SCHOOL OF NURSING, MIDWIFERY & SOCIAL WORK AND SOCIAL SCIENCE, COLLEGE OF HEALTH & SOCIAL CARE, UNIVERSITY OF SALFORD

Evaluating the Impact of Cheshire East Emotionally Health Schools Pilot Project

Interim Report: Early Findings
July 2016

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Tables and Figures

1. Research project focus and objectives

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

The emotionally healthy schools project (EHS) has been developed by Cheshire East Children's Service in order to address priority outcomes in it 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 project is being piloted in six secondary schools. Details of the EHS project can be found in the Emotionally Healthy Schools Service Specification (687890).

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, rate 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 the 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 Methodology

A mixed methods approach has been utilised to evaluate the success of the EHS project in achieving the above objectives. This has involved qualitative and quantitative approaches.

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/ and 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 (existing aggregated and anonymised data set, routinely collected by CWP camhs service) for the 6 participating schools for 6-month period prior to implementation of the EHS project and in the final 6-month period of the 12-month project. Data analysis will be via descriptive statistical analysis and, if indicated, subject to SPSS 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 have been invited to complete an anonymous online survey, administered using Bristol Online Survey system. This system allows for administration to a cohort who is spread across 6 geographical locations, full anonymity and in-programme collation of data for analysis.

There is a separate survey for Staff and for young people. Both instruments have been adapted from a methodology that has been previously tested and validated in 2 randomised control trials, evaluating the effects of Mental Health First Aid interventions

upon 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& Hansson, 2014; Jorm et al, 2010; Graham, Phelps et al, 2011)

This methodology 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 assess confidence and intention to help. For pupils; questions assess 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 choose from a series of responses, ranked across a Likert scale, that most apply to them.

A series of additional questions have been 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

These questions generate free text data that has been analysed using content analysis (Elo & Kyngas, 2007)

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

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

The questions relating to self-esteem and resilience have been 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.well-beingmeasure.com/about; BASC-2, Reynolds & Kamphaus, 2004; Resiliency Scales for Children & Adolescents, Prince-Embury, (2006);Child & Youth Resilience Measure(CYRM) Ungar & 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 were selected that assess self-perception of positive constructs of resilience, rather than questions relating to potential problems associated with resilience and self-esteem. 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 concurrent measure of school's provision of a relational environment that supports development of resilience (intended outcome 9). Language use and question construction and survey size has been informed by the National Children's Bureau Research Centre Guidelines for undertaking research with children and young people (Shaw, Brady & Davey, 2011).

Both surveys have been 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 are 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 are participating in the implementation of the EHS project and who have received training and support to take part in the project development alongside professional stakeholders), were invited to pilot the study and advise the research team on age/developmentally appropriate use of language and question construction.

Method 3

(Outcomes 1, 5 and 6)

Quantitative analysis of validated age appropriate outcome measures pre, mid and post completion of pupil or parent participation in a targeted intervention. This is data that is routinely collected as part of EHS project implementation and has been anonymised by the provider organisations before forwarding to the research team.

Measures used:

- For targeted group approaches for young people: Young Person Outcome Rating Scale (ORS) and Session Rating Scale (SRS) (Miller et al, 2003)
- Parent engagement strategies : Parent Session Feedback questionnaire (Chorpita, 2003)

Analysis will be undertaken using descriptive statistics. If the sample size is of sufficient size to ensure reliability for results, SPSS will be used to conduct analysis of statistical significance of levels of change pre and post intervention, using paired sample T-tests (at mid-point) and repeated measure ANOVA (at end point).

Method 4

(Outcomes 1,2,3)

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

3. Results

3a. Referral Data

Between January–June 2015 across all schools there were a recorded 115 referrals to CAMH's. 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 service, but did make one referral to the neighbouring CAMHS service. Data is based on the school in which the young person is on roll, therefore explaining no recorded referrals from Oakfield. Typically, the number of referrals is small without a clearly discernible pattern although mostly occurring during the first few months of the year.

All schools for which data is available referred 1 pupil in January. All except for Macclesfield referred in February with Eaton Bank referring 2. March was an interesting month with only Poynton referring 7 Pupils. This is the greatest number of referrals in one month and makes Poynton the school most likely to refer based on this data. In terms of referrals made to CAMH's in relation to the pilot schools, there was a total of 17 out of 115 (14.8%). Poynton made over 50% of these (52.9%) Eaton Bank and Macclesfield High School 17.6% each and Ruskin Sports College 11.8%.

The last time schools referred to CAMH's over the stated time period was in April, with Macclesfield referring 2 pupils. In terms of the overall referral rate across all schools recorded and based on this set of data it breaks down as follows;

Table 1

School	**Eaton Bank**	**Macclesfield High School**	**Poynton High School**	**Ruskin Sports College**	**Middlewich High School**
Number of Referrals	3	3	9	2	0 (Cheshire East) 1 (Cheshire West)
As a percentage of the total 115 (1 decimal place)	2.6%	2.6%	7.9%	1.7%	Referral to west Cheshire CAMHS service not included

Survey Data

3b. Survey Participation rates

Table 2 Staff and pupil participation by School

School	Teaching staff	Teaching assistants and support staff	No teaching staff participating	Pupils	Number opted out	Approx No. eligible to take part	Participants
Middlewich High School:	51	53	27 (26%)	668	20	645	422
Poynton High School:	160		0	1550	17	1530	0
Macclesfield Academy	43	18	23 (38%)	393	16	370	0
Oakfields, Cheshire East Pupil Referral Unit	10	8	0	max 30 places	2	25	0
Eaton Bank Academy	approx. 50	?	21 ()	approx. 750	16	730	284
Ruskin	40	36	6 (8%)	473	20	450	258
Not specified	-	-	**-**	**-**	**-**	**-**	23
Total	354	115		**3865**	**91 (2.4%)**	**3750**	**995** (26.5 of total cohort and 45% of participating schools)
	Combined staff total = 470		**77** (17% of total staff group and 25% of staff within the 5 participating schools)				

Table 3 Breakdown by year group

Year 7	277
Year 8	213
Year 9	188
Year 10	186
Year 11 & 12	91
Unspecified	40

Although it looks as though no young people from the pupil referral unit participated, 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 anonymity.

One of the 6 EHS schools Poynton High School, was not able to mobilise staff of students to participate in the baseline survey prior to the cut-off date. The local EHS implementation team are working with Poynton to try to ensure their participation in the mid-point survey. This will allow a measure of change to be taken between the mid-point and end of project survey for Poynton staff and pupils.

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 plus or minus 5%, we would need a sample size of

- Staff: 212
- Pupil: 520

Pupil participation (995) has far exceeded this minimum requirement and also breaks down to provide even levels of representation across each year group, allowing for reliable analysis between sub-groups at the mid and post project time points.

The staff response rate of 77, if taken as a percentage of the total staff within the five schools that participated (excluding Poynton) at this time point, 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).

Data in the main summary tables for both the pupil and staff surveys has been presented in the direction that is most likely to show change over the three time points of the evaluation period.

3c. Pupil Baseline Survey

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

Table 4 Student survey outcomes at pre-EHS implementation

	Baseline	Mid-point	Post-project
Mental health knowledge (%)			
Recognition of mental health issues in the vignette	79		
Knowledge of underlying causes	40		
Don't know/non-specific	15.7		
Stigmatising responses	4.6		
Personal stigma items: % ≥ *disagree*			
Personal weakness	57.2		
People with those problems are dangerous	47.8		
If they had a problem, they would not tell anyone	87.9		
Excuse for poor behaviour	48.2		
Should be taught alone	40.1		
Perceived stigma items: % ≥ *disagree*			
Other people believe a sign personal weakness	25.1		
Other people believe People with those problems are dangerous	22.4		
Other people would not tell anyone	88.2		
Other people believe it's an excuse for poor behaviour	29.5		
Other people believe Should be taught alone	23.2		
Confidence in own ability to stay emotionally healthy or help others: % ≥ Quite a bit			
Knowledge of places to get help	37.9		
Knowledge of sources of information	33.5		
Perception of own ability to generate ideas to stay well	36.9		
Beliefs and intentions about where to seek help: % Yes			
Belief in helpfulness of school staff	83.4		
Talked to a staff member about emotional health issue in the last month	12.6		
School-related indicators of resilience: % ≥ <u>disagree</u>			
I feel confident in school	17.5		
I feel hopeful that my school can help me achieve	10		
I feel I belong in my school	17.8		
In my school it feels safe to express difference or uniqueness	32		
Personal indicators of resilience: % ≥ <u>disagree</u>			
I can do things as well as most people	16.31		
When things go wrong I as though I can learn and bounce back	7.3		
I am as good as most other people	18.7		

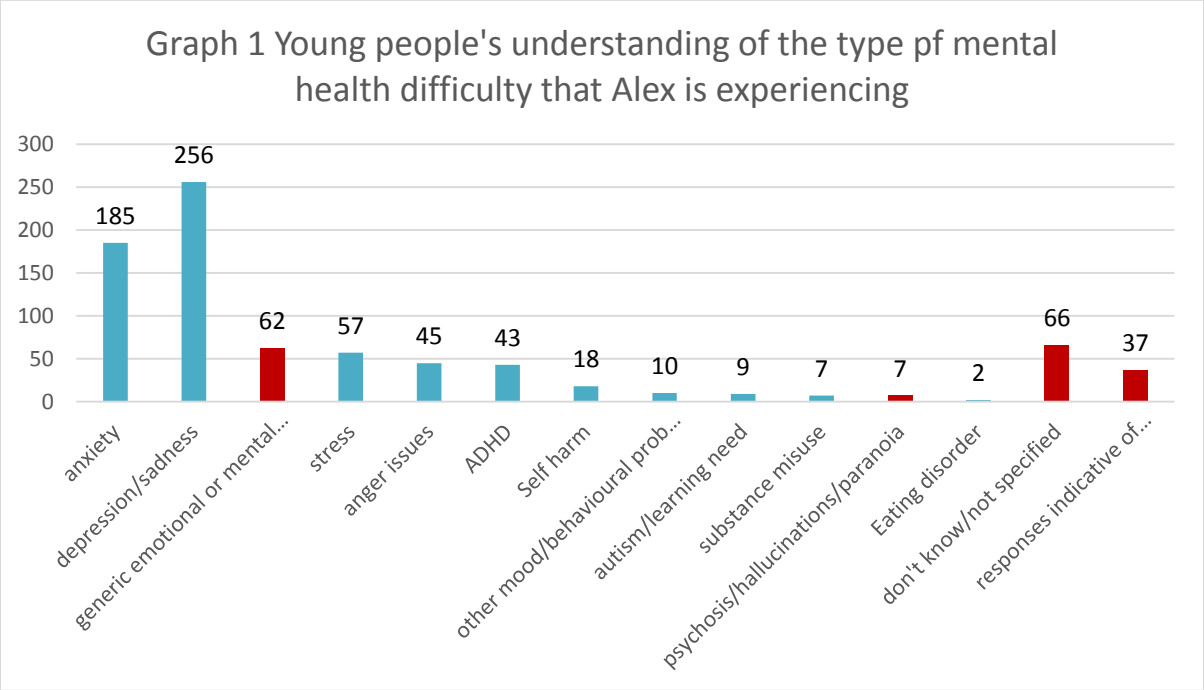
Knowledge of mental health difficulties

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

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.



7.7% of pupil participants were only able to say that Alex had a 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. As the overall level of knowledge is high, the figures marked in red are the ones that are likely to be sensitive markers for measuring change in the mid and post-project survey results.

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

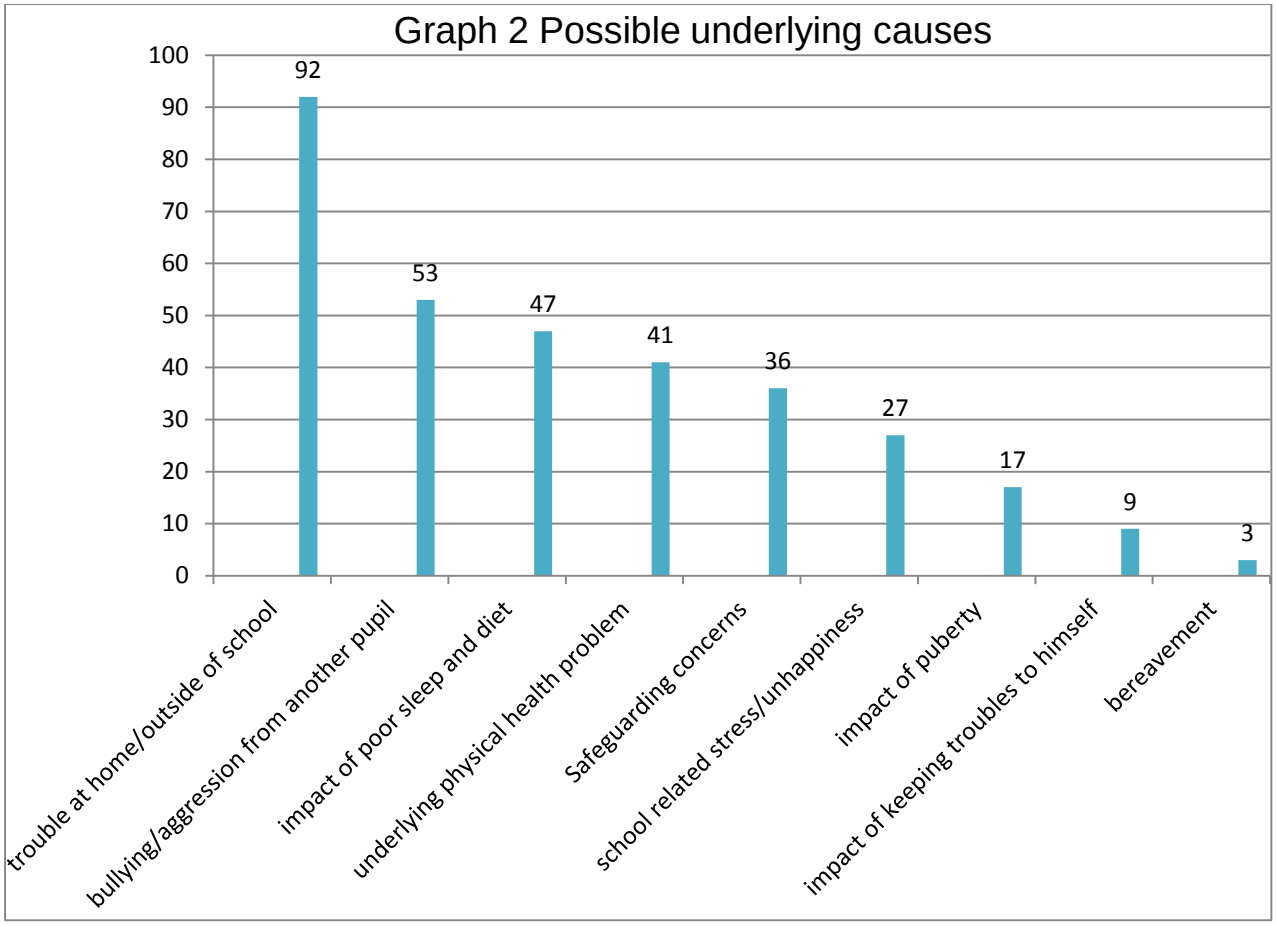
Box 1: Examples of stigmatizing statements

(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

Possible underlying causes

325 responses were received that 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'.



The results also highlight that, after problems at home, that bullying is a significant cause for concern for the pupil population.

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:

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.

47.8% disagreed with the statement that Alex is dangerous, but only 22.4% felt that other people would also disagree.

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. 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

Despite these concerns the likelihood that pupils would seek help if they had problems similar to Alex was high – 87.9% - with 32% agreeing that they would do so within a week of feeling this way. However, this statistic should be considered in the context of the responses given regarding talking to a teacher specifically – as it cannot be assumed that it would be school staff to whom pupils would choose to speak.

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

Pupil's 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 83% or above of respondents. Though it should be noted that 16% of the participant group indicated that they didn't think they could do this at all, indicating that a small but significant group will benefit from mental health promotion strategies and information

Beliefs and intentions about where to seek help

83.4% of pupils felt confident that staff in their school would help them to help another young person they were worried about

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

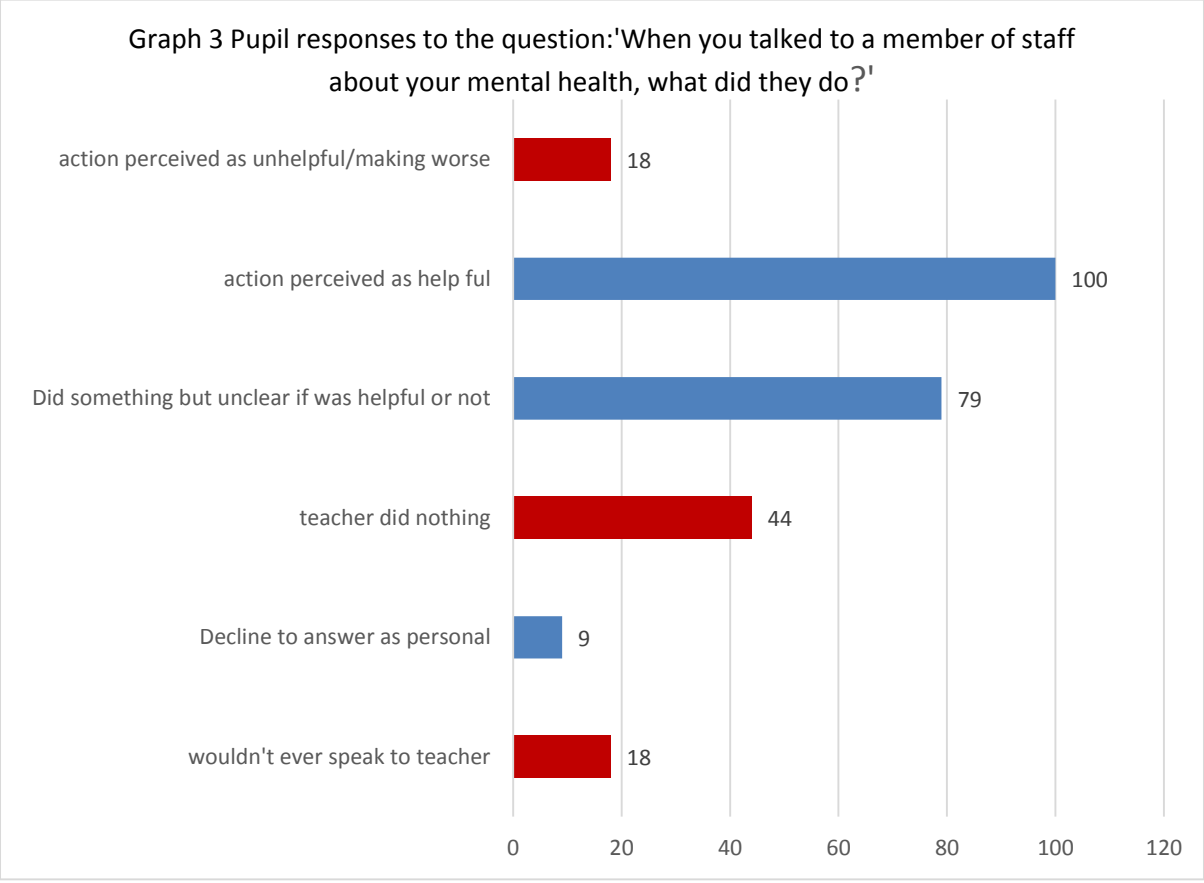
- 73.2% Parent or Carer
- 63% Pastoral support Team
- 62% School Nurse
- 54% Teacher
- 48.9% School Counsellor (although 10.3% thought this could be harmful)
- 35.8% Alex (27% thought this could be harmful)
- 41.1% Friends (21.5% thought this could be harmful)

Actual Help received from staff

12.6% of pupils reported that they had sought help from a staff member in the month prior to completing the survey.

Although the number of children approaching staff to talk about their emotional health looks relatively low, it is actually in line with the expected point prevalence of mental health issues within the 11-17 population (Melzer et al. 2003)

What did the teacher do?



There were 268 responses to this question. 18 Pupils stated that they would never speak to a teacher due to perceived lack of trustworthiness or potential to be helpful. Of the remaining 250 responses 40% (n=100) reported helpful responses. 31.5% of responses indicated that action had been taken but not whether it had been helpful or unhelpful. 17.6% indicated that the staff member had done nothing. This may be perception rather than an objective observation, but it indicates an area for development re: ensuring that staff members go back to young people to let them know what action has been taken. 7.2% of responses reported actions that had been actively unhelpful or in the young person's view made things worse. Categories in marked in red indicate those that may be sensitive to change or improvement at the mid and end-point of the project evaluation.

Supportive measures included: pupils feeling listened to, feeling safe and being helped to feel calmer, where teachers checked back with them that they were feeling better and that they were helped to consider strategies to help them cope such as problem solving. Referrals to counselling or CAMH's was 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 and school nurses, but it was not clear if this had been a positive or negative intervention. 5 responses specifically indicated that telling parents was helpful and 5 specifically indicated that it was unhelpful.

Actively unhelpful responses included being shouted at, being put in detention, breaches of confidence and being laughed at.

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 responses implied within them that the cause of their distress was related to bullying or negative peer interaction.

School related indicators of resilience

60% of participants reported feeling confident within their school. 72.2% of participants either agreed or strongly agreed with the statement "I feel hopeful my school can help me achieve".

However, only 54.3% pupils agreed that they feel like they belong within their school, and 40.2 % agreed with the statement "I feel safe to express things about me that are different"

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).

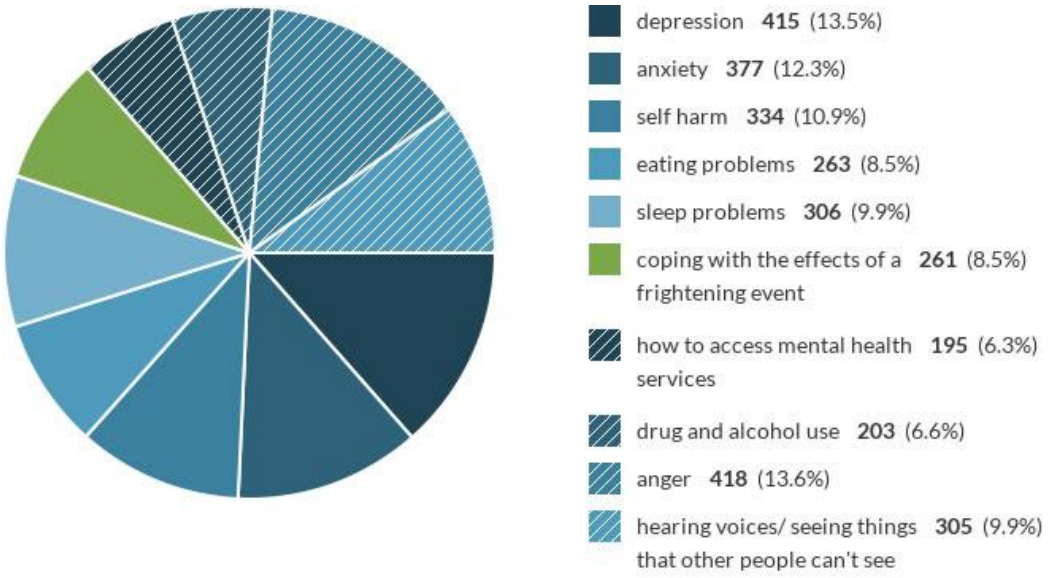
Personal indicators of resilience

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%). 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%. It is this group of responses that are most likely to provide a measure of impact of the EHS interventions as the project progresses.

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. The results are presented in graph 4

Graph 4

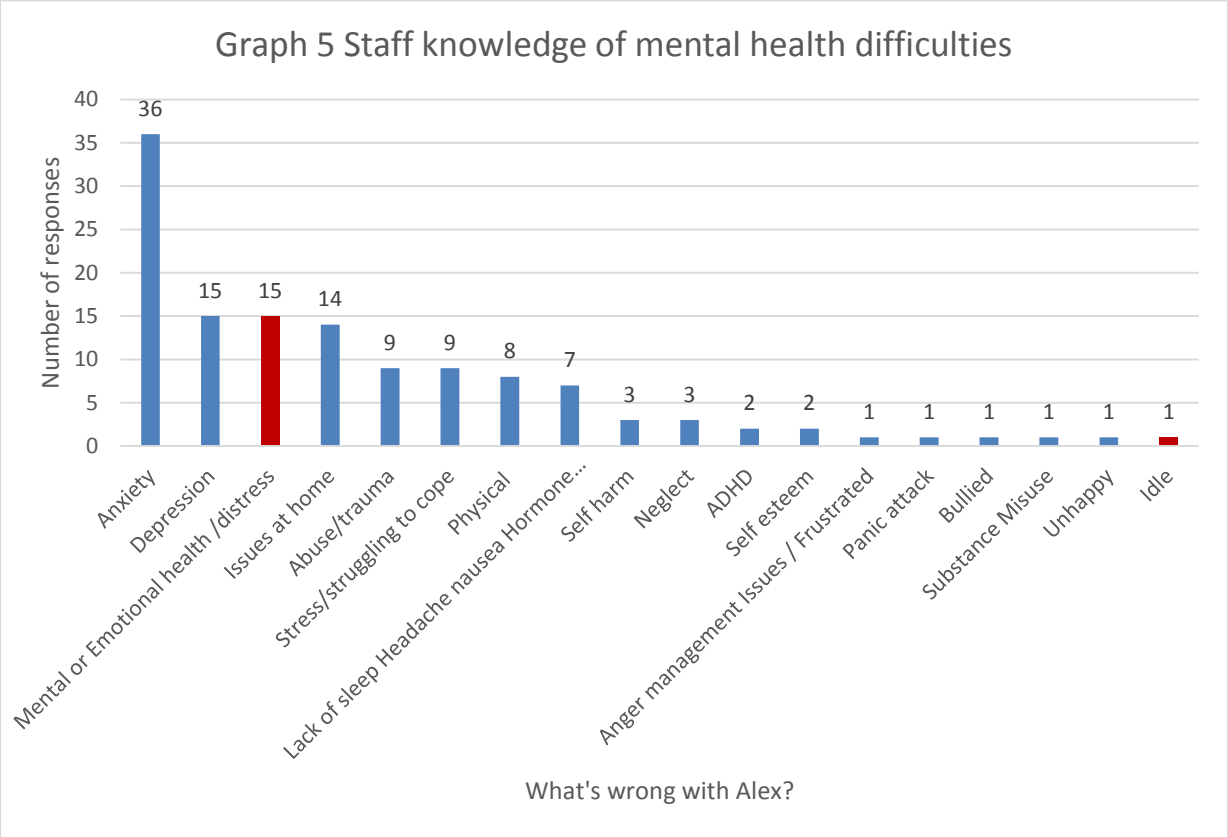


3d. Staff survey

There were staff 77 responses. This means for a confidence level of 95%, the confidence interval is 8. The impact of this upon the degree to which results of the staff survey can be generalised will be quantified further in the final report. The questions were not consistently responded to by all and percentages are rounded off to whole numbers.

Knowledge of mental health difficulties

In terms of what was understood to be wrong with Alex, the staff responses indicated as below;



129 distinct answers were given. 87 referred to types of mental health problem and 42 related to possible underlying causes or precipitants. It is notable that bullying was almost absent in the staff group as a possible underlying cause, as compared to the pupil responses.

The survey revealed the following information;

Table 5: Staff outcomes at pre-intervention

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

Questions relating to Stigma

Overall, these responses are positive in terms of perceived stigma although interestingly the perception of this in others is less positive than that judged by the individual in relation to their own beliefs concerning Alex.

Questions relating to confidence

As with the questions relating to stigma there were differences between the individual's perception and their perception of this in others with respondents feeling themselves to be less confident than their colleagues overall.

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
1	Discuss with school based health professional	67
2	Have a conversation with the pupil	55
3	Discuss with another teacher	39
4	Referral to CAMH's	23
5	Contact the family	20
6	Discuss with a member of the admin team	5
7	Talk to other students	2
7	Do nothing	2

As per the format throughout the rest of the report, red indicates the responses that we might expect to be markers of change at the mid and post-project time points

Actual help given to students

This reveals a mixed result with some staff having the opportunity or feeling able to provide this and others not doing. 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 have done this frequently. This may relate to role in the school and/or personal attributes in terms of being prepared and having the perceived knowledge, skills and attitudes to offer support.

Of these 46 responded with more detail as to what this entailed as follows;

Intervention	Number of responses
Discussion Listening Reassurance Time Supported Empathised	17 11 6 3 2 1 Total= 40
Discussed/referred with safeguard lead, pastoral support/line manager/SENCO	24
Advice, Sleep, Attend class, strategies	12
Contacted parents	4
PHSE sessions	1
Offered to mediate with parents	1
Opened a Common Assessment Framework	1

It is noteworthy that the responses that relate to personal interaction with the young person correlates to the types of response that the pupil respondents have identified as helpful.

Knowledge of sources of help and referral pathways within the locality

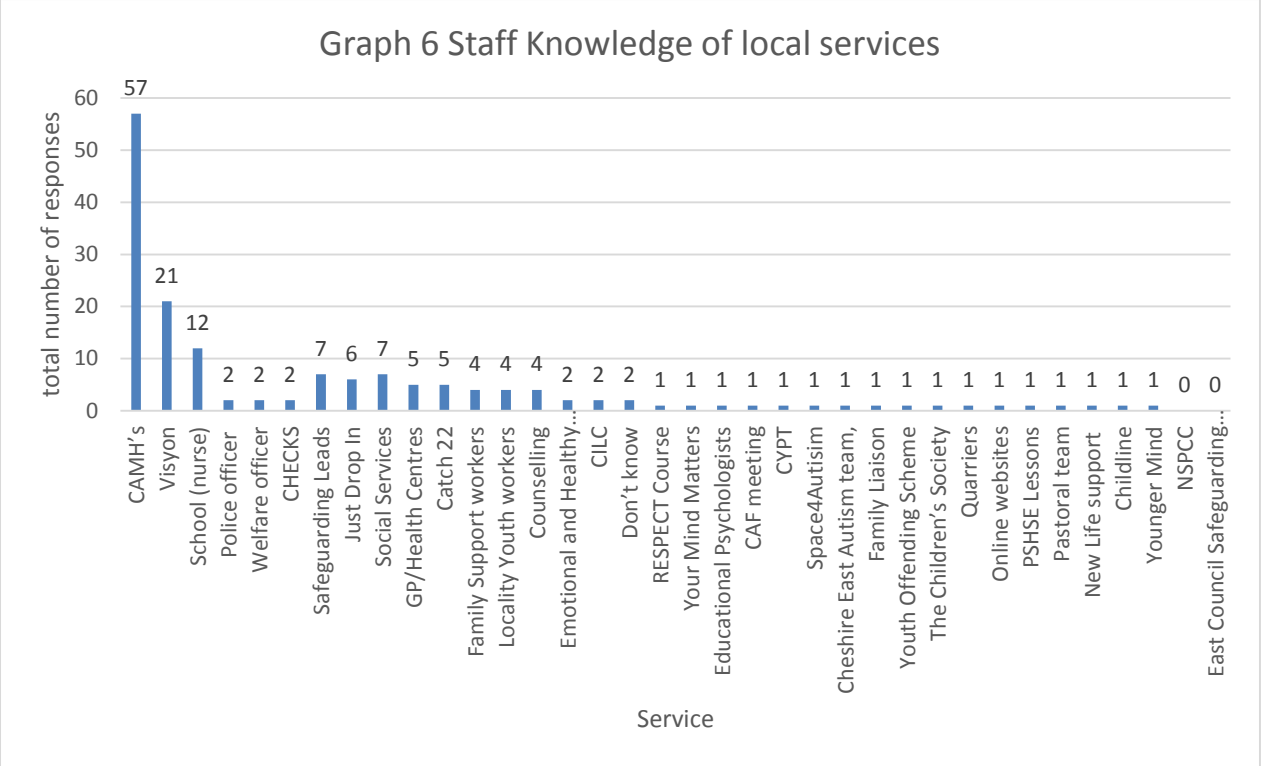
In terms of the individual's knowledge and awareness of services and organisations to refer or signpost Alex to, 75 respondents ranked this as follows;

1 poor	2	3	4	5	6	7	8	9	10 Excellent
4%	9%	9%	20%	17%	5%	16%	8%	4%	7%

In terms of the individual's knowledge and awareness of sources of information and advice, 75 respondents ranked this as follows;

1 poor	2	3	4	5	6	7	8	9	10 Excellent
7%	5%	12%	13%	16%	12%	19%	7%	4%	5%

63 responses were given in relation to an awareness of local services, these were mapped against a directory of local service provision provided by the EHS clinical lead



The graph 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.

Further information and training

Further information was requested in relation to the following emotional/mental health and wellbeing issues

Table 6

Issue	**Number of responses**
Self-harm	21
Any mental health issues	17
Anxiety	13
Depression	12 (2 specifically related to teenage depression)
Supportive talk/general help	6
Trans/gender issues	6
Stress	5
?	4
None	3
Domestic abuse	3
Eating Disorders	2
Bipolar	2
Anger management	2

Attachment	2
Psychosis	2
Resilience	2
Change management of self	2
Cheshire East Services on offer to support for young people	2
Neglect	2
Body Dysmorphia	1
Suicidal thoughts	1
Turbulent Home life	1
Personality Disorders	1
Social isolation	1
How to identifying issues	1
Obesity	1
Fine line between pastoral and safeguarding issue	1
Bullying	1

Mid and end point staff surveys will include a question reporting on training received in order to assess the impact of engaging with training upon knowledge, confidence and attitudes.

Overall notable themes from both the staff and pupil survey

Baseline knowledge of student mental health issues is demonstrated to be very good, with relatively low levels of personally held stigma, although there is potential for this to change further over the course of the project. Pupils were up to 2 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 to which this was present was lower.

There were quite good levels of awareness of what to do and where to get information and help, but a consistent percentage who felt they had no abilities in relation to helping themselves and others stay emotionally healthy (16%)

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.

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.

School-related resilience scores were good 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. Across all questions relating to personal indicators of resilience, approximately 17% consistently disagreed or strongly disagreed.

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.

3e. Targeted interventions for pupils

Schools have selected a menu of targeted programmes to address the needs of particular populations within each school that they intended to implement across the 12-month pilot. These are:

Table 7

Programme name	**Schools planning to implement**	**Year group targeted**
Exam Stress	Middlewich High School Eaton Bank Academy Ruskin High School	
Team of Life (using sport for resilience and skill building)	Middlewich High School Oakfield High School The Macclesfield Academy Poynton High School Eaton Bank Academy Ruskin High School	
Resilience for Life (Resilience building)	The Macclesfield Academy	
Cool Connections (CBT-based programme for increasing understanding of thoughts, feelings and behaviour and effective management)	Ruskin High School	
Form Room Mindfulness	The Macclesfield Academy	N/S
Transition Intervention	Eaton Bank Academy	N/S

At the mid-point of the project there were 3 schools acting as early implementers: Ruskin High School, Middlewich High School and Macclesfield Academy. As such, data at this point is only available in relation to these 3 schools. Data is pre-intervention data, so no measures of change/impact are available at this point.

Outcome Rating Scale (ORS) measures

Total of 34 pupils completed baseline outcome measures

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 scores for all dimensions and the combined scores by group are summarised in Table 8:

Table 8 Pre-intervention Mean ORS Scores by programme

Type of group attended		Personal Wellbeing	Interpersonal (Family, close relationships)	Socially (School, friendships)	Overall (Sense of Wellbeing)	Combined score
Exam stress	Mean	5.588	6.394	6.150	5.838	23.719
	N	16	16	16	16	16
	Std. Deviation	2.7602	2.7596	2.9216	2.3723	9.8836
team of Life	Mean	6.875	7.875	6.500	7.625	30.500
	N	8	8	8	8	8
	Std. Deviation	3.1254	2.1671	2.4495	1.8468	6.3752
Resilience for Life	Mean	5.411	7.578	7.000	6.522	26.511
	N	9	9	9	9	9
	Std. Deviation	2.9370	2.6456	1.9326	2.4144	7.6440
Cool connections	Mean	2.800	4.200	1.600	2.900	11.100
	N	5	5	5	5	5
	Std. Deviation	.4472	2.2804	.5477	.5477	3.0496
Total	Mean	5.450	6.697	5.826	5.989	24.147
	N	38	38	38	38	38
	Std. Deviation	2.8670	2.7244	2.8858	2.4833	9.7005

Across all groups and dimensions of wellbeing, the standard deviation indicates that the mean is a reliable fit in relation to the whole sample group. However, it should be noted that 38 is a small sample size, particularly when split down by group/ programme. It is notable that the wellbeing scores for pupils in the Cool Connections group are markedly lower than for the rest of the participants. As Cool Connections is a CBT-based group to help young people who are having difficulties understanding and managing their thoughts and feelings, we might expect a lower mean wellbeing score for participants in this group than the other groups, which are either resilience focused, or addressing specific sources of stress.

The ORS cut-off score which indicates that children scoring below this threshold may warrant some form of emotional or mental health intervention is 24. Table 9 shows the proportion of each group that fall below the cut off.

Table 9

Programme	School								
	Ruskin			Macclesfield			Middlewich		
	< 10	<24	Proportion	< 10	<24	Proportion	< 10	<24	Proportion
Cool Connections	2	3	100% (of 5)	/	/	/	/	/	/
Team of Life		1	25% (Of 4)	/	/	/	/	/	/
Resilience for life	/	/	/	0	4	44.4 % (Of 9)	/	/	/
Exam stress	1	1	25% (of 8)	/	/	/	1	4	62.5% (Of 8)

Although these are only very early indicators, they do suggest that school's mechanisms for targeting those pupils who would be most likely to benefit are appropriate. Prior to data being anonymised for the Salford research team, the needs of any young person scoring below the cut off were discussed by the school EHS project worker with the CAMHS project lead in order to ensure referral to further services where required.

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

35 SRS forms had been completed at the point at which this report was completed.

The mean satisfaction scores for each domain by school and programme/group are presented in Table 10.

Low standard deviation scores indicate that the mean is a good representative of the whole data set, however, again at this point caution should be taken as the sample size is low and there is significant range within all groups.

The mean SRS scores for Team of Life and Resilience for Life groups are uniformly in the top quartile, indicating a very high satisfaction rating. The mean SRS scores for Cool Connections are notably lower (though still above the 2nd quartile). Comparing mean scores by year group also highlighted lower satisfaction scores for year 7. However, this is also the year group that has been targeted for Cool Connections in

the data we have received so far. Therefore, there is insufficient data to make any reliable judgements regarding the direction of this relationship or whether it will bear out over time, as more schools implement the programme. I.e. are the SRS scores lower, because the young people in that group have lower baseline wellbeing scores? are year 7 pupils less likely to perceive benefit from group interventions? or is the Cool Connections group routinely being less well received by pupils than the other programmes? This will be monitored and analysed in the next cohort of outcome measure data received. It is too early in the data collection process to reliably analyse the data by gender, but this will be completed at the post-project time point.

Table 10 Mean SRS scores by group and school

School		type of group attended															
		Team of Life				Resilience for Life				Cool Connections				Total			
		Rel	G and T	Method	Overall	Rel	G and T	Method	Overall	Rel	G and T	Method	Overall	Rel	G and T	Method	Overall
Macclesfield high	**Mean**					**8.980**	**8.780**	**8.880**	**8.480**					**8.980**	**8.780**	**8.880**	**8.480**
	N					5	5	5	5					5	5	5	5
	Std. Deviation					2.2253	2.6725	2.4489	3.3432					2.2253	2.6725	2.4489	3.3432
	Range					5.0	6.0	5.5	7.5					5.0	6.0	5.5	7.5
Ruskin	**Mean**	**9.200**	**9.153**	**9.318**	**9.082**					**6.731**	**5.131**	**7.433**	**6.200**	**8.130**	**7.410**	**8.538**	**7.833**
	N	17	17	17	17					13	13	12	13	30	30	29	30
	Std. Deviation	.9804	1.2274	1.1154	1.3794					2.6825	2.3167	2.1210	2.2483	2.2487	2.6761	1.8358	2.2917
	Range	3.5	4.0	4.0	4.5					7.8	8.1	6.5	8.6	8.1	8.8	6.5	8.7
Total	**Mean**	**9.200**	**9.153**	**9.318**	**9.082**	**8.980**	**8.780**	**8.880**	**8.480**	**6.731**	**5.131**	**7.433**	**6.200**	**8.251**	**7.606**	**8.588**	**7.926**
	N	17	17	17	17	5	5	5	5	13	13	12	13	35	35	34	35
	Std. Deviation	.9804	1.2274	1.1154	1.3794	2.2253	2.6725	2.4489	3.3432	2.6825	2.3167	2.1210	2.2483	2.2331	2.6805	1.8978	2.4181
	Range	3.5	4.0	4.0	4.5	5.0	6.0	5.5	7.5	7.8	8.1	6.5	8.6	8.1	8.8	6.5	8.7

3f. Summary of the CORC Consultation feedback questionnaire.

12 feedback forms were received 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	8
Group	5
Face to face	0

In terms of who the consultation concerned, the feedback reported as follows;

Concern of the consultation	**Number of respondents**
An individual child	7
A group of children	5
An organisational issue	1

What respondents wanted from the consultation is illustrated below

Aim of the consultation	**Number of respondents**
Answers to questions on practice in general	7
Help to think about what to do next with this child	9
Help with assessment	0
Help with interventions	5
Help to think through my worries about this child or group ofchildren	10
Help to increase my confidence in managing the situation	11
Other	0

The strongest agreement being that the consultation helped people think through their worries and increase their confidence. Interestingly no respondents reported that the consultation had helped with assessment.

Nature of the Outcome	Number of respondents
A referral to specialist CAMH's	4- existing contact not a new referral
Child redirected to alternative services	1
Help to manage with no referral or redirection	4
other Students to be monitored, Meeting with CAMHS medical practitioner". Training completed	1 1 1

Based on this, there were no new referrals to CAMHS, 4 children had already been referred and the consultation helped them to manage the presenting issues.

Reduction in concerns	Number of respondents
A lot	5
A bit	7
Not at all	0

All 12 were happy with the outcome of the consultation and their concerns were thought to have been managed as above.

Ease to arrange consolation	Number of respondents
Not so easy	0
Easy	5
Very easy	2

Proposed improvements to the consultation service 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.

4. Discussion of headline findings from the interim EHS project evaluation data

Whole school measures of knowledge and stigma, and resilience

- There is a good overall level of knowledge in relation to emotional health in young people. However, within that approximately 18-20% of the cohort show either poor levels of knowledge or stigma. This is the sub-population within which any effects of the EHS whole school approaches would be expected to be seen, post project.
- Similarly, although overall measures of resilience are positive, a sub-cohort of pupils (16-18%) have reported indicators of low personal resilience.
- These 2 figures are in line with much larger, higher-powered previously published studies examining the impact of school-based universal mental health promotion strategies: In which overall most of the pupil population appear not to need nor benefit from whole school mental health promotion approaches as they are found to have good levels of knowledge and emotional health and wellbeing, but that a specific sub-group within the whole school population may well benefit and show change in levels of reported mental wellbeing over time (Spence et al. 2014).
- Self-held stigma is low in both staff and pupils but is consistently recorded to be perceived more readily when considering others views. The impact this might have on pupil likelihood to access emotional health and wellbeing strategies implemented within the school setting, and actions to mitigate against this potential barrier to access should be considered as the EHS project progresses.
- Staff survey results indicate that greater marketing is required of the full range of services and sources of advice available for staff to access, in relation to pupil emotional health and wellbeing.

Bullying

- Bullying is high on pupils' agenda, emotional health related concerns. However, this is not reciprocated in the information captured from staff groups. 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)

Staff intention to help

- Where school staff sought to actively help young people who reported emotional health concerns, the nature of the strategies they used mirrored the strategies that pupils reported had been helpful when they needed support. This is a positive finding and indicates that when school staff feel confident to act to help it tends to be well received by pupils. Within the pupil survey there were examples given of staff going to great lengths to help young people. However, there was also clear evidence of occasions when young people felt nothing had been done to help them (17.6%)
- Given these 2 findings, strategies that work to increase the overall frequency with which staff actively respond to young people who express emotional health concerns is likely to have a positive impact over time.
- Clearer mechanisms for feeding back to students, when actions have been taken to address their concerns, may also serve to improve pupil perception of school staff as helpful at times of distress.

Targeted interventions implemented so far

- The results from outcome measures at this preliminary stage suggest that the right pupils are being targeted for specific interventions (Cool Connections) and support for specific situational factors (Exam Stress). Thereby indicating a degree of confidence in screening mechanisms to identify pupils in need.
- Satisfaction measures collected thus far indicate high pupil satisfaction with the interventions overall.

Referral rates

- The pre-project CAMHS referral rate data suggests that overall rates of school-originated CAMHS referrals are not sufficiently large enough to give statistically reliable measures of change over the pilot project period. However, it is noteworthy that the CAMHS consultation evaluation data indicates 100% satisfaction with the outcome of the consultation and no new referrals to Tier 3 CAMHS generated as a result. Giving an early indicator that this is an effective intervention to help triage referrals into the Tier 3 CAMHS service appropriately. In addition, the school with the highest peak of CAMHS referrals over the baseline audit period had not engaged with any consultation sessions with the CAMHS Clinical Lead or with the EHS evaluation process at the data collection cut-off point for this interim report. Therefore, the relationship between CAMHS consultation access and CAMHS referral rates will be monitored by school, over the final period of the pilot.

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