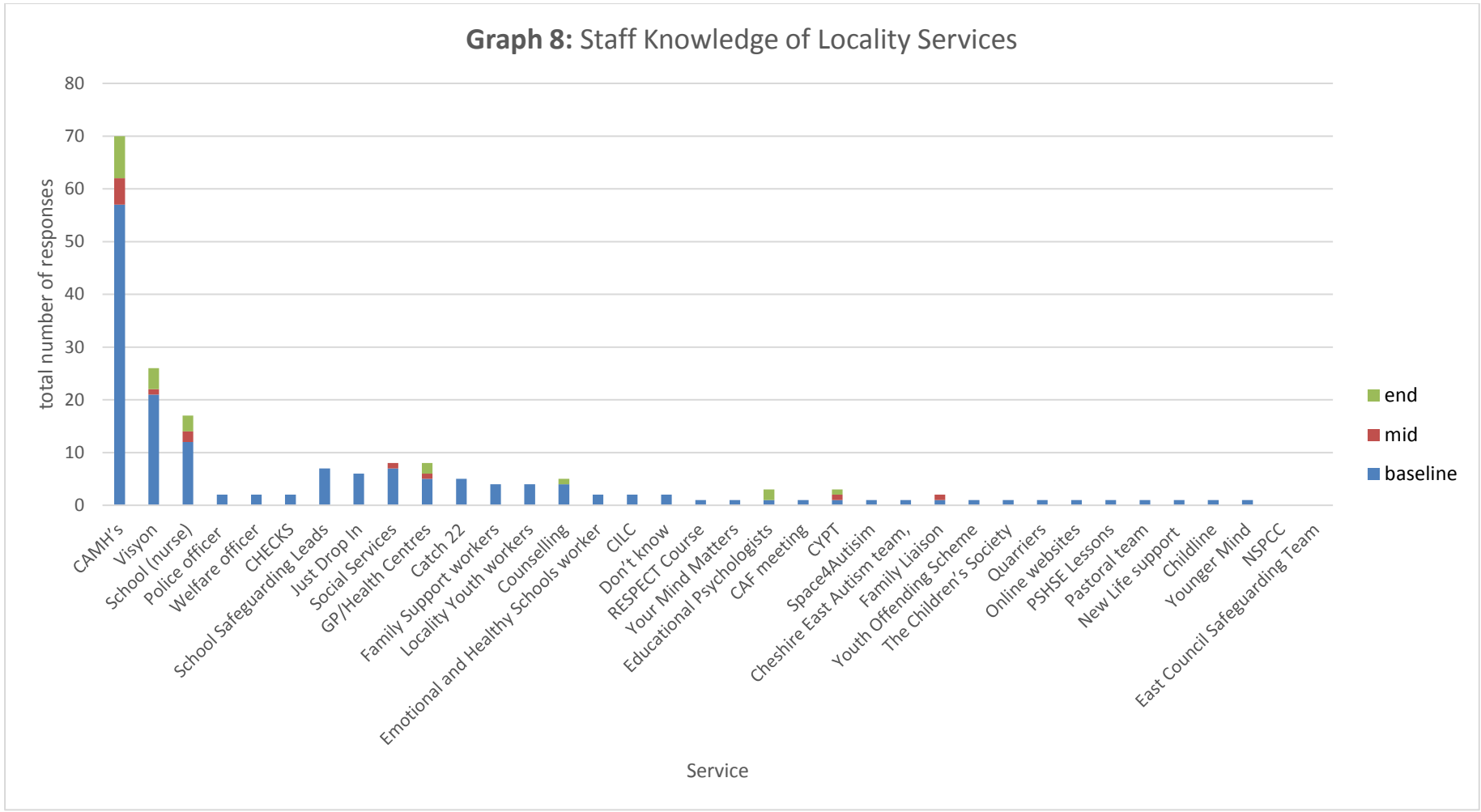


Both graphs show that at baseline respondents ranked themselves across a very broad distribution (indicating high variance in levels of knowledge within the sample). Whereas, at midpoint, responses are clustered around the median in the 2nd and 3rd quartile. At endpoint, although the distribution is broader again, overall, a higher proportion of participants have ranked their level of knowledge in the top quartile. Whilst this shows that participants rated their level of knowledge more highly at the endpoint, it should be noted that the very small sample size means that the effect size of each individual participant's response is significantly amplified. This means that a marked change in one participant's response can disproportionately affect the overall results.

Knowledge of local services

At each time point staff were asked to list local services that could support children with emotional health needs as a free text response (so as not to prime respondents with the answers). Responses were mapped against a directory of local service provision provided by the EHS clinical lead (Graph 8). This information is not intended to provide a measure of change, but to help identify those areas of service provision that require a higher level of visibility or benefit from greater marketing to school staff going forwards.

Graph 8 clearly demonstrates that three services were well known within the sample group, and that additional marketing and information-giving regarding other services within the Cheshire East locality may be indicated.


Graph 8: Staff Knowledge of Locality Services
total number of responses
80
70
60
50
40
30
20
10
0
CAMH's
Visyon
School (nurse)
Police officer
Welfare officer
CHECKS
School Safeguarding Leads
Just Drop In
Social Services
GP/Health Centres
Catch 22
Family Support workers
Locality Youth workers
Counselling
Emotional and Healthy Schools worker
CILC
Don't know
RESPECT Course
Your Mind Matters
Educational Psychologists
CAF meeting
CYPT
Space4Autisim
Cheshire East Autism team,
Family Liaison
Youth Offending Scheme
The Children's Society
Quarriers
Online websites
PSHSE Lessons
Pastoral team
New Life support
Childline
Younger Mind
NSPCC
East Council Safeguarding Team
Service
end
mid
baseline

Reported impact of EHS pilot project upon knowledge and confidence and its relationship with engagement with training opportunities

Participants of the end of project survey were asked to rate the extent to which they agreed with the statement: “Overall, I feel the emotionally healthy schools project in my school has positively impacted on my knowledge and confidence in dealing with the emotional health needs of pupils”. Responses were cross-tabulated with participant engagement in training opportunities provided as part of the EHS pilot in order to explore the relationship between the two variables.

Table 8: Relationship between engagement I training and perceived impact of EHS project upon levels of knowledge and confidence

To what extent to you agree with the statement: "Overall I feel the emotionally health schools project in my school has positively impacted on my knowledge and confidence in dealing with the emotional health needs of pupils"	Since the Emotionally Healthy School project began in your school, what training and development opportunities have you taken part in:				No answer	Totals
	MindEd e-learning module(s)	CAMHS Schools Link Training	Training Sessions delivered by Educational Psychologists working with your school	In-school training delivered by Dr Rob Lupton (Emotionally Healthy Schools clinical lead)		
Strongly disagree	0	0	0	0	0	0
Disagree	0	0	0	0	1	1
Neither disagree not agree	1	0	0	0	2	3
Agree	3	0	2	2	0	7
Strongly agree	2	1	0	2	0	5
No answer	0	0	0	0	0	0
Totals	**6**	**1**	**2**	**4**	**3**	**16**

Question	Response count
4	7
14	10

Whilst endpoint sample size means this cannot be generalised to the whole staff population within the pilot school, it can be said categorically that for those staff who completed the endpoint survey, engagement in training was positively correlated with a perceived improvement in levels of knowledge and confidence. Conversely, staff who responses indicated no perceived benefit from the EHS pilot project have engaged in no or little training opportunities.

Further information and training requests

At the project end respondents identified the following areas about which they would like further information and training:

- Self-Harm
- How to support young people with low self-esteem, anxiety and depression
- Understanding psychosis

- How to help young people get back in the classroom
- Updates on latest government initiatives relating to emotional health and wellbeing

Two respondents commented on having recently received a lot of help and information, so whilst not having any specific needs, registered their ongoing openness to further training.

Overall Notable Themes and Changes in Staff and Pupil survey

Baseline survey responses demonstrated that knowledge of student mental health issue was good in both pupils and staff. Further increases in knowledge were observed in both staff and pupil participants over time. In particular, there was more specific understanding of emotional health issues alongside pupils demonstrating increased knowledge of the of the importance of seeking help and staff showing increased readiness to engage with pupils and improved knowledge of where to refer or signpost.

At baseline, pupils and staff reported relatively low levels of personally held stigma, which decreased even further at the end of the project by a small degree. Pupils were up to two times more likely to expect others to think Alex was weak, dangerous, would be considered to have poor behaviour and should be taught away from the class, even though they generally didn't agree with this themselves. So expected stigma from others was more of an issue than judgement or stigma from the pupils themselves. The pattern of perceiving higher levels of stigma in other's attitudes rather than one's own was mirrored in staff survey responses. Although the degree of stigmatising attitudes thought be held by others was less than in the student group, there was a marked increase in levels of perceived stigma in others in staff participants at the endpoint

There were quite good levels of awareness of what to do and where to get information and help, but a consistent percentage of pupils felt they had no abilities in relation to helping themselves and others stay emotionally healthy (16%). This did not alter over time and may reflect the students who would be more likely to require targeted interventions.

Overwhelmingly, pupils would seek external help from staff family or friends if they had a friend like Alex but they were less likely to approach Alex himself, with some children expressed concern regarding the potential harm from speaking with Alex directly or involving counsellors. The likelihood and speed with which both pupils and staff would seek help showed a marked upward trend at the end of the project. For pupils this result is perhaps more important than whether there was a change in their perceived capacity to help themselves, as seeking assistance from an adult is a developmentally appropriate strategy for school age children.

Staff participant's perception of their knowledge, confidence and confidence in their colleagues' ability showed a positive trend over time, alongside an apparent increase in the frequency with which some staff spoke to young people about their emotional

health. This trend is further substantiated by results of the pupil survey which at endpoint showed that pupils were talking to teachers about their emotional health on a more frequent basis and indicated pupil-perceived increase in staff responsiveness.

There was a significant difference between staff and student survey responses in relation to the prominence of bullying as a factor associated with mental health issues, with pupils rating bullying as a much more central factor in their understanding of causes of mental distress at baseline. It is of note that concerns about bullying were much less present in pupil responses at midpoint and endpoint.

School-related resilience scores were good for most pupils, demonstrating confidence in school, that the school can help them to achieve and belong. Lowest scores were around being pupils feeling safe to express things about them that are different, but still 40% could express this. However, the EHS interventions appeared to have little impact upon these domains over time. Across all questions relating to personal indicators of resilience, approximately 17% consistently disagreed or strongly disagreed and this did not alter over time.

Staff and students identified very similar priorities in relation to mental health issues about which they would like more information. Staff awareness of local emotional health and wellbeing services show that there is a significant gap in knowledge of the range of services outside of T3 CAMHS and school-based services

3e. Targeted Interventions for Pupils

Participating schools selected a menu of targeted programmes to address the needs of particular populations within each school, to implement across the 12-month pilot. These were:

Table 9

Programme name	**Schools planning to implement**	**Year group targeted**	**Outcome measures completed?**
Exam Stress	Middlewich High School Eaton Bank Academy Ruskin High School	10, 11 11	Yes No Yes
Team of Life (using sport for resilience and skill building)	Middlewich High School Oakfield High School Poynton High School Eaton Bank Academy Ruskin High School	7, 8, 9 / 8, 9, 10 / 7, 8, 9,10	Yes No Yes No Yes
Resilience for Life (Resilience building)	The Macclesfield Academy	7, 8, 9	Pre only
Cool Connections (CBT-based programme for increasing understanding of thoughts, feelings and behaviour and effective management)	Ruskin High School	7	Yes
Form Room Mindfulness	The Macclesfield Academy	Not Specified	N
Transition Intervention	Eaton Bank Academy	Not specified	N

Outcome Rating Scales (ORS)

The ORS measures 4 dimensions of wellbeing and the combined score can be used to identify those young people who may warrant additional mental health assessment and intervention. The mean ORS scores for each domain at pre, mid and time points are presented by group programme on page 37.

Table 10: Mean ORS Scores for Cool Connections Group

	Personal wellbeing				Interpersonal Wellbeing				Social Wellbeing				Overall Wellbeing				Combined score			
Time points	Mean	N	Std. Deviation	P Value	Mean	N	Std. Deviation	P Value	Mean	N	Std. Deviation	P Value	Mean	N	Std. Deviation	P Value	Mean	N	Std. Deviation	P Value
Pre	2.800	5	.4472		4.200	5	2.2804		1.600	5	.5477		2.900	5	.5477		11.100	5	3.0496	
Mid	4.667	6	2.3381		7.500	6	1.7607		4.833	6	2.4833		4.167	6	1.3292		21.167	6	4.1673	
Post	7.033	6	1.9866	.005	5.800	6	2.5140	.399	5.583	6	1.1035	.005	3.367	6	1.4989	.443	21.783	6	4.2541	.006

Table 11: Mean ORS Scores for Team of Life

	Personal wellbeing				Interpersonal wellbeing				Social wellbeing				Overall wellbeing				Combined score			
Time points	Mean	N	Std. Deviation	P Value	Mean	N	Std. Deviation	P Value	Mean	N	Std. Deviation	P Value	Mean	N	Std. Deviation	P Value	Mean	N	Std. Deviation	P Value
Pre	5.509	33	2.7590		5.161	33	3.0023		5.773	33	2.8203		5.812	33	2.8708		22.882	33	9.0230	
Mid	6.160	15	2.2746		7.013	15	2.9157		6.427	15	1.8281		7.013	15	2.0000		26.947	15	8.4008	
Post	6.496	25	2.4864	.197	6.148	25	2.7467	.254	6.628	25	2.6776	.208	6.508	25	2.4406	.413	25.676	25	9.4790	.388

Table 12: Mean ORS Scores for Exam Stress

	Personal wellbeing				Interpersonal wellbeing				Social wellbeing				Overall wellbeing				Combined score			
Time points	Mean	N	Std. Deviation	P Value	Mean	N	Std. Deviation	P Value	Mean	N	Std. Deviation	P Value	Mean	N	Std. Deviation	P Value	Mean	N	Std. Deviation	P Value
Pre	5.496	23	2.4462		5.926	23	2.7143		6.083	23	2.6198		5.670	23	2.2445		23.000	23	8.6925	
Mid	6.917	6	2.1075	.214	7.167	6	3.0768	.331	6.667	6	2.9609	.608	7.500	6	2.9326	.075	28.250	6	10.7645	.206

Across all groups for which outcome measures were completed, and across all 4dimensions of wellbeing, the standard deviation indicates that the mean is a reliable fit in relation to the whole sample group from which it is derived.

COOL CONNECTIONS

As Cool Connections was a CBT-based group to help young people who were having difficulties understanding and managing their thoughts and feelings, wellbeing scores at baseline were notably lower than for the other groups. This is expected for a group that is providing intervention for pupils experiencing an emotional health problem, rather than focusing on resilience or addressing a specific source of stress.

Cool connections showed the greatest level of improvement over time, with scores improving in each of the four domains at mid and endpoint. A Mann Whitney U test revealed that the degree of change between pre and post scores was statistically significant in the domains of personal wellbeing ($U=.00$, $p<0.01$), social wellbeing ($U=.00$, $p<0.01$) and for the combined score ($U=.00$, $p<0.01$). Analysis of inferential statistics revealed that the degree of improvement in combined score at midpoint was also statistically significant ($U=.00$, $p=0.006$). Highlighting that the positive effects of the cool connections programme begin to take hold early in the intervention.

EXAM STRESS

ORS measures were administered for pre and mid-point only by the locality team. However, there was an improvement in the mean of all four sub-scores and the combined scores at the mid-point. The mean combined score at midpoint shows an improvement of 20%. A Mann Whitney U test showed that the level of change did not meet statistical significance in any of the domains. This is to be expected given that outcome measures taken before completion of the programme. However, the level of change in overall wellbeing did approach statistical significance ($U=36.00$), $p=0.075$), and the trend towards improvement at mid-point indicates that levels of improvement may have tended toward the level of statistical significance had outcome measures been administered at the actual end-point.

TEAM OF LIFE

Again, positive improvements in mean scores at mid and post time points are seen in all sub-scores and the combined score for the team of life programme. However, in this sample the level of improvement did not reach statistical significance.

DIFFERENCES BY GENDER AND YEAR

Results for all three groups were analysed to establish if there were any notable differences in outcomes based on gender or year group. Only the Team of Life group showed statistical difference between scores by gender. Analysis highlighted that this related to differences in how participants scored themselves at each time point (with girls tending to score themselves proportionately lower than boys on each sub-score). It did not show any difference in levels of improvement between boys and girls.

In relation to differences between year groups, again, only Team of Life showed any notable difference. The degree of improvement in sense of overall wellbeing was smaller in years 9 and 10, compared to other years. In the year 9 group, the mean combined score actually reduced at midpoint, compared with baseline and then showed improvement at the endpoint. However, the larger standard deviation in this group's scores (SD= 6.7), which shows a greater variance of score between individual group members, combined with the smaller number of participants within the subgroup, indicates that this result is likely to be a result of the increased effect size of individual participant scores on the group mean.

Session Rating Scales (SRS)

SRS is a measure of participant satisfaction with the delivery of the intervention and its 'fit' with the pupil's perceived areas of difficulty or priority. Satisfaction is rated in relation to the degree to which the pupil feels:

- Relationship: Listened to, respected and understood
- Goals and Topic: The session topic or goals fit with their needs
- Method: The facilitator's approach is a good fit for them
- Overall: The session was useful overall

123 SRS forms have been completed by pupils attending groups over the course of the EHS pilot project.

The mean satisfaction scores for each domain by programme/group are presented in Table 11.

Low standard deviation scores indicate that the mean score is a good representative of the whole data set. However, a conservative approach to interpreting the results should still be taken as once broken down by group, the sample sizes are relatively small and there is significant range within all groups.

The mean SRS scores for Team of Life, Exam Stress and Resilience for Life groups are uniformly in the top quartile, indicating a very high satisfaction rating. Although overall the SRS scores still indicate a good level of satisfaction, Cool Connections received the most mixed evaluation from participants, despite it having the most significant impact upon participant levels of wellbeing (as measured by ORS scores). In particular, perceived satisfaction with the fit of the session goals and topic were in the second quartile. This may be understood in terms of difference in focus of Cool connections, where the alignment of pupil worries and the stated focus may not be as transparent as for example an exam stress group. Participants in Cool Connections also had significantly lower wellbeing scores at commencement of the programme. Lower mood and wellbeing can have a negative impact upon the degree of hopefulness individuals have in relation to the intervention they are engaged in effectively meeting their needs (Salovey and Birnbaum, 1989)

Analysis of SRS scores by year group as well as programme revealed notable differences in the degree of satisfaction reported by Year 11 and Year 10 pupils undertaking the exam stress group. Year 11 pupils reported a higher satisfaction rating across all scores compared to Year 10. It is possible to assume that the degree of urgency and relevance of this group to Year 11 pupils may account for the difference. No other significant differences in satisfaction rating were noted between year groups.

Analysis of difference by gender groups highlighted one significant difference ($p<0.05$) between boy's and girl's rating of Relationship (degree to which they felt respected and understood) within the resilience for life group. Female participants mean score for relationship was almost 3 points lower than the male participants (although still good). As this group only took place in one school, it is reasonable to assume that the difference is related to gender rather than other confounding variables. This finding indicates that further work considering the impact of gender difference in facilitator and participant engagement style may help to augment the effectiveness of targeted group for participants of both gender.

Table 13: Mean SRS Scores by Group

type of group attended		Relationship	Goals and Topic	Method	Overall
Exam stress	Mean	8.378	7.991	8.661	8.313
	N	23	23	23	23
	Std. Deviation	1.4777	1.5288	1.4099	1.3818
Team of Life	Mean	7.781	7.948	8.571	8.300
	N	48	48	48	48
	Std. Deviation	2.2689	2.1319	1.6238	1.7629
Resilience for Life	Mean	8.082	7.579	8.504	8.171
	N	28	28	28	28
	Std. Deviation	2.7217	2.4426	2.2240	2.4396
Cool Connections	Mean	7.263	5.904	7.717	7.058
	N	24	24	23	24
	Std. Deviation	2.3717	2.2027	1.9722	2.2177
Total	Mean	7.860	7.473	8.411	8.031
	N	123	123	122	123
	Std. Deviation	2.2829	2.2436	1.8199	2.0050

3f. Summary of the CORC Consultation Feedback Questionnaire.

62 feedback forms were received at final point of the project from staff who had been in receipt of consultation with the EHS clinical lead for CAMHS. Respondents were in a variety of academic and student support posts.

Nature of the consultation	**Number of respondents**
A one off	3
A one to one	0
Over the telephone	0
One of a series of planned consultations	40
Group	18
Face to face	9

The feedback reported as follows:

Concern of the consultation (In terms of who the consultation concerned)	**Number of respondents**
An individual child	51
A group of children	10
An organisational issue	19

What respondents wanted from the consultation is illustrated below

Aim of the consultation	**Number of respondents**
Answers to questions on practice in general	27
Help to think about what to do next with this child	40
Help with assessment	10
Help with interventions	36
Help to think through my worries about this child or group of children	28
Help to increase my confidence in managing the situation	35
Other (communication) support for the parent x1	3

The highest agreement being that the consultation helped people think what to do next with this child. The second highest statement was that the consultation helped with interventions and increased confidence was third highest.

Nature of the Outcome	Number of respondents
A referral to specialist CAMH's	4 existing: contact not a new referral 1 new referral 2 spoke with CAMHS
Child redirected to alternative services	1
Help to manage with no referral or redirection	32
other (text listed below) Action plan for school Students to be monitored, Meeting with CAMHS medical practitioner. To seek advice from Youth Forum Training completed Group discussion/reflection with Nick Change to intervention Proposal for professionals meeting Advice given	14 1 2 1 1 6 1 1 1

Based on this, there was only one new referral to CAMHS over the length of the project, four pupils had already been referred and the consultation helped staff members to manage the presenting issues. The highest scores were that the consultation helped them to manage with no referral or redirection.

Reduction in concerns	Number of respondents
A lot	20
A bit	16
Not at all	21

At the final point of the project, 54 (87%) participants were happy with the outcome of the consultation and their concerns were thought to have been managed as above. One person at mid-point was not happy with the outcome, stating there was "no real conclusions for this one"

Ease to arrange consultation	Number of respondents
Not so easy	0
Easy	24
Very easy	16

At the first report, the proposed improvements to the consultation service section was mainly left blank but suggestions were that additional training had been useful and

Wednesdays were a challenge for one respondent due to competing activities on that day.

For the midpoint collection, there were no reported issues with the above. One person stated they wanted more time to prepare. Two people stated that they found the sessions really useful and would like these to continue. All other forms were left blank.

By the final collection, the only thing reported by one participant was that the staff attending the consultation could have improved in their planning. Otherwise, there were no other reported improvements.

4. Key Messages and Findings in Relation to the EHS Pilot Project Intended Outcomes

An important finding of this evaluation is that baseline data indicated that prior to any of the EHS strategies being implemented overall the pilot schools were doing a good job in relation to supporting emotional health and wellbeing. Pupil levels of knowledge and confidence in their school to support them were already high and staff levels of knowledge and attitudes overall were good. This creates a ceiling effect, where any changes as a result of the EHS project implementation will therefore be likely to be of small magnitude (Svensson and Hansson, 2014).

Despite this phenomenon, there are a number of distinct indicators of positive changes because of the EHS pilot project. These are summarised in the relation to the EHS project's intended outcomes

Reduction in inappropriate referrals to CAMHS and an increase in appropriate referrals

Analysis of referral data, pre and post project implementation combined with CORC consultation evaluation outcomes demonstrated that access to a Tier 3 CAMH clinician for consultation; delivery of targeted interventions for pupils at risk within the school setting; and whole school approaches, combined to positively impact upon rates of CAMHS referrals made by the schools, and on how appropriate those referrals were.

Reduction in stigma around emotional health and wellbeing

The results present a complex picture in relation to this intended outcome. Perceived stigma from others was a concern for participants at baseline and remained so at the end of the project, with staff participants showing an increase in perceived stigma in others. However, personally held stigmatising attitudes were low in staff and pupils and reduced further over the project period.

These findings are in keeping with prior research studies. Research participants typically assess themselves as less stigmatising than others and personally held views have been shown to be more sensitive to change following interventions aimed at reducing stigma (Quinn et al., 2011). Jorm et al. (2010) found that very few student-focused outcomes showed positive impact of a staff mental health training programme and showed increase in perception of stigma within others.

Despite the challenges of finding anti-stigma strategies that are effective at reducing perceived stigma, this is an important area on which to focus future school-based strategies. Perceived stigmatising views of others has been shown to act as a deterrent to help seeking and to have a disproportionately high impact upon young people (Clement et al., 2015). Focus on giving pupils clear and congruent messages

(direct and in direct), about the accepting and receptive nature of their school and the staff within it may be more effective use of resources than approaches that seek to further increase pupil level of knowledge. It is also important to hold in mind that changes in culture, attitude and belief are often longer-term outcomes of intervention. The relatively short evaluation period of this study may not have captured the full extent of the impact of EHS strategies, which may continue beyond the length of the study period, indicating the need evaluation of medium and long-term impacts (Mehta et al., 2015).

Increase in awareness and knowledge of emotional mental health and wellbeing

Baseline knowledge in young people was demonstrated to be good and sophisticated. Construction of mental distress in staff ran more along the line of naming symptoms within a biomedical framework (as is the case in the adult population generally). Whereas, pupils were more likely to construct mental distress in relation to possible underlying external causes (systemic, environmental and social factors)

There was a moderate improvement in demonstrated knowledge in both groups and self-reported improvement in knowledge in staff respondents at the end of the project. In young people, this related to more specific knowledge and availability of a mental health language with which to describe what they were seeing

There was a marked increase in the degree to which pupil participants understood the importance of seeking help alongside the potential harm of doing nothing or keeping troubles to themselves.

Increased confidence of staff and pupils relating to emotional health and wellbeing

Staff respondents demonstrated an improvement in their perceived confidence and knowledge about referral, signposting and in their colleagues' capacity to help. This was mirrored in pupil reports of increased frequency with which they had spoken with a member of staff about emotional health concerns in the month prior to the final survey and the pupil's perception of increased responsiveness of staff when they did seek help.

For the staff who participated in the research there was a clear relationship between engagement in training opportunities provided and a positive perception of the impact of the EHS pilot project upon their knowledge and confidence levels to young people.

Young people having and keeping mentally healthy with the knowledge of what is required to maintain this and knowing where to go for help if they need it

The most important changing trend highlighted by a number of measures in this study was the increase in the number of pupil who would seek help, the speed with which they thought they would seek help, and the number of pupils actually talking to teachers about their concerns.

At all time points approximately 16% of pupil participants felt they had no abilities to help themselves stay well. This percentage perhaps reflects the cohort of pupils who need targeted interventions, and is positively mitigated by pupil increase in capacity and tendency to seek the help of a staff member.

Better understanding by of what provision is available additional to CAMHS

Staff participants reported an increase in confidence and perceived knowledge of sources of referral and help. The objective measure indicated that knowledge of services external to the school still fell within the narrow range of CAMHS and the voluntary sector provider working with their specific school. Greater awareness raising of the range of support services and agencies within the locality is indicated.

Increased confidence, school-focused measures self-esteem and resilience levels in young people who have participated in targeted group or participatory activities

All targeted interventions for children identified as at risk of mental distress or in need of help with specific stressors, that this study assessed, demonstrated marked improvement in all measures of wellbeing, self-esteem and resilience for participating pupils. Cool Connections in particular demonstrated a statistically significant level of improvement for a group of pupils who presented with very low levels of wellbeing prior to intervention. Pupil evaluation of suitability and acceptability of all three interventions were uniformly in the top quartile showing a high level of satisfaction. These findings are in line with previous research studies investigating the impact of school-based mental health strategies, which not surprisingly show that targeted interventions tends to have a more measurable impact than whole school approaches. This is partly because most children within the school environment are not in need of additional emotional wellbeing support and those who do are a much smaller group hidden within the whole population. This makes measuring statistically significant change at a whole pupil population difficult (Spence, 2014).

A School environment that promotes and sustains pupil resilience, sense of worth and esteem

Pupil sense of confidence in their school remained stable at all time points. There was a small reduction in pupil's sense of their school's ability to help them achieve,

which may be related to timing of the final survey at a time of high performance demand (e.g. exams). The percentage of pupils with markers of low resilience remained stable over time (approx. 16%) and access to targeted interventions are more likely to be effective for this cohort.

Relatively low levels of pupils who participated reported feeling comfortable to express aspects of their identity that were different or unique within their school setting. Although it can be predicted that the nature of ordinary adolescent preoccupation with fitting in with their peer group will place a ceiling on how much this could be improved, this finding also needs to be considered alongside the higher level of concern about stigmatising attitudes in others. Any activities that create a greater sense of acceptance of all forms of difference are also likely to improve concerns about being judged for having emotional health difficulties.

Bullying was high on pupils' agenda of emotional health related concerns. However, this was not reciprocated in the information captured from staff groups. Graham et al. (2011) have highlighted the importance of understanding teachers' perceptions and awareness of the events and situation that impact on students' emotional wellbeing and how they align (or not) with student priorities, as they inform teachers' ability to respond appropriately in classroom contexts. The effects of being both a victim and perpetrator of bullying have been shown to be directly associated with rates of depression, anxiety, self-harm and suicidality in childhood, and to last into early adulthood (Copeland et al., 2013). Given the strength of this correlation within published evidence, and that both pupils and staff rate anxiety, depression and self-harm as primary areas about which they would want further information and training, the potential suitability and feasibility of evidence-based whole school anti-bullying measures and programmes could be explored. As a starting point, an example of such a programme is KiVa (http://www.kivaprogram.net/), which has been successfully piloted and evaluated within the UK school setting (Hutchings and Clarkson, 2015).

It is of note that whilst staff were less likely to consider bullying as a high priority issue, engagement with School Leads for the EHS pilot project did highlight that broader problems with interpersonal effectiveness within peer relationships was highlighted by staff as a priority and that whole school approaches were being put in place to support students in this domain. Within the pupil survey results, concern with bullying reduced at mid-point and was not reported at all by the endpoint participants.

Overall, the results of the EHS pilot project evaluation are in line with trends identified within other published research studies investigating the effectiveness of mental health awareness and promotion in school settings. These show highest rates of effectiveness in targeted interventions for pupils and staff, identify the

greatest level of impact of whole school approaches upon levels of knowledge and readiness to help or seek help, and show limited or mixed impact upon staff and pupil attitudes (Svensson and Hansson, 2014; Quinn et al., 2011, Jorm et al., 2010).

Recommendations

1) School-located, targeted interventions for pupils identified as at risk and school-located access to consultation from a CAMHS practitioner have been demonstrated to be effective strategies for improving identification, support and access to early help for pupils who are raising concern but may not yet meet the threshold for secondary mental health services.

    a. Ongoing use of routine outcome measures (ORS and SRS) to monitor impact of targeted interventions may provide important information regarding any emerging gender differences in experience of and in response to particular programmes.

2) Future activities to include a focus on working to break down concern about stigmatizing attitudes of others as a barrier for help seeking.

    a. Given the relatively low level of perceived safety to express differences reported in the participant group, adopting approaches that promote inclusivity and celebration of difference more broadly, rather than focusing on mental wellbeing specifically, may be more likely to have impact.

3) Consideration of pilot implementation of evidence-based whole school programme for prevention of bullying.

4) Follow-up assessment of the longer-term impact of the EHS pilot project is warranted to identify any further improvements over time and to establish if positive changes identified within this study have been sustained over time.

5. Strengths, Limitations and Learning from the Evaluation Process

There are a number of factors that impacted on the final analysis of the project due to data collection challenges and levels of individual school engagement with different components of the evaluation. These are useful to consider from a position of learning from the process and informing future activities.

As illustrated in the report, individual schools were able to be active participants in different components for the evaluation strategy, but few pilot schools were able to engage in all evaluation methods. Enabling students to participate in the mid and endpoint survey appeared to be particularly challenging for a number of schools. As the EHS project progressed EHS School Leads reported that there were multiple evaluation projects using survey methods happening concurrently. Whilst some schools managed this and were able to support the data collection process, for others capacity to enable students to complete the survey was significantly impacted upon. Given this, it may be reasonable to suggest that survey fatigue and lack of clarity with regard to what was being measured, how and why, were interfering factors.

With this in mind, future project evaluation would be served well if this was organised across specific timeframes to avoid the clumping together of numerous forms of data collection. This may assist in the reducing the issues mentioned above and may also positively impact on how confidently the results for a particular project may be reported.

The evaluation depended on being able to collect data at three fixed project points, pre mid and final. These were negotiated with schools in an attempt to enhance engagement and to gain as informed a view as possible of the progression of the project. The mid and final project points for data collection fell at challenging times in the school year, these being the end of the academic year and Christmas/January. Whilst there is never an ideal time given that the primary task in schools is the education of its pupils and evaluation of projects must give way to this, the level of participation compared to baseline measures is noticeably reduced and warrants consideration. Aside from the challenges of school priorities, it is clear that when administrative support for the evaluation process, as well as project delivery within the locality was in place, this was highly instrumental in ensuring data collection. As the project progressed identified administrative support for evaluation data collection was lost and its impact was experienced significantly.

Similarly, having a designated project manager, supported by prioritisation of some of the EHS project administrative time to implementation of the evaluation, at the beginning of the project was crucial in ensuring the recruitment and consent process was undertaken in an ethical and informed way. It also enabled a clear point of contact between the commissioned research team and the EHS project delivery steering group, for brokering pragmatic solutions to emerging logistical problems. This is in keeping with findings from similar types of interdisciplinary collaborations that have highlighted local project manager oversight as an effective means of

improving and project effectiveness and outcome (Foster et al., 2015; Ranade and Hudson, 2003).

The timing of the financial incentive provided to schools who engaged with the EHS project and its evaluation warrants consideration. This was provided in its entirety early in the life of the EHS pilot delivery and potentially meant that there was little incentive for persisting with the evaluation process. This was particularly apparent given the sustainment of the project constituted additional work and logistical organisation within schools and which was in addition to the usual demands within busy secondary schools. It may be reasonable to consider whether future projects of this type use pre and final points as an appropriate time to release any financial incentives to assist with this issue.

The design of the evaluation project could have taken a cross sectional approach to avoid some of the issues with participation. However, this is not an appropriate method for measuring impact over time against project objectives. With this in mind, it may be prudent to build a longer run-in period to any future evaluation where staff are more actively engaged to understand the nature of studies using repeated measures at pre and post intervals. This is more likely to ensure buy in and is particularly important given that staff were not just participants in their own right, but also the gatekeepers for pupil participation.

The successful implementation of any project depends on the drivers and infrastructure which support them. In this respect staff on the steering group were highly committed to improving emotional wellbeing and de-stigmatising in their approach, this translated to the project aims and objectives and therefore underpinned the entire project.

Given the nature of the aim and objectives set out in the evaluation, multi methods were useful to tailor make the research strategy to address these in an informed way and which makes for a more holistic evaluation then might otherwise have been conducted using a single methodology.

Before the survey data collection instruments were disseminated for use, feedback from young advisors who piloted the survey was invaluable. This enabled adjustment to be made prior to administration to the whole pupil population that enhanced the survey's usability for a variety of people and age groups in terms of language, clarity and expedient completion. The use of a video/audio clip to engage pupil participants in the process of informed consent derived from the young advisor's feedback and was an informed addition to the recruitment process. What could not be tested was the usability of free text responses in the survey data analysis process. However, learning from the baseline survey data analysis allowed for a number of small changes to be made in the mid and endpoint survey structure in order to mitigate any problems highlighted at baseline.

As with any method of data collection there are strengths and limitations. The online survey method was useful in that it made participation possible for all pupils across multiple sites, but it was difficult to sustain the logistical organisation needed in schools to administer it to pupils and this affected the number of respondents at mid

and final project points. In contrast, where hard copies of CORC outcome measures were used to evaluate targeted group interventions as hard copies at the end of the sessions, this was more laborious from a data collection and analysis point of view, but provided a very reliable data source. Relying on locality project staff to oversee data collection contributed to overall value for money of the commissioned research evaluation. Contracting the commissioned research team to manage and drive data collection processes in each school site would have likely improved participation rates, but would have been much less cost-effective for Cheshire East Council as commissioners. Overall, the use of a multi-methods approach allowed for comparison, corroboration and integration of emerging trends from the data that was collected to overcome the challenges highlighted and ensure that a balanced and reliable appraisal of the impact of the EHS project upon each intended outcome could be provided.

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Celeste Foster
Dr Gillian Rayner
Dr Shelly Allen

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