



Local evaluation of the Gloucestershire Mental Health Services and Schools Link Pilot

Final report to NHS Gloucestershire CCG



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1.0 Introduction

This report presents the findings and recommendations of the independent ***Evaluation of the Gloucestershire Mental Health Services and Schools Link Pilot***. The evaluation was carried out by Ecorys on behalf of NHS Gloucestershire Clinical Commissioning Group ('The CCG'). The pilot is part of the Mental Health Services and Schools Link Pilots, funded by NHS England and the Department for Education ('The Department'). The evaluation started in February 2016 and this report represents its culmination.

1.1 Programme Overview

NHS Gloucestershire CCG was one of 22 local areas that were successful in applying for funding and support as part of the national Mental Health Services and Schools Link Pilots. Funded with £50,000 from the Department and NHS England, the CCG matched this funding with a £50,000 investment made in the pilot locally. From this pilot budget, up to £3,500 was made available to each school participating in the pilot scheme.

The overall aim, as defined by the original Expression of Interest (see Annex 2), was to "improve joint working between school settings and child and adolescent mental health services (local NHS funded CAMHS)," (DoE and NHS England, 2015).

In September 2014, the Government established the Children and Young People's Mental Health Taskforce. The aim of this taskforce was:

"to identify what needs to be done to improve children and young people's mental health and wellbeing, with a particular focus on making it easier to access help and support, and to improve how children and young people's mental health services are organised, commissioned and provided," (ibid).

This Taskforce produced the *Future in Mind* (March 2015) report, which recommended the establishment of a named point of contact within CAMHS and a named lead within each school.

"The named lead in schools would be responsible for mental health, developing closer relationships with CAMHS in support of timely and appropriate referrals to services"

(DoE and NHS England, 2015).

In addition, the *Future in Mind* report suggested a joint training programme for named school leads and CAMHS to be developed. The pilot programme represents the testing of a named lead approach and joint training programme by the Department and NHS England.

The core offer for pilot areas was to be:

- **Funding** as outlined above;
- The development and delivery of a **joint training programme** by the Anna Freud Centre, which would take place over 2 days and would aim to: raise awareness and improve knowledge of mental health issues among school staff; improve CAMHS understanding of

specific mental health and wellbeing issues within schools; and support more effective joint working between schools and CAMHS;

- **The opportunity to help develop and influence new ways of working** with the aim of improving outcomes for children and young people;
- **Specific training to support effective joint working** between CAMHS and schools;
- **Support with local transformation**, since participation in the pilot “should be included in Local Transformation Plans as an indicator of robust local planning across agencies,” (ibid).

Each area was expected to identify a CAMHS lead and 10 or more local schools to take part in the pilot. Each participating school should nominate a ‘lead person’ with an overview of mental health issues within the school, as well as up to 2 additional staff who could also attend the training. CCGs were asked to ‘support the testing of the training programme with the training organisation’ (ibid).

Each CAMHS team was asked to: identify and support named CAMHS leads for each school; test this named lead approach; commit to relevant staff training; and participate in the pilot evaluation. Schools were asked to commit to collaborative working, both with the training organisation and the evaluators. It was recommended that as part of the pilot, “CCGs, CAMHS and schools will also need to collaboratively develop local protocols for joint working across schools and CAMHS,” (ibid).

1.1.1 The local pilot

The CCG identified 14 educational settings with which to implement the pilot, within the district of Stroud/Berkeley Vale. Stroud College also joined the pilot at a later stage. More than 50 schools in the county had expressed an interest in participation. The CCG decided to pinpoint the semi urban/rural district of Stroud/Berkeley Vale in order to “*test out the best way of joining up and working more collaboratively with the challenges of rurality*” (*Expression of Interest*, 2015) as well as to help with the engagement between mental health services and schools on a locality basis. A further selection criteria for the schools, as set out in the CCG’s *Expression of Interest*, was the school’s engagement with the Gloucestershire Online Pupil Survey, the Gloucestershire Healthy Learning and Living programme, and/or the ‘mental health first aid’ course, so that the schools selected were likely to be ready to engage.

Gloucestershire’s Transformation Plan had identified a key theme of ensuring much better links between schools and CYP mental health services, such that whichever ‘door’ a young person walks through to the services, an appropriate response is given. The CCG aspires to support the development of a system “*without tiers*”, and both of these made the area a good fit for participation in the pilot programme. According to the CCG’s *Expression of Interest*, the CCG had:

“identified a real need for a locality model and network approach across all sectors, to ensure that our response to CYP is more joined up and there is greater capacity in the mental health workforce to support schools and further develop joint work and training packages across the wider network of partners”.

Figure 1.1 Local aspirations for the pilot

The CCG hoped that involvement with the pilot would lead to:

- Better understanding and support between CYP mental health services and schools
- A more advanced collaborative approach between schools and mental health services to early intervention, including advice and guidance (and support and supervision) for schools to support their ability and capacity/confidence in managing low level needs.
- A more joined up system with easier access, supporting the development of a system without tiers, supporting children to cope in the wider system and getting swift access to the right support and evidence based treatments when needed.

The development of a core offer to support schools, including understanding workforce and capacity requirements across a rural locality.

- The development of an effective system of support which would develop further resilience and improve outcomes for children and young people.
- Development of a more strategic approach to ensuring training support for schools is delivered across a network.
- Collaborative working to support further work on the reduction of mental health stigma and promote parity of esteem.
- Measurement of impact and improving outcomes, both in terms of outcome measures and development of the existing Gloucestershire Healthy Living and Learning accreditation framework.

1.2 Evaluation Aims, Objectives, and Methodology

The evaluation aimed to provide an independent review of the lessons learned from the pilot, and the extent to which the aims were met; to provide an independent assessment of effectiveness and outcomes; and to make recommendations to inform decision-making about sustainability and wider rollout. A detailed list of research questions for the evaluation was agreed (see Annex 2) along with a mix of research methods, designed to produce a thorough response to those questions.

Planned methods included a combination of: desk research; analysis of existing local data; qualitative telephone interviews, in depth face-to-face interviews and focus groups; a survey; and some qualitative work directly with children and young people. The draft outcomes framework for the evaluation proposed the following measures:

- Contact time and pilot/service intensity
- Pilot/service satisfaction: satisfaction levels of schools, CYPS and partner organisations
- Volume and quality of referrals: numbers and source of referrals; source of referrals; referral appropriateness and quality
- Pilot/service outcomes: children and young people's outcomes

1.2.1 Sources of evidence

This report is based on evidence from the following data collection and analysis tasks:

- An initial inception and planning stage, including consultation, feedback and revision on the research questions, a stakeholder inception meeting, and early discussions about available sources of secondary data.
- In-depth telephone interviews with the lead contact from each pilot school (n=13).
- In-depth telephone interviews with professionals engaged within the local mental health networks (n=5).
- Case study work in 4 pilot schools, comprising of interviews and focus groups with 18 school staff in total and a brief meeting with 6 pupils.
- Case study work with the CYP mental health service team, including an observation of a support group with teenage participants and evaluations from a primary school 'worry' group.
- Survey research carried out by Ecorys with 5 pilot schools, 3 comparison schools, and 9 professionals engaged within the local mental health networks.
- An observation of Gloucestershire's first 'joint training workshop' in November 2015.
- Pilot referral and activity data from the CYP mental health service.
- Mental health professional advice line user data from the CYP mental health service.
- The CYP mental health service pilot programme report to the CCG.

1.3 Report Structure

The remainder of the report is structured as follows:

- **Section two** describes the local context before the Gloucestershire Mental Health Services and Schools Link Pilot ('Stroud Schools Pilot') began, how the pilot was structured and set up.
- **Section three** presents the key findings from the implementation of the Stroud Schools Pilot, including: the training offered and undertaken; the characteristics of this pilot and the nature of those key professional roles; referral pathways and the impact of the pilot on the structure of these; and activities undertaken by schools during the pilot.
- **Section four** considers the evidence for any outcomes achieved by the Stroud Schools Pilot: both in terms of outcomes for young people, and improvements to services and systems for relationship building between schools and CYP mental health services. We also take a look at the wider network of mental health services and professionals in the area, in relation to their engagement with the pilot and the potential for improved future collaboration in the interests of young people. And finally;
- **Section five** draws together our conclusions about the effectiveness, outcomes, impact and sustainability of the pilot programme, the extent to which the original aims were met, and recommendations for the CCG where appropriate.

2.0 Setting-up the ‘Stroud Schools Pilot’

This section of the report describes the local context before the Gloucestershire Mental Health Services and Schools Link Pilot (‘Stroud Schools Pilot’) began, how the pilot was structured and factors involved in its set up.

2.1 Overview of the local context pre-pilot

Prior to the pilot there was consensus among local schools in Stroud that demand for mental health services within schools had been increasing. The CCG was quick to respond to the national programme because of local concentration on improving mental health links and services. These needs were outlined in the local area Transformation Plan. According to the pilot schools, relationships between schools and the Children and Young People’s mental health service (CYPS) were of varying quality before the pilot. Little direct contact was made with the CYPS teams by mainstream schools in the pilot group, and staff told Ecorys that they would routinely advise parents to attend the GP for referral, rather than contacting CYPS directly themselves. Those that did have direct experience of working with CYPS reported mixed experiences, with negatives concentrating mainly on communication of assessment feedback and longer than helpful waiting times.

One CYPS worker commented that while the service did have good relationships with some schools, these were restricted to schools that would seek out contact with them. This was principally because their remit at that time was focussed on supporting young people across the county who were not necessarily located in any particular setting rather than collaboration with individual education institutions. Prior to the pilot, the Primary Mental Health Worker (PMHW) team was a small resource, available county wide. The pilot provided an opportunity to test what a more intensively resourced model could achieve. It must also be noted that CYPS had operated a professional helpline for five years, which was originally set-up and funded through the 2007/08 TAMHS¹ pilot, which many schools were unaware of despite it being widely advertised. This may be explained by schools’ reflected staff turnover and therefore low levels of awareness of the existence of this resource. Due to the limited resources within the PMHW team, it had not been possible to engage with schools on a level that was possible during the pilot, and it became apparent during the first workshop sessions that there were tensions and a distance between the communication perceived by schools and the efforts that the CYPS team felt that they were making within the limited resources available.

Schools felt that they were lacking in knowledge and confidence when dealing with what they perceived to be increases in the level of need for mental health services.

“We had quite a large number of children with [MH] needs. We had a drop-in system, but we wanted more advice and support.”
– School lead.

¹ Targeted Mental Health in Schools (TAMHS)

"We were frustrated ... We were swimming in the dark." – School lead.

Some of the schools had made their own arrangements to provide mental health support for their young people, by bringing in counsellors, engaging their Family Support Worker/Parent Support Advisor in work in this area, or training up teaching or teaching assistant staff to take on some support, such as running nurture groups.

"We were already running a group for invited children with issues such as transition, socialisation or trouble at home. We were obviously giving them mental health support, but it was reactionary rather than proactionary [sic]. At our [staff] meetings we always had an agenda item on vulnerable groups and children of concern. We were not bad at identifying when there were issues, but we were not necessarily great at specifically what the issues were." – School lead.

2.2 The pilot schools

In general, the pilot began with confusion within the group about what was being offered and what in fact the pilot consisted of due a lack of communication from the Anna Freud Centre², who facilitated the first two workshop sessions. Much of the confusion seems to have been exacerbated by the first training workshop, which we look at in more detail below. For many schools, the local engagement that happened following that first workshop and then in particular the commencement of PMHW school visits transformed their understanding of the pilot and – as we will see – their working relationship with CYPS.

By the time Ecorys interviewed the school leads for the pilot, they had a good understanding of the pilot's aims, including improvements in training and skills, an opportunity to plan future services, to develop better preventative and early help services for mental health, to increase awareness of local provision, and to increase awareness and priority of mental health problems among schools. Interestingly, specifically improving links and working relationships with CYPS was mentioned twice in responses to this question, but did not feature prominently in responses overall. The focus for schools had evidently been understood to be much broader.

The aim of the pilot had been to pilot this new way of working in a variety of schools, including primary, secondary, special schools and alternative provision. What arose from the analysis was that schools who do not fit in the category of 'mainstream secondary' required more tailoring of the offer to meet the different need levels of these schools. Suggested adjustments to the approach ranged from requests for 'clusters' of similar schools, to allocating CYPS time 'pro rata' according to level of need.

² The Anna Freud Centre were commissioned by NHS England and the Department for Education to deliver the first two workshops, after which the CCG led on workshop development and delivery.

Overall, CYPS workers considered that there had been a good level of collaboration in the planning between partners from health and education, and that the approach had been successful. The decision by the CCG to continue to chair a steering group for the pilot proved to be a success factor in this respect. Meetings to discuss the scope and limitations of their pilot work continued every two to three months during the pilot programme, and provided a forum for keeping channels of communication open beyond the relationship with individual schools.

There were some quite specific expectations from the CYPS team about what they anticipated the pilot would achieve:

"I would hope that those children who are sometimes missed because they're not smashing up the classroom or they're not on SEN are being picked up earlier to share their worries, because very often they're just small worries. If they're left they grow into big worries. [I hope] the staff feel more inclined to say, 'It's ok for me to ask.'"

The observation has been made that schools often need higher levels of support at the time when they begin working with the CYPS team, but that this tended to reduce as staff built their knowledge and experience. For example, CYPS workers reported that:

"We are often in [the school] once a week for the first couple of months. Then we reduce it to fortnightly."

"I don't think we will need fortnightly meetings in the future. Once every 6 weeks would be good."

Changes in levels of support were thought to be largely dependent on service flexibility, and the effectiveness of collaboration between PMHWs and schools at the initial planning stage to reach consensus on the level of support required. However, there was a capacity and sustainability challenge here, which was summarised by one member of the CYPS team as follows:

"My concern is whether or not the high level of input, from especially us, could be maintained, because we're a very small team. Outside the pilot, we cannot offer 14 schools something and 200 schools nothing."

Another factor affecting the capacity of the CYPS team was the travel time between schools. According to CYPS data, the estimated total travel time of PMHWs during the first half of the pilot was 238 hours. It was felt that there may be a risk that in-school consultations would become less frequent when capacity challenges arose, unless there was a mechanism to embed them within a service offer.

The CYPS team also highlighted that in structuring future delivery, it would be important to understand the professional interest and development needs of the CYPS workers. Specifically, it was felt that a variety of intervention types and levels of need incorporated into weekly patterns would help with the retention and motivation of staff, and that school allocations should take this into account.

2.5 School workforce and capacity requirements

“The internal cost is time.” – school lead.

On the whole, school leads accepted the additional time requirements placed on them by the pilot. There was a general sense that supporting pupils already takes up so much of their time that implementing better quality support is time well spent. The most prominent workforce difficulty for schools was releasing staff members from their classroom or supervisory duties to attend training sessions. Pilot funding sometimes enabled cover to be provided for staff training, but even this was not always possible.

“There has been no impact on our workloads. We had [time set aside] for pupils anyway. I would like more time, but nothing has changed really [relating to capacity] as part of the pilot.” – school lead.

“The pilot funding has enabled me to spend extra hours on this, to go on training and to get cover for that time.” – school lead.

It was difficult for school leads to quantify the amount of time that they have spent on engagement with the pilot programme. Several were able to give illustrative indications of the sorts of tasks encompassed by the pilot and the approximate time burden they comprise. We insert some of those examples here for illustration:

School time commitments. *The following is an illustration of the scale of the time commitments pilot school leads have reported for their various pilot activities. Most schools in the pilot are carrying out several, but not all, of the following:*

- 1.5 hour per fortnight of CYPS visits / consultation sessions.
- Group sessions lasting 1.5 hours per week for 4/6 weeks at a time.
- Training days (either 2 days or 0.5 day per staff member).
- About an hour per week of admin time and ad-hoc support for pupils.
- Time at staff meetings for presentation of the pilot.

3.0 Implementing the ‘Stroud Schools Pilot’

This section of the report presents the key findings from the implementation of the Stroud Schools Pilot, including: the training offered and undertaken; characteristics of the pilot and the nature of key professional roles; referral pathways and the impact of the pilot on the structure of these; and activities undertaken by schools during the pilot.

3.1 Training

Gloucestershire Healthy Living and Learning (GHLL) is the local delivery body for the previous National Healthy Schools accreditation scheme. GHLL offers free training to schools via their emotional health and wellbeing offer, including the ‘Mental Health First Aid’ (MHFA) training courses³, the core one of which is a two day course with a half day ‘lite’ option. These courses were offered to pilot schools as part of the scheme. In setting up the training offer for pilot schools, it was felt that there could have been a greater awareness of the unique way staff training is organised in schools as a result of time pressures on school staff. The training offered by both CYPS and GHLL had to be delivered as after-school ‘twilight’ sessions, or during ‘inset’ days set aside for staff training. These sessions were often planned a year in advance, as schools have a variety of regulatory and professional obligations with regard to training that need to be included in the calendar, such as regular safeguarding and first aid refresher sessions.

There were delays experienced by several of the pilot schools in receiving the mental health training. This is despite GHLL offering these sessions free of charge to schools. School leads attributed the difficulties to the challenge of fitting all-staff training in to the calendar, as well as the logistics of releasing small groups or even individual staff for sessions, due to the need for classroom cover. The pilot funding covered the costs of supply staff, but the difficulties of the availability of stand-in teachers and a consideration of the impact on young people’s learning remained. Overall, schools recommended that planning for training needed to happen at least one academic year in advance. This challenge was acknowledged and accepted by mental health professionals spoken to during our evaluation.

The usual training model reported by pilot schools was that all staff received the half day version of the training and some (usually two) members of staff received the full two-day mental health first aid course. At least nine of the 14 pilot schools adopted this approach. All of the pilot schools engaged in the mental health first aid training. In contrast, none of the comparison (non-pilot) schools who responded to our survey had delivered ‘all-staff’ mental health training. We can see then that the training rate among pilot schools in Gloucestershire is comparatively high.

During our evaluation, some schools mentioned the confusion that can arise for them in the different training offers available. This confusion was found to arise from the fact that some courses are free, some are charged for, and the difference in content was not always felt to be obvious. In order to address the issue of clarity around the local market for mental health training in Gloucestershire, GHLL, CYPS and the CCG were in the process of developing a ‘training matrix’, setting-out for schools what is available nationally and locally and what might be most appropriate.

³ <https://www.ghll.org.uk/training-programme/item/emotional-health-and-wellbeing>

This is work in progress for the local agencies, but there appeared to be appetite for this information from the pilot schools that we spoke to.

Comments from school leads on training

"Mental Health First Aid was brilliant!"

"It has been really positive to have the basic training."

"Training all staff has made them more supportive, e.g. of group work."

"It can be hard to facilitate training."

"I want all staff to do the 'lite' course, but it's hard to schedule and I'm struggling to do that because we have so many staff."

"After the Mental Health First Aid course, I recognise that the potential mental health roots [of some behaviours] are more than I would have thought, and that changes my expectations of certain children."

"We have used our training to benefit students."

The CCG in partnership with children and young people and local partners had also set up an advice site for children and young people. This new website, '*What's on your mind?*'⁴ guides young people through ways that they can help themselves, resources that they can use such as smartphone apps, for example to help control the urge to self-harm, and places they can go for further help such as telephone helplines or local organisations (TIC+ for example, or The Door youth centre).

In addition, pilot school staff received what many of them regarded as tailored training from their visiting PMHW during the pilot. One member of the CYPS team commented that:

"When we say 'training' I like to say it's more of a two-way conversation with them to talk about what they do with children who self-harm, what do they do with children who are on the spectrum who are showing high anxiety..."

Despite the training delivered during the pilot and its reported impact, the survey responses suggest that there remains substantial demand, with only one of the pilot schools selecting 'no' when asked if further training is required. Providing further information about this perceived training need, respondents cited quite a wide range of requirements, some of which pointed towards a more bespoke offer:

- *"The vast majority of staff here are very skilled - training at a 'higher level' would be beneficial."*

⁴ <https://www.onyourmindglos.nhs.uk/>

- *“More specialist training on SEN and mental health would be beneficial.”*
- *“Running “nurture” groups... measuring impact.”*
- *“I think more people should do the full 2 day course.”*

All respondents in comparison group also said that school staff had training needs. They detailed that they would like training to cover:

- *“Common mental health issues in the young...how to spot them...what to do next.”*
- *“How to recognise the first signs [of mental health problems] and offer support.”*
- *“More training could be given on the referral pathways. Staff also need training on assessing their own mental health and strategies for dealing with stress etc.”*

These responses appear to highlight differences in knowledge and confidence between staff in the two groups of schools, with pilot school comments requesting specific or more advanced training, while the comparison schools were asking for ‘basic’ information on the characteristics of mental health problems and systemic structures.

The training workshops

At the first ‘joint training workshop’ in November 2015 to launch the local pilot, 14 schools were represented, two staff members from CYPS, and numerous other agencies such as School Nursing, the Educational Psychology Service, GHLL, Prospects and other Voluntary and Community Sector Organisations (VCS). Ecorys also attended in order to observe.

The day included coverage of Anna Freud Centre’s standard framework delivery, followed by a tailored presentation from the CCG designed to emphasise that the idea of the national pilot scheme was to tailor it to meet local needs and to complement the local area Transformation Plan. In addition, the CCG delivered information on the diversity of NHS commissioned services in the county. Presentations by GHLL and a local school who were taking part in the pilot were delivered. The morning session included interactive small group and feedback sections, and some priority issues for the pilot were flushed out. Afternoon sessions concentrating on mental health knowledge and Anna Freud’s framework were less well received for being abstract rather than focused on local delivery, though the networking opportunities provided by lunch appeared to work well.

Following that first workshop, the CYPS team visited each of the pilot schools and had input into the development of the agenda for the second workshop, which was later generally agreed to have been more constructive.

3.2 A professional-led pilot

There has been a growing emphasis from some of those spoken to about the value of the Primary Mental Health Workers’ time with *teachers*. While this does not preclude the value of direct work done by the CYPS team with young people, on the whole there has been consensus that clear value has been gained from the pilot’s focus on working with professionals.

It was not anticipated that many children receiving support would have been aware that there was a pilot underway however, there were no negative comments made about this characteristic of the

work when Ecorys spoke to school leads, senior management and other staff as part of our qualitative evaluation work. Indeed, some of the most dramatic effects appear to have been felt in schools where the concentration of pilot working has been on supporting, supervising and upskilling teachers rather than on working directly with students (for example, see Case Study 1).

There is clear preference for flexibility in the way schools are supported to improve their mental health provision by CYPS, and in fact the focus on working with school staff to determine the most appropriate areas for activity is likely to have contributed to the ability of CYPS workers to understand specific needs and to tailor their offer.

The nature of the school lead role

"We are not therapists or mental health workers, we are teachers."

While the single 'point of contact' model envisioned by the Department for Education was generally true for the distribution of roles within the CYPS team, for the most part schools were working within their existing pastoral or student welfare structures to build these external relationships.

School leads spoke to Ecorys about who had been chosen to take on the role of lead contact for the pilot, and it was generally thought to have been an easy choice, with the head of safeguarding, the Special Educational Needs Co-ordinator (SENCO), or a member of senior management with a particular interest in the topic stepping up to take on the role.

Figure 3.1 overleaf provides a further set of quotes illustrating how school lead contacts described their role, in their own words. As the diagram illustrates, schools' understanding of what that role entailed was generally clear and relevant. However, the scope of the role varied considerably, from, *"Awareness, signposting and being a point of contact"* to *"To look at the current provision and be a part of influencing it."* To some extent these varying perspectives reflect the seniority of the respondent, but it is also true that the pilot setup and attitude towards it varied a lot from school to school, even within this relatively small geographical area.

One of the CYPS workers raised the concern that allocating a mental health 'lead' in a school could be problematic if schools were to compartmentalise the pastoral scope of the role. There was a strong feeling that mental health should be everyone's business, and that having a single point of contact nominally for the purpose of liaison with CYPS should not detract from the responsibilities of all school staff to acquire an understanding of referral routes and support. For example, one CYPS worker commented that:

"I have concerns that if a young person chooses to tell you something, sometimes it's very damaging to say, 'Now I'm going to pass you to this person,' because they have chosen you above any other adult for a reason. Sometimes that reason is because they trust you, and if you [pass them on to someone else] that could be quite destructive for a young person. It could cause disengagement. There's a lot of negatives to having one person for the young person themselves, though there might not be for the professionals who want a discussion."

Figure 3.1 School leads talk about their role.



The nature of the Primary Mental Health Worker's role

When Ecorys asked schools about the role of the PMHW (or CYPS worker) attached to their school, many of them spoke warmly about the value of having a link worker with professional knowledge who was a named contact for them to go to.

The descriptions of the role given by school leads, though relatively similar in general, served to highlight the flexibility that this kind of model offers in terms of tailoring support to each school. This is evidenced by the range of activity types the school leads listed as having been covered by the PMHWs. These include: attending regular staff consultations, providing advice and consultation, making suggestions for how to proceed, working together as part of a team, giving us the

opportunity to reflect more objectively, providing a method for clear communication with CYPS, being easy to contact, giving advice and guidance, helping us and modelling how to assess students, talking through cases, giving sessions with children, making a basic assessment within the school, staff training, giving advice to other staff if required, giving us the opportunity to run small groups, meeting with parents if required, doing whatever we need to meet our needs.

Direct, on-site contact with a specific individual PMHW was highlighted as one of the most important aspects of the pilot offer, with an emphasis on face-to-face communication. The CYPS team agreed with the importance of working within the school environment with the ability to see children of concern where appropriate. CYPS management reported that there was low demand for additional PMHW Network Plan Meetings [i.e. face-to-face consultations], for schools who have already been worked with by CYPS, although the source of this demand data is unclear. Primary schools were noted by CYPS to be the highest users of PMHW consultation provision.

Ecorys spoke to CYPS workers about the aims and purpose of their role with schools, and one theme that emerged was their intention to shift the viewpoint of school staff to a more holistic view of a young person's behaviour, taking wider factors about their circumstances into account and enabling them to see:

“that it's not so much that the child is the problem, but that the child has a problem or the family has a problem”.

The CYPS team also felt that part of their role was to calm the anxiety and approach of school staff towards perceived mental health challenges, and to help them support student's individual needs arising from mental health issues. Some of this anxiety was found to stem from uncertainty about how urgently support is required and whether there may be a safeguarding risk.

Non-mainstream schools

It was reported by the specialist schools in the pilot that their levels of expertise in mental health prior to the pilot beginning were already at a higher level than some of their counterpart schools, due to the different student needs within these settings. As such, the needs of these schools from the PMHW team were different. This is a learning point for future commissioning of these services as different schools will have different needs and the level of input required will vary.

These schools certainly felt that they would benefit from additional mental health support, and some suggested the formation of a sub-group of high need schools or another way to determine the best way of effectively working together in the future.

3.3 Referral pathways

There was a general view among pilot schools that the pilot had equipped them with a pathway for working with CYPS, which centred on their named contact within the service. Overall, schools felt that they were now confident that they could easily access mental health services for their pupils when necessary, and would know where to go for advice at all levels. The difference this made in giving schools a clear route to referral and assessment is demonstrated by the uncertainty that was voiced by several schools, who wondered what would happen if the named link worker structure

was discontinued after the pilot or if face-to-face consultations stopped, in relation to making referrals for young people in the future.

Previously to the pilot, some schools had little direct contact with the CYP mental health service. Many schools said that they would usually advise parents to seek a referral for mental health services via their GP:

“I can’t remember really referring before the pilot. Our predominant route to referral was through the parent and GP. We would often use the term ‘medical’. It was all very vague.”

This was potentially problematic as it relied on the parent following through in making and attending that appointment, and then communicating effectively with the doctor. Schools said that where this happens, they would not necessarily be kept informed about the outcome of the appointment and any referral made, so they could be left ‘in the dark’ about the outcome and whether the child was receiving any support at all.

It was reported that schools are inevitably able to provide a fuller account of the child’s circumstances and behaviour than health professionals. Nonetheless, GP referrals are and continue to be the biggest source of referrals into the CYP mental health service in Gloucestershire, and CYPS data shows that 45% of total referrals in the year to October 2016 came from GPs.

Other common difficulties related to the threshold for accessing mental health services. Before the pilot, school staff felt this was set high. For example, school staff reported that they may see a case where they had significant concerns about the behaviour of a teenager, but they would receive a written response to their referral saying that the child did not meet the criteria for assessment. There are competing professional perspectives here that we observed during our evaluation. The school sees a problem that interferes with the life and the lives of others in a way that is severe. A mental health practitioner may judge that the key underlying issue is unlikely to be in relation to mental health and that therefore referral to other services that can focus on behavioural or environmental strategies might be more appropriate. So the judgement of ‘severity’ is made along different criteria.

“Pre-pilot our referrals experience with CYPS wasn’t great. We made four referrals, none of which met the threshold, including cases that seemed really severe to us.” – school lead.

“All our referrals met with limited success [before the pilot].” – school lead.

Added to this, the thresholds were perceived to have left a ‘gap’ between needs that schools were trained and able to support, and needs that meet the required level for specialist support. Further, waiting lists for both assessment and treatment for those who do meet thresholds were felt to be long by several schools, referencing their pre-pilot experiences.

School leads speak about referral pathways

"Referrals to CYPS have happened more since the pilot. It has raised our awareness of [appropriate] alarm signals. Success rates of engagement with agencies by families have improved since we have been on the pilot. Referrals are more streamlined. Quicker. We have the helpline... better access to forms..."

"Now we consult with the PMHW who advises us."

"We haven't made any referrals during the pilot. Possibly we have kept them at bay because of the lead contact."

"Actual referrals have stayed the same, although many more children have been discussed and advice taken – without referrals being made – through the fortnightly consultations with the primary mental health worker."

In setting up the pilot, the CCG hoped that it would provide faster, simpler access to appropriate high-quality services through a variety of routes. These included: the direct contact with a link worker; better awareness of the mental health advice line and other local resources; more knowledgeable school staff leading to more appropriate referrals and consequent improvements to waiting times; pre-referral discussion between schools and MH services to improve appropriateness of referrals; increases to the amount of low-level support schools are able to offer themselves, and training for schools to enable the delivery of effective group work. The key priorities here for addressing referral pathways were thought to be the quality of the pre-referral discussion between the school and the CYPS worker, and the greater knowledge of referring school staff about mental health issues, risks and severity.

Figure 3.2 Schools mental health pilot pathway

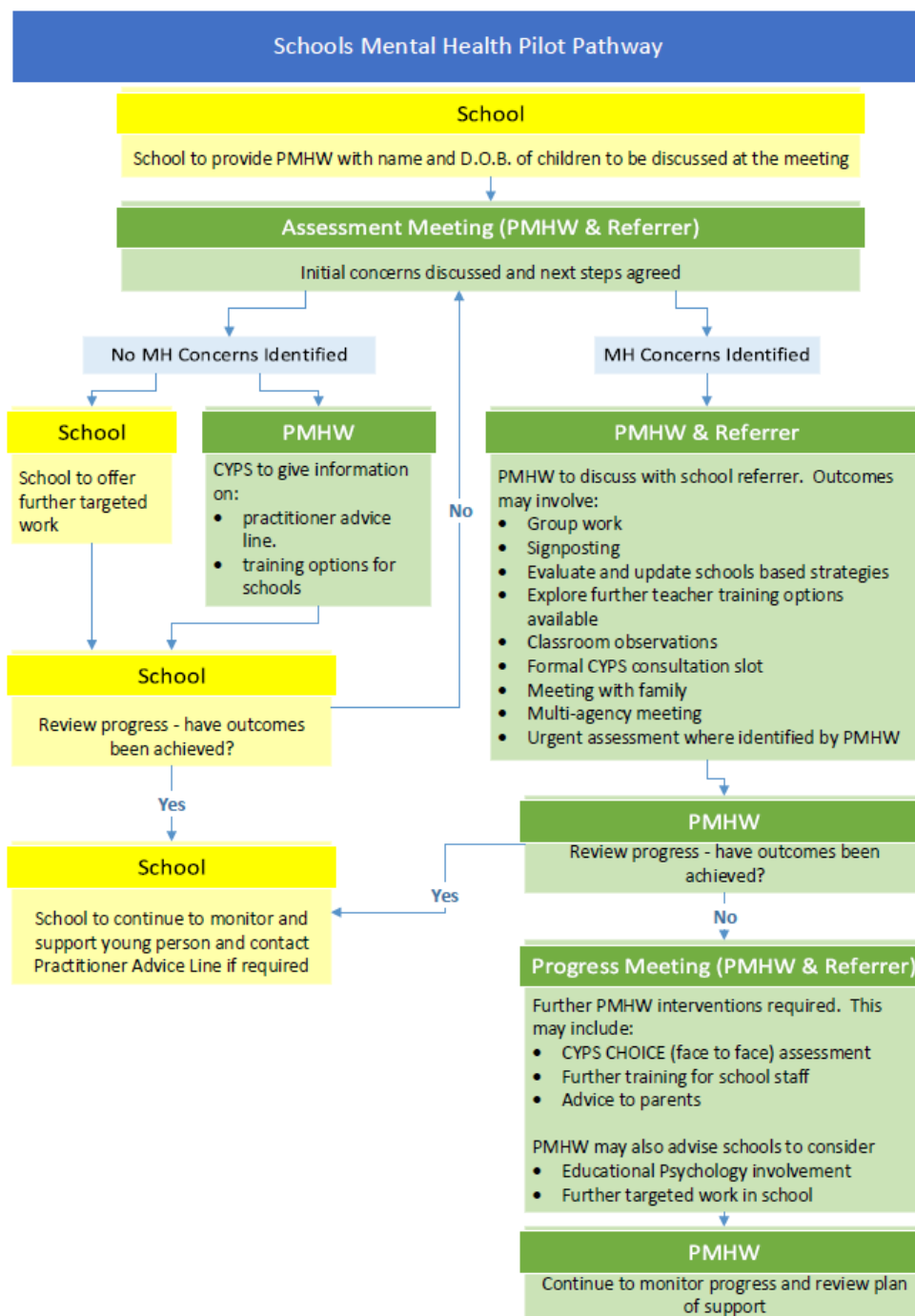
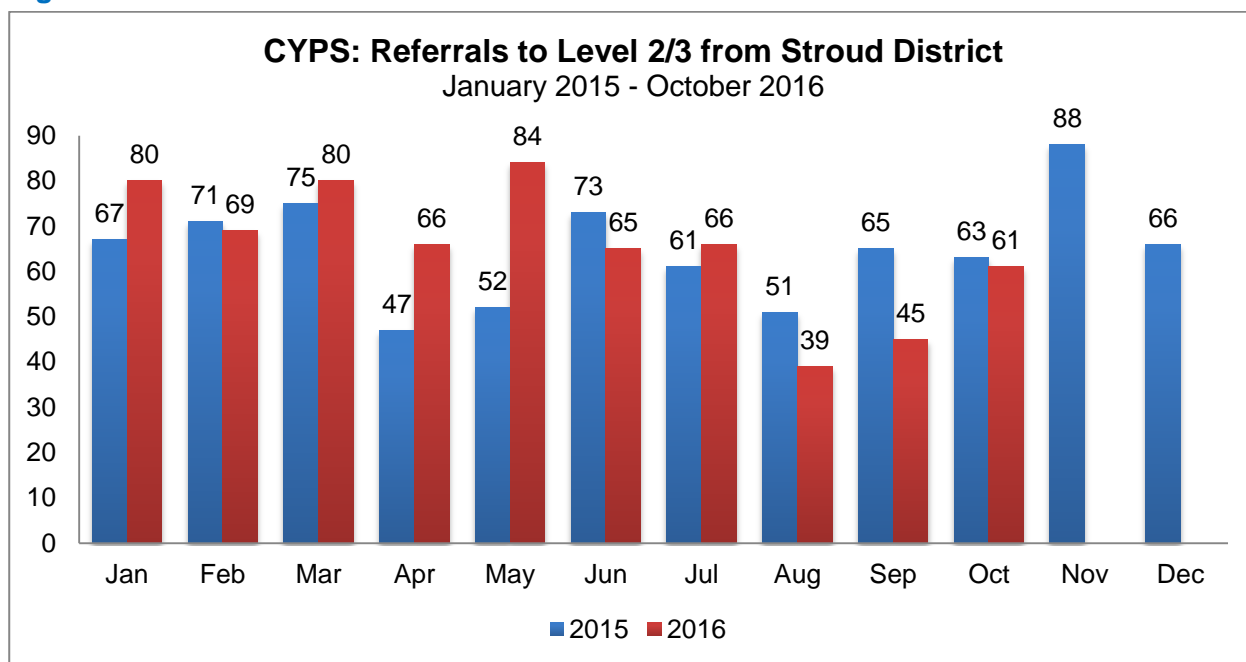


Figure 3.2 (above) shows the pilot pathway that was developed by CYPS. It follows a ‘plan, do, review’ approach and notably there is a strand of activity for which, following advice given at the ‘assessment meeting’ (face-to-face consultation), there is no further mental health service input but rather ongoing targeted support and monitoring from schools with the potential to contact the Practitioner Advice Line if required.

The pilot model does seem to have had an effect on referral routes and approaches. CYPS data for the period between January and October 2016 shows a 5% increase overall in referrals to the CYP mental health service, for young people who live in Stroud (determined by their GP’s location), compared with the same period a year earlier (see fig 3.3).

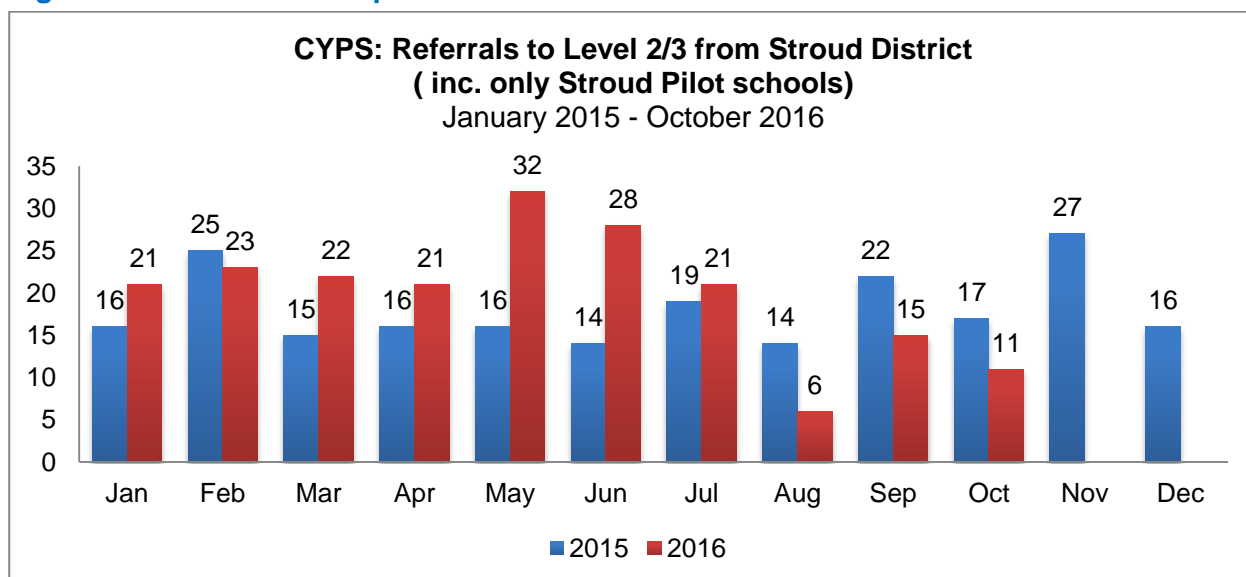
Figure 3.3



[CYPS data]

CYPS also hold some data on 13 of the pilot schools specifically. It should be noted that these data are incomplete, as referrals into CYPS do not always contain named information regarding the school the child attends. However, data from 2015 has the same limitation and so the two may be considered comparable. This comparison shows a 13% increase in referrals from Stroud Pilot schools to CYPS overall, compared with a year earlier (see fig 3.4). This data therefore suggests that the pilot is likely to have contributed towards quite a significant increase in the number of referrals being received by the CYP mental health service.

Figure 3.4 Referrals from pilot schools.

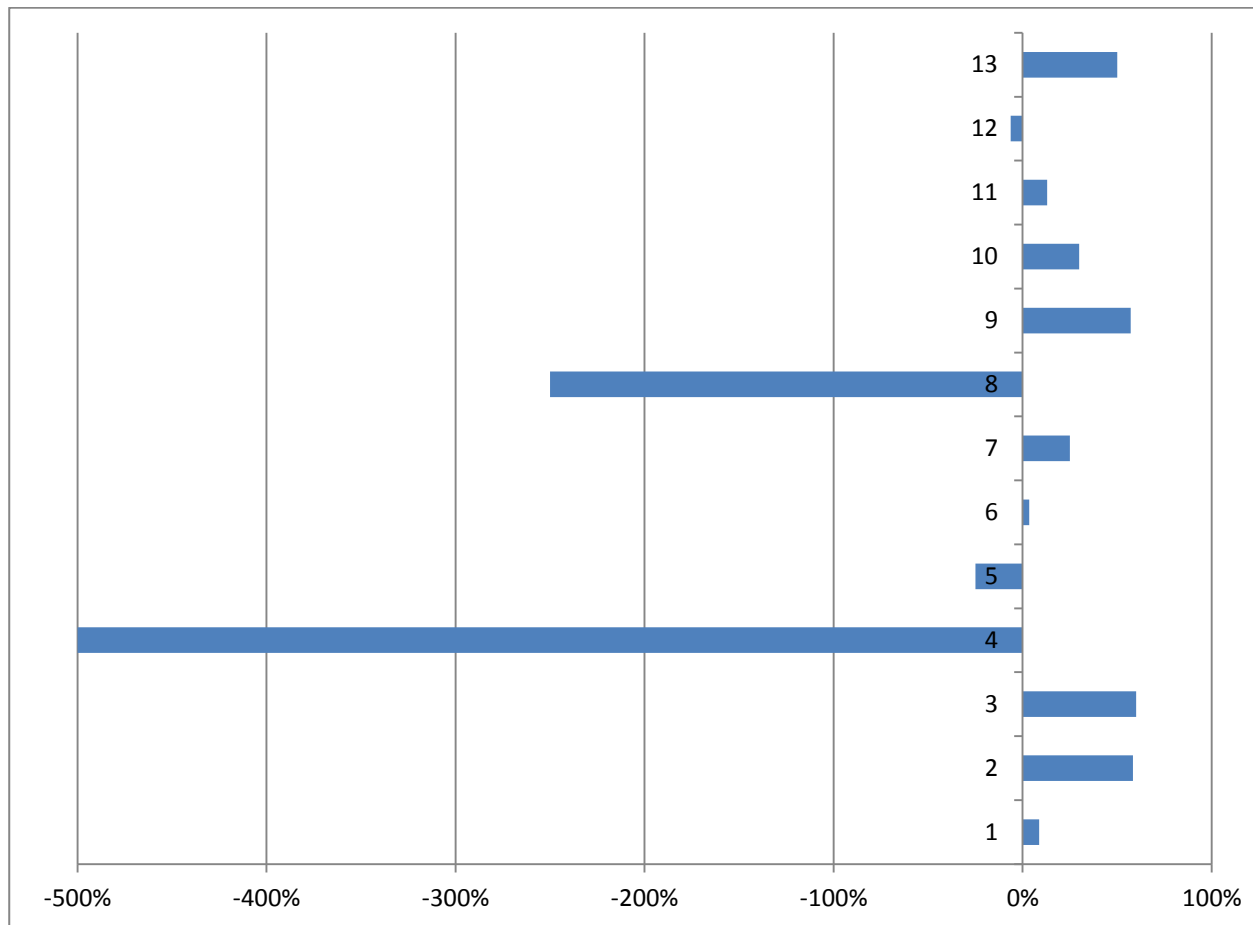


[CYPS data]

When we look at a school level however, we can see that there is a substantial variation in the impact the pilot has had by school, such that we cannot make any general statement about the

pilot impact on referral rates. The following chart (fig 3.5) shows the percentage change in referrals between 2015 and 2015, for each of the 13 pilot schools for which data is available.

Figure 3.5 %change in CYPS referrals by school.

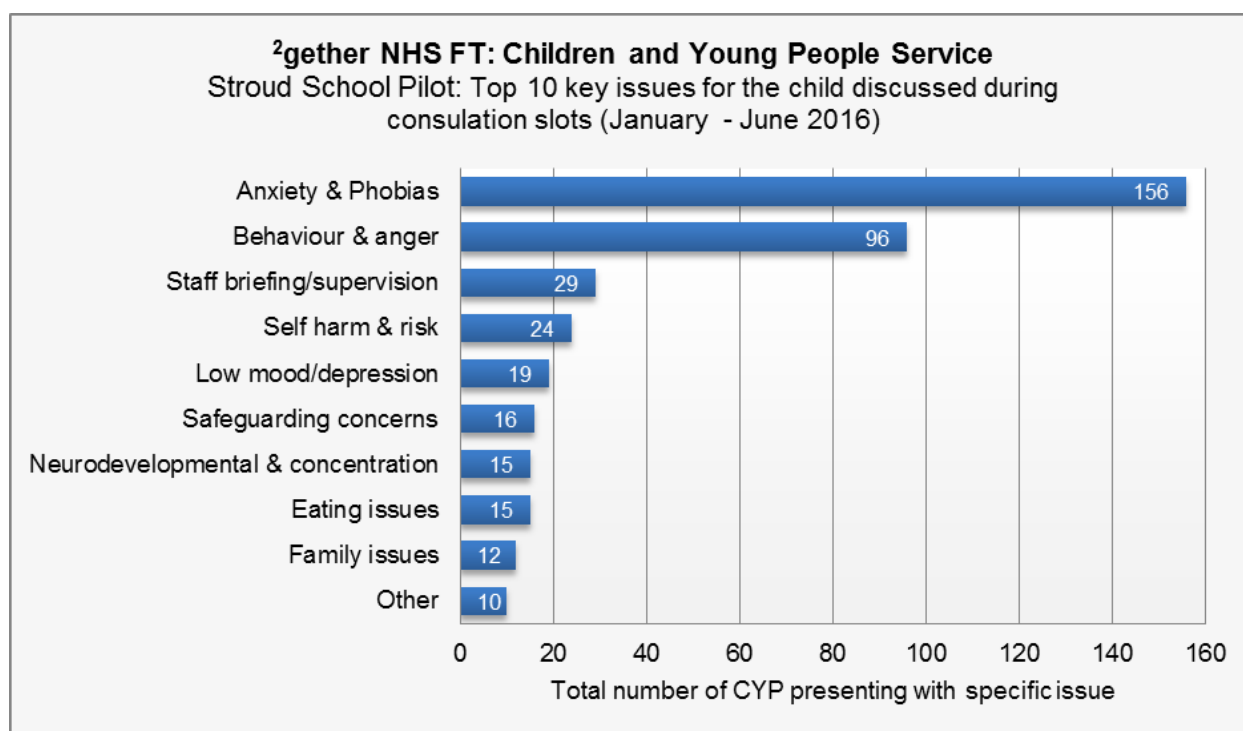


[CYPS data]

Figure 3.6 below shows the most common issues discussed during PMHW consultations with school staff. Clearly the most common reason is for consultation with a PMHW was anxiety/phobias, which ties in with other information that has been obtained through a recent mental health needs assessment undertaken by the CCG as part of the Future in Mind⁵ transformation work. PMHWs have offered specific sessions relating to children and young people relating to anxiety where schools have highlighted this as an issue.

⁵ Future in Mind relates to the 5 year transformation plan for children and young people's mental health, which followed from a taskforce review of current provision.

Figure 3.6 Common issues discussed during PMHW consultations



3.4 The professional advice line

“I didn’t really understand the purpose of [the advice line] before. I misunderstood that it was for discussing referrals. I would probably have used it more. I have better awareness now.”

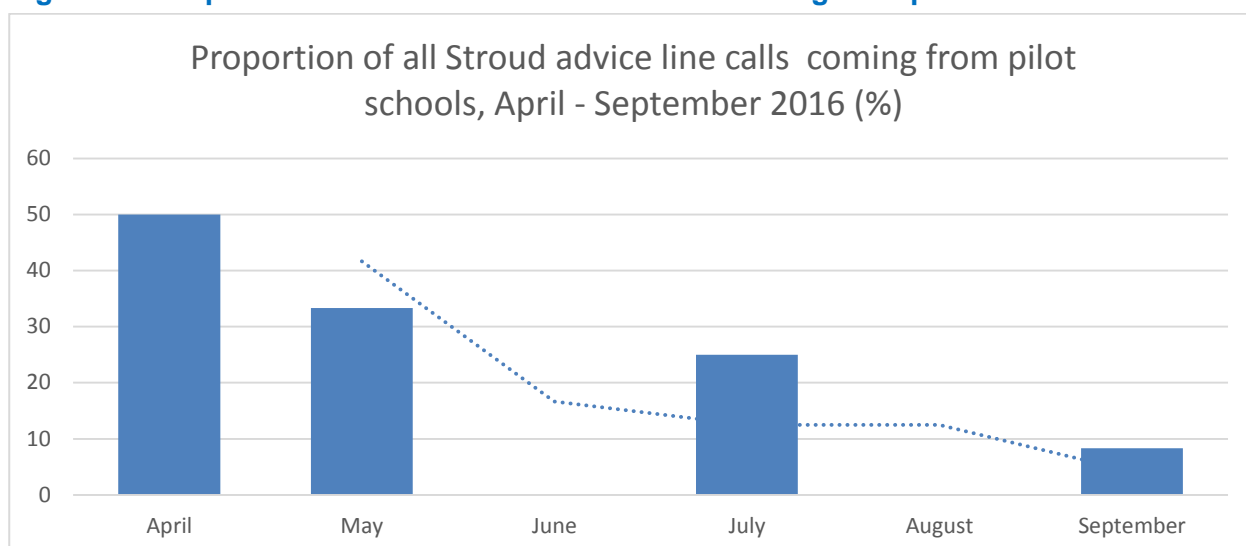
- school lead.

An advice line for professionals to call the CYP mental health service has been operating since 2010. At the point that the Stroud Schools Pilot was initiated, it had been designated the ‘front door’ into the Gloucestershire CAMHS service for any type of enquiry. The advice line number had been provided to every school in the area, along with a dedicated email address for the PMHW team that teachers could contact with any non-urgent queries.

Re-sharing the practitioner advice line number proved to be a real ‘quick win’, and a prime example of how the pilot had achieved the more effective use of existing local resources. In our survey, combining all respondent groups, continuation of the mental health practitioner advice line came out as the joint-top most important asset in improving mental health support for CYP in Gloucestershire in the future (see more detail on the responses to this question below).

It was anticipated by CYPS that calls to the advice line would be likely to decline as a result of the time being spent with staff in schools. CYPS routinely collect advice line call data, which show that of all the advice line calls coming from Stroud, the proportion coming from pilot schools declined over the course of the pilot (fig 3.7). This suggests that enquiries which may usually have been raised via telephone consultation had instead been picked up by the face-to-face consultations offered as part of the pilot scheme, or the direct email contact offered by the CYPS school pilot team to pilot schools. For the time period January – June 2016, 172 emails from pilot schools to the dedicated pilot PMHW email inbox had been received.

Figure 3.7 Proportion of all Stroud advice line calls coming from pilot schools



[CYPS data]

3.5 Pilot activities

CYPS data details the number of 'direct contacts' that occurred between PMHWs and schools between the first half of the pilot, i.e. January – June 2016. Some 246 school visits were recorded over this period, resulting in 419 individual consultations being provided. In addition, 43 group sessions took place, 4 on call/duty contacts and 1 formal training session was recorded.

In order to compare the impact that the pilot had upon schools, a survey was sent in October 2016 to all pilot schools and a comparison group of schools in the neighbouring area of the Forest of Dean – selected for their range of types of geographical locations, and type of school, and a selection of professionals working in the administration or delivery of local mental health services, within public, private or third sector organisations.

We had completed responses from 5 pilot schools, 3 comparison group schools and 9 mental health professionals. This response rate was acceptable from pilot schools at 36% and fairly strong from mental health professionals at 47%. Responses from the comparison schools were 19%. Given this, and the small number of responses overall, we are not able to draw generalisations about the picture of all local schools as we make our conclusions. However, there are still many interesting things to be discovered from the responses.

We asked each respondent about a range of mental health activities that schools had participated in. The list of 28 activities was as follows:

1. Notice boards, information screens, or leaflets have been put up in/around school raising awareness of mental health issues
2. Some staff have received mental health training (0.5 days 'lite' course)
3. All staff have received mental health training (0.5 days 'lite' course)
4. Some staff have received mental health training (2 days 'first aid')
5. All staff have received mental health training (2 days 'first aid')
6. Staff have received mental health training jointly with another school
7. Mental health has been discussed at staff meetings

8. Mental health is a routine subject for discussion at staff meetings
9. We have held assemblies on the topic of mental health
10. There has been class time focused on the topic of mental health
11. School staff have convened groups or workshops for selected groups of CYP, such as nurture, 'feel-good' or anxiety sessions
12. A mental health professional has convened groups or workshops for selected groups of CYP, such as nurture, 'feel-good' or anxiety sessions
13. Children in our school have received 1-2-1 support from a staff member for their mental health
14. Children in our school have received 1-2-1 support from a mental health professional
15. Mental health has been introduced as part of our curriculum
16. We use the 'PINK curriculum'⁶ in our school
17. We have delivered general information for parents on mental health
18. We have engaged with parents on the subject of their child's mental health
19. We have delivered training/advice on managing mental health issues to parents
20. We have addressed the subject of staff mental health
21. We have taken action to provide mental health support for staff
22. Mental health features on our school's transformation/development plan
23. Mental health has been discussed with our school governors
24. Our governors are actively engaged with/involved in developing the school's approach to mental health
25. A staff member has intentionally discussed their concerns about a child's mental health with a mental health professional on the phone or by email (e.g. via the CYPS practitioner advice line)
26. A staff member has intentionally discussed their concerns about a child's mental health with a mental health professional in person
27. The school has referred a child to external services (such as CYPS or a voluntary sector organisation) for specialist/additional mental health support
28. None of these

The survey shows that at the start of the pilot, the pilot schools who responded had already planned or actioned 13.6 of these activities each on average (N.B. all averages are mean values). The figure for the responding comparison group schools was less than this, at 11.7 activities each. There is a suggestion here that pilot schools may have been schools who had slightly higher levels of activity in this area even before the pilot began. However, during the course of the pilot, each of the pilot schools responding to the survey participated in an additional 6 mental health activities, such that by the end of the pilot they had participated in an average of 19.6 mental health activities overall.

Average number of mental health activities engaged in by a school responding to the survey, which has engaged in the pilot programme	Average number of mental health activities engaged in by a school responding to the survey, which has not engaged in the pilot programme
19.6	11.7

⁶ The People in the Know - 'PINK curriculum' is an initiative that has been developed by GHLL. The aim of the PINK curriculum is to support the development of the necessary skills and knowledge that our children need to lead a happy, safe, healthy life.

So we can see that the pilot has notably increased mental health activity levels in participating schools that responded to the survey.

It is worth noting that the comparison schools that responded to our survey are likely to also be more engaged than average in this topic area, as they have taken the time to respond and contribute to this evaluation. So these figures are likely to be an underestimate of the impact of the pilot on school activity levels. This is further demonstrated by the schools' responses to our question about the use of the 'PINK curriculum'. Four of the responding pilot schools and two of the responding comparison group schools said that they were using the 'PINK curriculum' and the pilot made no difference to this in the pilot schools group.

Many more observations from the survey responses can be made along these lines. For example, none of the comparison group schools had rolled out all-staff mental health training, whereas three of the pilot schools (more than half of those responding) had implemented this. By the end of the pilot, all five of the schools reported that their governors were actively engaged with / involved in developing the school's approach to mental health, compared with none of the pilot schools.

Case study 1: A Stroud primary school

“We believe that the pilot has been a really positive thing for the school”

Ecorys visited a pilot primary school, where we spoke with seven staff members and six children from Year 6. This school was very engaged with the pilot and had taken a ‘whole school’ approach to making changes in mental health provision. The head-teacher commented that: :

“The pilot gave us permission to have mental health high on our agenda and to make sure mental health underpins academic learning,”

The school delivered mental health first aid ‘lite’ training to all staff, and believed that this was really important in creating cultural change within the school. It seemed clear that the pilot was successful in having an impact within this school’s culture, with a changed dynamic in the language used around the school, which all staff spoke of. According to the head teacher:

“We have developed a new shared vocabulary around mental health. In some cases we are now using language that is more specific. More ‘correct’. Our community is more knowledgeable about what the appropriate vocabulary is and that makes a difference when you are talking to the children. It gives the children confidence, the tools to talk, and normalises the discussion. There has also been a reduction of stigma within the school, and this is down to the confidence of individuals with the subject matter.”

The interviews indicated that there had been a structural impact on school systems and processes, with mental health now a part of the head’s routine update to the governors and making up a regular section in the weekly staff meeting. Mental health training had also been included in standard training for new starters among the staff.

The impact had reached the school’s wider community too, with staff empowered to speak to parents about their child’s mental health.

“We told parents about our involvement with the pilot via our newsletter and the website. We haven’t really had challenges with parents around this, but there have been one or two hiccups, such as parents feeling that the nurture group might be questioning their parental nurturing. That has been easy to iron out though, by setting out the individual benefits that we anticipate for the child. Parental feedback from the interventions has been exclusively positive and people are very much on board and supportive.”

4.0 Pilot impacts, outcomes and sustainability

This section of the report considers the evidence for any outcomes achieved by the Stroud Schools Pilot: both in terms of outcomes for young people, and improvements to services and systems for relationship building between schools and CYP mental health services.

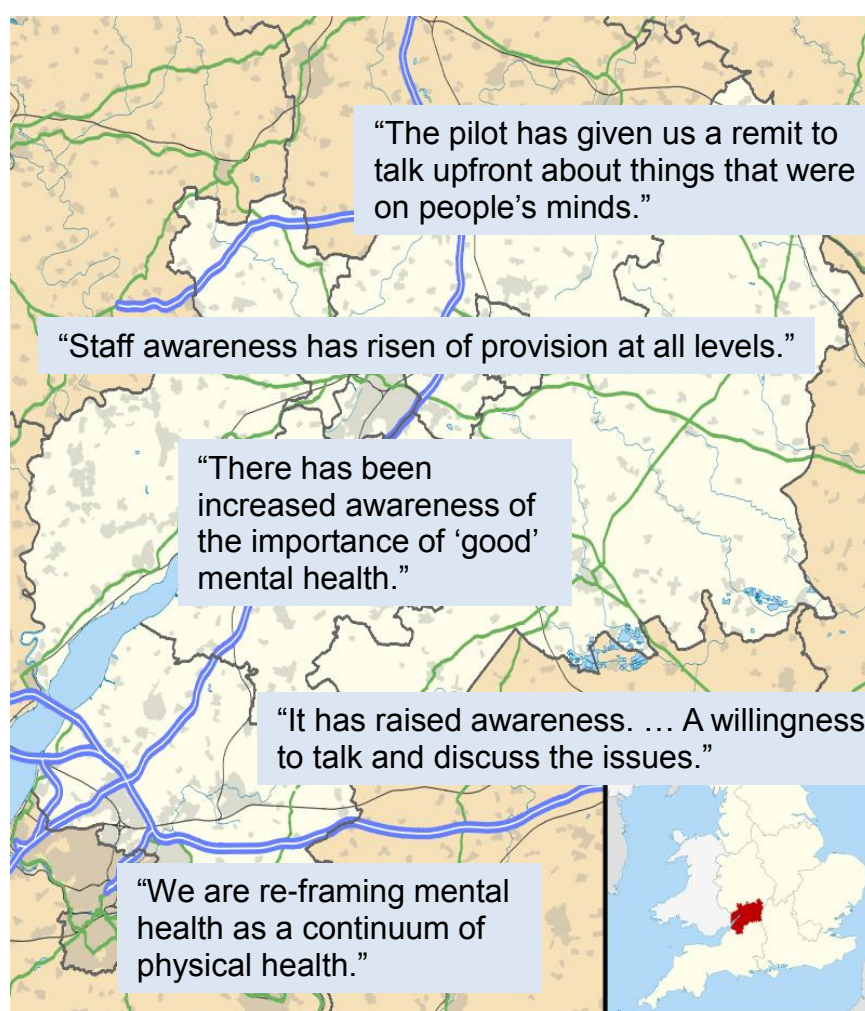
4.1 The priority of mental health

The impact of the pilot on awareness about the importance of mental health within schools cropped up across the length and breadth of the evaluation. It is not possible for us to measure the true impact of such an observation, and it manifests itself in many different ways that are hard to capture: in the number of casual conversations that take place about mental health; in a reduction of stigma or lower levels of embarrassment when discussing the subject; in a high-level strategic conversation or engagement about action; in the language used to talk about everyday stresses and emotions; in the new awareness of a vision for 'parity of esteem' between mental and physical health. But unquestionably, school leads felt that the pilot had raised the priority of mental health within their school. This was also reflected by comments from mental health professionals.

"The whole profile of provision for meeting young peoples' mental health needs has been raised,"

- mental health professional

Figure 4.1 School leads talk about the impact of the pilot on mental health awareness in schools.



4.2 Professional knowledge, awareness and understanding. Working relationships.

There was substantial variation in the experience and practical knowledge held within pilot schools around the subject of mental health, which in many cases seems to have been structural and may be unavoidable, for example because they have generally low-risk intake groups or smaller pupil numbers. One CYPS worker summarised this as follows:

“I think the larger schools in the more needy areas are the ones that will contact us more and see more of us. Some schools are little, so they contain or they manage certain difficulties and don’t ask for help”.

From the information given by schools responding to our survey however, even with low overall numbers we can see a clear difference in the confidence and skills reported by the pilot schools compared with those reported by the comparison schools (though we do not have the evidence to state that this is attributable to the pilot rather than other confounding factors). We can see on the chart below (see fig 4.2) that the ratings given by the responding pilot schools (green) are higher overall for these four questions relating to confidence in their skills and abilities in mental health than the ratings that were given by the responding comparison schools. The four questions asked how the respondent would rate: “Your knowledge and awareness of mental health issues affecting children and young people”; “Your confidence to support children and young people affected by mental health issues in the future”; “Your ability to build resilience in children and young people in your school”; “Your ability to deliver mental health learning or support to children and young people in your school, such as leading nurture groups or PSHE sessions”.

When asked specifically whether the pilot had brought about improvements to their knowledge and awareness of mental health issues affecting children and young people, all respondents from pilot schools selected either ‘agree’ or ‘strongly agree’. This was reflected by CYPS workers, who reported that over time, the children being referred to them by school staff were ‘more appropriate’ and that there had been a change in the types of children referred (e.g. from children with high level learning difficulties or behavioural needs, to children with low-level mental health needs), reflecting changes in the knowledge and awareness levels of school staff.

There was an observed strong preference among all key stakeholders for mental health support which can be tailored to the needs of individual schools, and which may help to support schools during times of particular need. As mentioned above, the named CYPS link worker model was credited with enabling the service flexibility to provide a tailored approach to each school, ranging from one-to-one consultations with staff, to the delivery of ad-hoc all-staff training, group work with CYP including the modelling to school staff of how to run the groups, or on-site assessments with young people of concern.

Figure 4.2 School leads' confidence in their mental health skills/abilities



Rating scale: 1, poor/requires attention; 2, functional/acceptable; 3, good but it's an area I'd like to see improve; 4, skilled and/or effective; 5, exemplar/centre of excellence.

In addition to the flexibility provided by this model, many of the school leads spoke to Ecorys of the confidence-building effect of having consultation time with the CYPS team, and the value of having much of their existing work and approaches with young people validated by specialists. All of the pilot school respondents to our survey selected 'strongly agree' to the question, 'Overall, to what extent would you say that the pilot programme has brought about improvements to the validation of work that you were already doing to support children and young people affected by mental health issues?'. To the question, 'Overall, to what extent would you say that the pilot programme has brought about improvements to your confidence to support children and young people affected by mental health issues in the future?', all pilot school respondents selected either 'agree' or 'strongly agree' in response.

"Without the pilot funding we would not have had the time to be so flexible."

- CYPS worker

There were concerns at the beginning of the pilot to ensure that school staff were not being asked to take on roles that were inappropriate in relation to mental health, such as by attempting to diagnose mental health conditions in their pupils. However, the school staff interviewed for the evaluation were clear that they do not make diagnoses, and that by increasing their knowledge and awareness of mental health, the pilot had made inappropriate assumptions on their part less likely as a result of being better informed.

Working relationships

Most of the school leads reported improved relationships between themselves and CYPS following the pilot. Factors contributing to this include a better mutual understanding of the challenges and limitations of each environment, and the development of specific professional connections between the CYPS and school leads. For example, one school lead told us during a telephone interview that *“The named individual has been key. She has got to know us, our community, our ethos and approach”*. Having a mental health professional on site also seemed to have eliminated some of the frustration and anxiety teachers felt over waiting lists for assessment and treatment. This was because the oversight of the CYPS worker helped them to feel that the potential risks to the young person and their peers were being managed during this time. One CYPS worker commented that: *“Now we have some really good working relationships with schools. I feel embedded in the school”*.

There was a general sense that working relationships could continue to be improved and pathways firmed up in the future: *“We still need to build on our mutual respect. This is the start.”*

Little difference could be observed between responses from pilot and non-pilot schools responding to the survey question, ‘How would you rate the effectiveness of joint professional working between schools and CYPS in Gloucestershire?’, with 5 out of the 6 who responded to that question selecting the response, ‘Good, but it's an area I'd like to see improve’.

4.3 Referral speeds

The picture for impact of the pilot on referrals is complex. We have seen that the effect on CYPS referral volumes varied widely from school to school and that pathways within the pilot were distinct, with lower use of the advice line by pilot schools and increased use of face-to-face consultations and email queries. Several of the schools reported that referral experiences and speeds had improved during the course of the pilot, but it has not been possible to track referral speeds from pilot schools in order to inform the question of impact here. The widespread view was that schools were now making more appropriate, better informed referrals, which should enable faster access for those young people in need of mental health support, even if more of those individuals are now being discovered.

CYPS data shows that approaching three quarters (75%) of the cases discussed during face-to-face consultations resulted in further support strategies and/or intervention from school or other external agencies. The majority of cases did not result in the CYPS PMHW working directly with the child or making a specialist referral.

School leads commenting on referral speeds:

“We have now had more timely and appropriate support, rather than just referring and waiting.”

“There has been a swifter and more informed response for individuals. Better recognition and a more coordinated, informed, effective, preventative response, with better access to specialist advice.”

4.4 Organisational cultures

The evaluation found that there were significant challenges in bringing together the two organisational cultures of schools and the CYPS service. These are groups of professionals with very different areas of expertise. Differences include schools' focus on pupil 'behaviour for learning' versus CYPS' focus on underlying causes of behaviour; the pressures of time and targets in schools versus the need for calm and space for open questions within CYPS; the need for clarity and clear action plans in schools in the context of daily timetables during which children move between locations, staff and subjects rapidly, in contrast to the CYPS service approach of enabling individuals to make choices and implement changes to their lifestyle or environment.

While the focus of the evaluation has been largely on the upskilling of teachers, we have observed that there may be future requirement for further training and development for PMHWs, if their role expands to leading group sessions without the presence of school staff. The exploratory, cautious and gentle approach of a PMHW may not always be productive in managing a challenging group of young people, and in directing the session positively and efficiently towards its stated aims. School staff, of course, face this challenge routinely. In the session observed by Ecorys, the frustration of teenagers at being unable to control their own environment sufficiently to embed practical strategies such as quiet and uninterrupted study and forward planning was evident. School staff would be in a strong position to tackle this frustration of autonomy with experience and pragmatism, and it may be that they are better placed to deliver group sessions, or instead to embed mental health-aware approaches in their everyday conversations with young people.

Most striking among these differences are the triggers for concern which schools observe in young people compared to CYPS workers: most prominently in the case of self-harming students. School staff often described self-harm as a safeguarding issue, raising concerns for them about the potential danger of serious harm to a student or their peers. Mental health professionals were more likely to describe self-harming as a 'maladaptive coping mechanism' for an underlying mental health problem such as anxiety.

The pilot seems to have enabled a space to open for growth in mutual understanding as well as developing shared knowledge. The current focus on professionals collaborating together seems a strong foundation for developing this cultural shift.

4.5 The voices of young people

We asked for the opinions of the members of a primary school 'worry group', which is a CYPS-supervised group that teaches skills for life in managing anxiety and other emotions. The CYPS team facilitated paper evaluation forms at the end of one of the sessions. The children all reported high levels of enjoyment and specific learning gained from the group. More detail about this is given in Case Study 3.

Ecorys also spoke to a group of six Year 6 pupils in one primary school about the ways in which they felt talking about their feelings at school was important, and what activities they could remember having done recently that helped them to learn about their feelings and emotions.

The children were able to name a long list of things that they had been doing in school that related to mental health:

<ul style="list-style-type: none"> • RelaxKids • 'How to be me' • Storywriting club • Reflexology • Mental Health lessons – "My brain hurts" 	<ul style="list-style-type: none"> • PSHE • 'Blob tree' • 'GEM powers' • 'Dr Tom'
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One child spoke of a notepad that they had been given to write anything that happened at home in as a way of telling their teacher, and how much this had helped them to be able to express their feelings whenever they needed to and in private. The following quotes are from the young people in that group, talking about the mental health learning and support they have participated in:

Figure 4.3 Year 6 pupils speak about their mental health learning and experiences in school



4.6 Working with young people using a preventative approach

There was general support among teachers in the pilot schools for a gradual move towards a preventative model where young people taught life skills at primary school and in years 7/8 and perhaps offered low-level group support where appropriate, in order to help prevent problems that often surface around the middle of secondary education. Teachers also identified a need to receive advice on how to handle young people in distress or crisis, how to judge and manage risk, and where to turn for appropriate and prompt support. CYPS workers observed examples of changed approaches by school staff, where they were empowered to see challenges faced by pupils (such as difficulties at home) as opportunities to build their resilience and coping skills for life. One CYPS worker also spoke positively of the fact that, *“we have been able to meet parents and young people without them having to be ‘in the system’.”*

Curriculum

Some of the school leads talked about the possibility of further embedding mental health work into the school curriculum, to ensure that priority continues to go to delivering learning and discussion on the subject. One of the ways of doing this is to incorporate it into the PSHE curriculum, which two of the schools said that they had now explicitly done. One school lead said that: *“We wanted to make it explicit: to say ‘we are not afraid to use the correct terms’ and to give it dedicated time and lesson planning to deliver”.*

One primary school lead contact commented that while they aspired to embed mental health learning in their curriculum, the current primary school curriculum is “saturated” and so mental health might instead be covered during the ‘theme weeks’ which already occur. The majority of schools (both pilot and non-pilot schools) responding to Ecorys’ survey said that they use the ‘PINK curriculum’ in their school, and demonstrates that there is already some widespread inclusion of mental health issues in county school curricula.

Engaging with parents

There was some limited engagement with parents during the course of the pilot. Some schools had told parents that they were taking part in the pilot through their regular newsletter. In some cases, parental consent for interventions or group activities was sought and this had raised awareness among parents. PMHWs had spoken to parents on occasion to discuss the needs and plan for their child, and in one case the parents of a nurture group cohort attended a meeting with the PMHW to brief them on the sessions.

Two school leads reported that they felt constrained and frustrated by the need for parental consent for interventions. “It can be a problem such that we want to help but we are constrained,” one explained.

4.7 The ‘mental health network’

Substantial work has gone into improving links between all parties in the wider mental health network as part of the pilot, in addition to improving working relationships between CYPS and schools. The initial joint training workshops, follow up meetings hosted by the CCG, development

of the training matrix as discussed above and the development of a local online information resource have all represented work in this direction.

In addition, the CCG has brought Active Gloucestershire,⁷ Family Lives⁸, Facts4Life (who offer training about the ups and downs of normal mental and physical illness) and Educational Psychology on board with the pilot, giving them the opportunity to contact and connect with schools in order to form new links. The School Nursing service has also been working with the pilot and the Early Help Hub has done some networking activity around the topic. This means that schools are now being offered more services that can help with managing lower levels of need.

Concerns were raised by school leads that the services to which they are being pointed – such as VCS organisations which provide services at a level below that of CYPS – are themselves facing substantial funding challenges, and that this may not be a sustainable solution.

Schools were keen to continue the networking with other schools interested in mental health issues which began during the pilot. One school lead said that: *“It has been a good opportunity for networking. It would be good to do more.”*

4.8 Sustainability of the pilot model

We asked survey respondents: “How important do you think the following are for improving mental health support for CYP in Gloucestershire in the future?” When we combine all survey responses and rank them in order of prevalence, we find that the following ranking occurs:

1. ‘Continuation of the mental health practitioner advice line’ and ‘Access to mental health support flexibly at a variety of locations (including home and community-based)’ were jointly ranked as most important by the respondents.
2. ‘Each school having a named CYPS worker who can be contacted directly’
3. ‘Face-to-face consultations regularly delivered in school by mental health professionals’.
4. ‘Development of a system to measure/track mental wellbeing in your school’ and ‘Development of networks of schools with shared interests/characteristics/locality to share ways of working regarding mental health’ were jointly ranked next.
5. ‘Bespoke training delivered to schools by CYPS workers’ was rated as the least important of the options given. However, there was still a strong feeling that this is an important thing for CYP in Gloucestershire.

We then asked respondents, “What is the single most important thing that could be done to further improve mental health support for CYP in Gloucestershire in the future?” Responses from pilot schools were as follows:

1. “Provide more appointments.”
2. “An open environment where CYP are able to talk about worries and staff that know what to do when a YP opens up to them.”

⁷ Active Gloucestershire are a local voluntary and community sector (VCS) who promote and support physical activity for everyone including those with mental health needs.

⁸ Family Lives are a local VCS organisation who offer support and advice for families in England.

3. "Practical training on "how" to support / run groups."
4. "Continuing to ensure awareness of all school staff."
5. "Being able to fund services for more support or being able to continue with the level of support the school has received being part of the pilot."

Responses from the comparison group schools were:

1. "Quick access to counsellors and help for school leavers with mental health difficulties to access suitable financial support. For people with mental health the process can be crippling, both emotionally and financially. I know this is not relevant to primary schools, but it is a something I have observed in young people first hand."
2. "Continuation of a helpline."
3. "Inset training."

The mental health professionals responded:

1. "Funding continuing to ensure MHFA training can continue along with Government and Ofsted agreement that PSHE is integral to CYP education."
2. "More primary mental health staff to enable support to all county wide schools regularly through consultation and named contact support."
3. "Face-to-face consultations regularly delivered in school by MH professionals for those requiring interventions, alongside a comprehensive delivery of a health resilience curriculum (such as Facts4Life) for all students."
4. "Self-referral."
5. "Rolling out Facts4Life to more schools and include more information about mental health. Starting good self-care behaviours at a very young age."
6. "I'd like to see the pilot being rolled out across Gloucestershire. I think ensuring that parents/carers and the young people themselves are consulted fully with regards to the nature of the mental health support they want, and their views are heard and addressed i.e. that it's not just 'parenting courses', but bespoke support."
7. "Improve access to support services for individuals at a level below the current threshold for eligibility alongside the availability of a mental health resilience programme for all children such as Facts4Life."
8. "Easier access to services - the threshold is still too high and CYP not meeting it need help too - we need to be able to access training in the voluntary sector too."

So what will the future of CYP mental health services look like in relation to school activity? There is a general expectation that the face-to-face consultations will not continue beyond the pilot. Indeed, the CYPs team had started to 'prepare' schools for the time when these sessions will stop at the point when the last of the fieldwork took place for the evaluation. It was estimated by CYPs management that rolling out the face-to-face contact model across the county would require between 20 and 25 PMHWs.

While this was also anticipated by schools, there was nonetheless a sense of disappointment:

"It feels as though it is being run for lip service. I don't feel as if we are getting something sustainable."

"If the school lead left it would be a significant problem. It would mean a watered-down version moving forwards."

However, there is plenty of momentum for scaling up mental health links with schools in the future, and many of those we spoke to had begun planning for how to build on the pilot's work for the benefit of young people. Plans included "Development of mental health in the curriculum"; "Group work on resilience building and the development of formal pathways incorporating assessment and review"; "We plan to further develop the ways we support staff well-being"; and "More information to parents on how they can support their child."

"There is a risk now of decline. We need to build it into the curriculum. How do you deliver these things on a day-to-day basis within a school?"

- School lead.

There was also some discussion of how to build training in to the teachers' calendars. Several schools are intending to deliver 'Mental Health First Aid' training as part of their new-starter induction training courses. One school lead proposed following the safeguarding model of refresher training every three years.

Case study 2: A Stroud secondary school

“Like gold dust”

This secondary school envisioned a ‘top-down’ pilot, led from the senior management team in order to enable it to be given a high priority and the weight of decision-makers.

School staff had noticed a growing issue with mental health problems among students, which they put down to declining external agency support; societal pressures on teenagers; and increased pressure caused by curriculum changes. They appointed a counsellor, but felt that they still needed to do more. They had had good experiences in the past with CYPS where there were children with high levels of mental health support need, but it was:

“...where the needs are lower level or don’t meet the threshold that frustrations arise. ... I don’t think this is just an issue with CYPS, but we felt that the threshold for referrals was creeping ever upwards”.

While demand was usually high, there were peak times around exams, and they considered Years 7 and 10 to be ‘crisis’ years, because they are times of transition within school. There was a feeling that primary schools were not making diagnoses, but instead just ‘muddling through’ and leaving it to be sorted out at secondary school.

““There was an increasing amount of undiagnosed need coming in at Year 7, perhaps because of anxiety or connected to an educational need that has gone undiagnosed.”

Year 9 was also noted to be challenging because there is a peak in social issues arising outside of school.















The CYPS worker was reported to have provided the central cog in the wheel of the pilot for this school. The school expected that CYPS would provide direct delivery of support, but found the confidence- building with front line staff equally beneficial. The CYPS workers were clear that they had the clinical expertise and access, such as in giving help to access a child’s records.

When the school had their first meeting with the CYPS worker they received a direct email and direct phone number which they couldn’t believe: *“Getting that help is like gold dust”*, they said. There was a powerful sense of relief from staff in this school, though they still felt there was a long way to go:


























“We actually have felt like someone has listened, that for the first time since I’ve been here mental health has been on the agenda – it felt like the forgotten illness.”

Case study 3: A primary school 'worry group'







Circle or colour the faces to show how you feel about each sentence

I like school	    
I have friends at school	    
I feel safe at school	    
I feel safe at home	    
I like coming to this group	    














Circle or colour the faces to show how you feel about each sentence

I like school	    
I have friends at school	    
I feel safe at school	    
I feel safe at home	    
I like coming to this group	    


























Circle or colour the faces to show how you feel about each sentence

I like school	    
I have friends at school	    
I feel safe at school	    
I feel safe at home	    
I like coming to this group	    

Circle or colour the faces to show how you feel about each sentence

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I feel safe at home	    
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I feel safe at home	    
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Circle or colour the faces to show how you feel about each sentence

I like school	    
I have friends at school	    
I feel safe at school	    
I feel safe at home	    
I like coming to this group	    

get sweets, and are
able to say thing without
getting T adged

Talk about different emojis.

talk about feelings and emotions.

have a talk about our feelings.

DO games and have lots of fun.

I have learned that you can't
be ~~honest~~ ^{honest} about your feelings.

I have learned... how to make myself happy!!!

I have learned... *different way to controll anger.*

I have learned that you can feel two emotions at the same time.

I have learned about feeling positive all the time.

I have learned... how to always
feel good and stay
happy.

5.0 Conclusions and recommendations

“This is the start. A spark. We need to run with it now.”

- Pilot school headteacher

In the previous chapters we discussed the characteristics, context and setup of the pilot. We have examined its structure and networks, its implementation and execution, the processes and services within and around it, and its outcomes and impacts.

Looking across all strands of the evaluation, it is evident that the pilot was very successful in achieving the original objectives. What really stands out from the evidence in the report is its apparent impact on intangible factors such as the priority afforded to mental health across different settings, the meeting of and dialogue between organisational cultures, and the confidence and cooperation of very distinct professional groups.

The lynchpin for achieving this appears to be the focus on professional relationships, named contacts, and easy access to advice and consultation.

More specifically, we note:

- The pilot has been popular across all stakeholder groups consulted.
- The pilot has increased mental health activity in schools.
- Relationships have improved between schools and CYPS
- The knowledge and skills of teachers have improved.
- Schools' understanding of referral routes, service challenges, and the wider mental health network have improved.
- School leads' knowledge of the advice line is better, although schools prefer the direct forms of contact and use of the advice line in pilot schools has decreased during the pilot. Email has been well used. This was a new contact option introduced by CYPS for the pilot.
- CYPS team have a better understanding of schools and their working methods. They have a greater appreciation of the time challenges faced by teachers amongst other things.
- CYPS have been given more opportunities for acting preventatively through the development of their remit to work in schools.
- CYPS team are gaining experience in running group sessions.
- School leads have welcomed the raising of the profile of mental health within the school and the opportunity to introduce higher quality internal strategies for managing the needs of CYP with MH problems.
- There have been changes to school systems and processes, and there is evidence that much can be done to embed better approaches within schools, thus giving the promise of some legacy for the pilot work.

- The whole school community has often been engaged with the pilot, with involvement from staff of all types, pupils, parents and governors, although there still remains an issue for some schools around parental engagement and permission being required for intervention.
- The issue of communicating a young person's treatment between services, so that health, mental health and education service are all able to know when a child needs or is receiving support, has been raised.

We also observe:

- There have been significant challenges in bringing together the two organisational cultures of schools and the CYPS service. The pilot seems to have enabled a space to open for growth in their mutual understanding as well as their shared knowledge.
- The pilot has meant a range of professionals have been brought together on the subject of CYP mental health. This multidisciplinary approach to a societal problem has many benefits.
- Teachers feel that they have needed professional advice on how to handle young people in distress or crisis, how to judge and manage risk, what triggers of concern to look for, and where to turn to for appropriate and prompt support.
- Guidance for schools pre-referral prevents inappropriate referrals, and schools can be upskilled in this area so that over time they are able to make more appropriate referrals with less guidance.
- There is a sense that the pilot is a good *start* and that things should move forward from here.
- Schools have experienced a change in the language they use around mental health issues. This is likely to help to improve stigma around the area of mental health and to enable CYP to communicate their feelings more clearly and prevent misunderstandings.
- There is a desire that things should move towards a preventative model where young people taught resilience and coping skills for life at primary school and in years 7/8 and perhaps offered low-level group support where appropriate, in order to help prevent problems that often surface around the middle of secondary education.

The following may prove important in the future:

- Schools need a flexible approach to mental health support that enables it to be tailored to the particular school's starting point and changing needs. In particular, the ability to provide bespoke training is valuable. This is particularly true for schools whose pupils have higher levels of need.
- There are likely to be efficiencies from reductions in inappropriate referrals, the use of GPs as a referral 'broker', and better preventative support as a result of the pilot.
- There are concerns about the sustainability of the pilot's face-to-face consultation model, and alongside this there are questions about the efficacy of any diluted model, because the face-to-face consultations have been important to the pilot's success.
- It may be that schools need higher levels of support at the beginning of any project roll out, but that this can be phased out over time as the skills and confidence of staff improves.
- Some schools spoke of their concern that less engaged schools need help to appreciate the importance of the issue, and that networking and 'champion school' efforts may be necessary

in order to ensure that any rollout of the project reaches all children in the county who are in need.

We particularly note the cultural change that has occurred during the course of this pilot. It was a challenge for professional groups with very different backgrounds and approaches to come together to make changes to outcomes for young people, but it is our view that there has been a difference made to the environment and opportunities for young people Stroud, and which may prove to be a sustainable model for embedding measurable and sustained change in the future. These changes include:

- The upskilling of staff members, who come into contact with many hundreds of young people through their careers, through training and supervision;
- More appropriate referrals being made to the CYPS service by schools, which has positive implications for waiting list lengths, CYPS service demands, and demands placed on GPs and other health services;
- The development of improved language and communication on the subject of mental health within schools;
- The reduction in stigma that may follow from pilot work in schools;
- The structural changes in schools that deliver a higher priority for mental health work, such as governor involvement and embedding in Transformation Plans and headteacher reports;
- The opening of conversation about mental health with the wider school community and parents in particular;
- The improvement of the overall understanding of the mental health training market and the development of a clearer training offer to schools;
- Improved mutual knowledge of services and providers within Gloucestershire who can support the delivery of preventative and low-level mental health services.

Annexes

Annex one: Individual case studies

One of the measures examined during the evaluation was the impact of the pilot upon individual CYP. Individual case studies were provided by schools taking part:

Student A (primary school):

Student A was identified as having behavioural issues that were related to an underlying mental health issue and his attendance at school was poor. The monthly visits provided by PMHWs as part of the Stroud pilot helped teaching staff to develop strategies to keep Student A in school. The close work carried out with the student and teaching staff involved in looking after him helped teachers to work with the student, and in turn have improved his self-esteem and overall behaviour.

Student B (secondary school):

Student B improved her attendance and attainment throughout year 11. However, exam performance continued to be a concern as Student B continued to suffer with stress and anxiety throughout the exam period. As part of the Stroud pilot CYPS offered 'stress-busting' sessions, which Student B attended. As a result, Student B attended all her exams. Although her performance tailed off, her final results were in a better position than her starting point prior to any interventions put in place in term 5 of year 10.

Student C (secondary school):

Home life was difficult for this individual. His attendance in school disintegrated, between 1st September 2015 and the 12th February 2016 his actual attendance in school was 57.1%, 13.6% authorised absence and 29.3% unauthorised. The Educational Welfare Officer was involved. School referred Student C to CYPS as part of the Stroud pilot after a discussion with the PMHW. An agreed action plan with Student C was put in place and passed to teachers to support him in class. Since the original referral, a PMHW has been consistently involved with Student C. Student C's attendance from 12th February 2016 to 24th June 2016 rose significantly to 85.62%; improving his overall attendance to 69.2%. Attendance to date in year 10 is 79% and improving. Student C has had 6 days authorised absence due to illness (up to January 2017) compared to 24.5 days last year.

General comments:

Teaching staff fed back that all students within their primary school had benefitted from the all staff Mental Health First Aid course, for the simple reason that staff were better equipped to identify and support students with mental health issues, and that this had had a huge impact with their school.

Annex two: Technical Appendix



Publications Gateway Ref. 03603

Child and Adolescent Mental Health Service and Schools Link Pilot Scheme

NHS England and the Department for Education are inviting proposals from CCGs working with partners, to apply to become a pilot to improve joint working between school settings and child and adolescent mental health services (local NHS funded CAMHS). Grants of up to £50,000 are available per CCG taking part in the pilot. CCGs will be required to match fund this amount. Up to £3,500 is also available to each school taking part in the pilot. Additional funding of up to £100,000 per CCG will also be available for a small number of CCGs, to opt in to an extension of the pilots which will look at developing models of how to better integrate with children's services that are delivering support to vulnerable children.

Background

Improving children and young people's mental health and wellbeing is one of this Government's key priorities as part of the drive to put mental health on an equal footing with physical health. This pilot is part of the strategic vision for shaping sustainable system wide transformation, to close the treatment gap and ensure support is built around the needs of children and young people.

In September 2014, the Government established the Children and Young People's Mental Health Taskforce. This brought together experts on children and young people's mental health including children and young people themselves, with leaders from key national and local organisations across health, social care, youth justice and education sectors. The aim of the Taskforce was to identify what needs to be done to improve children and young people's mental health and wellbeing, with a particular focus on making it easier to access help and support, and to improve how children and young people's mental health services are organised, commissioned and provided.

The Taskforce report *Future in Mind*¹, published in March 2015, identified that the current system has unintentionally created barriers between services and can result in children and young people falling between gaps, and experiencing poor transition between services. It highlighted some key principles about how to make it easier for children and young people to access high quality mental health care when they need it.

The report outlined a number of actions to help improve access to effective support for children and young people. The actions included the establishment of a named point of contact within CAMHS and a named lead within each school. The named lead in schools would be responsible for mental health, developing closer relationships with CAMHS in support of

¹ *Future in Mind*: promoting, protecting and improving our children and young people's mental health and wellbeing (March 2015)

Key research questions

Key research questions	Research methods					
	Analysis of CYPS / schools admin data	Survey research	Telephone interviews with schools and CYP MH services	Focus groups with CYPS and schools	Focus groups with parents and carers	Interviews with children and young people
A) Processes						
a) What have been the main lessons learned from setting-up and implementing the pilot?			x	x	x	x
b) What are the success factors for having a single point of contact between CYPS and schools, and in what contexts has this worked well / less well?		X	x	x	x	x
c) What role have other organisations within the CAMHS network played within the pilot, and how successfully have they been engaged?		X	x	x	x	x
d) What was is the contribution of the-pilot in strengthening and streamlining relationships between CYPS, schools, educational psychology and the wider CAMHS network?		X	x	x		
e) How have these relationships been maintained, beyond the workshops, and what format / frequency of communication have been needed?		X	x	x		
f) Are there any key messages in terms of working with schools of a different type / profile?		X	x	x	x	x
g) Have all schools engaged with, and achieved, GHLL accreditation?		X	x	x		
h) Are schools, CYPS and other key stakeholders within the wider CAMHS network satisfied with the pilot in terms of the quality and relevance of the		x	x	x		

Key research questions	Research methods					
	Analysis of CYPS / schools admin data	Survey research	Telephone interviews with schools and CYP MH services	Focus groups with CYPS and schools	Focus groups with parents and carers	Interviews with children and young people
training and the value of having the lead points of contact?						
B) Outcomes						
i) Have there been changes to the numbers or type of referrals made <i>internally</i> within schools, and does the pilot demonstrate latent (unmet) demand for support?	x	X	x	x		
j) Is there a net increase in the number / proportion of referrals coming to CYPS from pilot schools over the period covered by the pilot?	x	X				
k) Are similar effects experienced by other partner organisations within the CAMHS network (i.e. educational psychology, school nurses, VCOs)?		X	x			
l) Is there a net decrease in the number / proportion of referrals coming to CYPS from GPs over the period covered by the pilot?	x	x		x		
m) Does the pilot result in improvements to the perceived quality and appropriateness of referrals to CYPS?		x	x	x		
n) Does the pilot result in increased levels and frequency of contact between a) schools and CYPS, and b) CYPS and children and young people, within the pilot schools?	x	x	x	x		
o) Does the pilot result in increased numbers / proportions of referrals converting to Choice	x		x	x		

Key research questions		Research methods					
		Analysis of CYPS / schools admin data	Survey research	Telephone interviews with schools and CYP MH services	Focus groups with CYPS and schools	Focus groups with parents and carers	Interviews with children and young people
	appointments, under the Choice and Partnership model?						
p)	Does the pilot result in improved outcomes for children and young people receiving support from CYPS?	x	x	x	x	x	x
q)	Has the pilot resulted in new or improved systems and processes for handling mental health issues within schools?		x	x	x	x	x
r)	Has the pilot built knowledge and capacity within schools, for supporting children and young people’s emotional wellbeing?		x	x	x	x	x
s)	Did the training provided through the pilot increase levels of skills and knowledge amongst school staff?		x	x	x		
t)	Do staff/pupils know the pathways for support, and do the staff know there is a pilot?		x	x	x	x	x
u)	Has the educational psychology support enhanced whole school approaches to improving mental health including that of staff and pupils?	x	x	x	x	x	x
v)	Are there any other unexpected outcomes from the pilot?	x	x	x	x	x	x
C) Sustainability							
w)	What have been the time / cost implications of participation in the pilot for CYPS, including management, administrative and single point of contact time / costs?	x	x	x	x		

Key research questions	Research methods					
	Analysis of CYPS / schools admin data	Survey research	Telephone interviews with schools and CYP MH services	Focus groups with CYPS and schools	Focus groups with parents and carers	Interviews with children and young people
x) What have been the time / cost implications of participation in the pilot for schools, including management, administrative and single point of contact time / costs?	x	x	x			
y) Does the pilot reduce the demand on PMHWs to deliver training, thereby increasing their capacity to undertake direct clinical work?	x	x	x			
z) How sustainable is the model, and to what extent are PMHW staffing levels / ratios appropriate?	x	x	x	x		
aa) Which elements have the best potential to be scaled-up / replicated within other localities or school clusters in Gloucestershire, and how might this be achieved?	x	x	x	x	x	x

Full list of schools' pilot motivation responses (used to build word cloud):

- Training for the rest of the staff.
- To raise the profile of positive mental health across the whole school.
- We wanted input into how to move forward.
- We wanted support for our children.
- We wanted more confidence for staff about what they were doing already.
- We wanted a more preventative approach.
- We have always had children who are challenged and a caring ethos and this was an opportunity to extend that.
- We have an ever increasing number of students with issues. Self-harm, low moods, school refusers... We felt that we were lacking skills. It was upsetting. Affecting performance and attendance. We felt helpless and the numbers were alarmingly high. None of the help seemed to be joined up.
- There has been a rise in excluded pupils with MH problems.
- There is no provision for children who are self-harming.
- We know our children very well and it became obvious that there were increasing numbers of children needing help.
- We are passionate about this [subject] area.
- We have significant numbers [of pupils] with mental health difficulties.
- We wanted quicker access to support.
- We perceived a need that is growing. We have a ceiling where we know the children need more intense support than we can give.
- We would not have wanted to not be involved.
- We are very passionate about our pastoral work.
- About 18-24 months ago we noticed increasing concerns about the number of mental health cases we were seeing in school.
- We had an appetite for it.
- We wanted to be proactive in the setup of young person's services.
- There was a lack of understanding about why the resources were not there.
- It was a financial incentive to develop and build on our work.
- We had had a couple of pupils who had reached the CYPS threshold but many other children who were not at crisis point and we wanted to improve access for them.

Suggestions for coping with stress

Below are a few practical steps to maintain your health and decrease stress:

- Stay in touch with people who can provide emotional and other support. Ask for help from friends, family, and community or religious organizations to reduce stress due to work burdens or family issues, such as caring for a loved one.
- Recognize signs of your body's response to stress, such as difficulty sleeping, increased alcohol and other substance use, being easily angered, feeling depressed, and having low energy.
- Set priorities-decide what must get done and what can wait, and learn to say no to new tasks if they are putting you into overload.
- Note what you have accomplished at the end of the day, not what you have been unable to do.
- Avoid dwelling on problems. If you can't do this on your own, seek help from a qualified mental health professional who can guide you.
- Exercise regularly-just 30 minutes per day of gentle walking can help boost mood and reduce stress.
- Schedule regular times for healthy and relaxing activities.
- Explore stress coping programs, which may incorporate meditation, yoga, tai chi, or other gentle exercises.
- Seek help if you are overwhelmed, feel you cannot cope, have suicidal thoughts, or are using drugs or alcohol to cope.

Progressive Muscle Relaxation

Sit in a comfortable chair (or lie on the floor, or on a bed).

Ensure you will not be disturbed by other noises.

If you become aware of sounds - just try to ignore them and let them leave your mind just as soon as they enter.

Make sure the whole of your body is comfortably supported - including your arms, head and feet. (Rest your arms on the arms of the chair, with your feet flat on the floor)

Close your eyes. Feel the bed or chair supporting your whole body - your legs, your arms, your head.

If you can feel any tension, begin to let it go.

Take 2 slow and deep breaths, and let the tension begin to flow out.

Become aware of your head - notice how your forehead feels.

Let any tension go and feel your forehead become smooth and wide.

Let any tension go from around your eyes, your mouth, your cheeks and your jaw. Let your teeth part slightly and feel the tension go.

Now focus on your neck - let the chair take the weight of your head and feel your neck relax. Now your head is feeling heavy and floppy. Let your shoulders lower gently down. Your shoulders are wider, your neck is longer.

Notice how your body feels as you begin to relax.

Be aware of your arms and your hands. Let them sink down into the chair. Now they are feeling heavy and limp.

Think about your back, from your neck to your hips. Let the tension go and feel yourself sinking down into the chair. Let your hips, your legs and your feet relax and roll outwards. Notice the feeling of relaxation taking over.

Think about your breathing - your abdomen gently rising and falling as you breathe.

Let your next breath be a little deeper, a little slower...

Now, you are feeling completely relaxed and heavy.

Lie still and concentrate on slow, rhythmic breathing.

When you want to, count back from 5 to 1 and open your eyes.

Wiggle your fingers and toes, breathe deeply and stretch.

Pause before gently rising.

What to do when you feel anxious

STOPP Pause, take a breath, don't react automatically



THINKING DIFFERENTLY

Ask yourself

- What am I reacting to?
- What is it that I think is going to happen here?
- **Is this fact or opinion?**
- What's the worst (and best) that could happen? What's most likely to happen?
- Am I getting things out of proportion?
- How important is this really? How important will it be in 6 months time?
- Am I overestimating the danger?
- Am I underestimating my ability to cope?
- Am I mind-reading what others might be thinking?
- Am I believing I can predict the future?
- Is there another way of looking at this? What's the **helicopter view?**
- What advice would I give someone else in this situation?
- Am I putting more pressure on myself?
- Just because I feel bad, doesn't mean things really are bad.
- What do I want or need from this person or situation? What do they want or need from me? Is there a compromise?
- What would be the consequences of responding the way I usually do?
- Is there another way of dealing with this? What would be the most helpful and effective action to take? (for me, for the situation, for others)
- **Challenge your automatic thoughts**

Visualise yourself successfully coping with the situation that you feel anxious about. See it through to a successful completion.

CYPS STROUD SCHOOL PILOT NETWORK PLAN MEETING FORM

DATE:

Following the initial visit to school please complete this data sheet....

School Information		Type of Meeting (if not a Network Plan Meeting) please select one	
School Name		Team Around a Child Meeting	
School Year		Child Protection	
Gender		High Risk Planning Meeting	
		SEND	
		Direct contact with CYP/Parent	

Key Issues (please select one for each category)	For CHILD discussed	For STAFF
Anxiety and Phobias (inc Generalised Mental Health Issues & Emotional Dysregulation)		
Behaviour and Anger Issues		
Eating Issues		
Family Issues (inc Domestic Violence)		
Gender Identity Issues		
Low Mood/Depression		
Neurodevelopmental and Concentration Issues		
No Mental Health Issues identified		
Psychosis Concerns		
Safeguarding Concerns / Procedures		
School Based Concerns (inc Attendance and Learning Difficulties)		
Self-Harm and Risk (inc Suicidal Ideation)		
Social/Peer Isolation		
Substance Misuse		
Managing a Child's Distress	
Reflective Practice	
Staff Wellbeing	
Training / Staff briefing or Supervision	
Other (specify)	

Outcome of Network Plan Meeting agreed with	School (select one)
Advice via Practitioner Helpline	Training options (inc CYPS specify)
Classroom Observation	Signposting (specify) _____
CYPS Consultation Slot	Training request received
Further work needed by School	Advice to Parents
Group Work	CYPS CHOICE meeting (venue tba) **
MAM	Direct Work by PMHW
Meeting completed/No further action	Further targeted school intervention required

** Please check if already open to CYPS. If not, please refer to CYPS.

CYPS Staff information resource

Signposting Options
ED Psych
Families First
Families Lives
GP
None
Paediatrician
Parenting Course
School Nursing
Self Help
Social Care
Social Groups/Clubs
The Door
Local Counselling (TiC+, GSC)
Winston's Wish
You, Me and Mum
YST / Police
YST & TIC
Other (please specify)
Self-help/ Online resources

**CYPS STROUD SCHOOL PILOT
GROUP WORK FORM**

The form needs to be completed following each group session.

School Information	
School Name	
School Year	
Gender	

Group Details	
Group title	
Date	
Total attendances	
Total no of sessions	

Focus of Group Session	
Coping Strategies	
Peer Relationships	
Think Good Feel Good	
Exam Stress	
Other (specify)	

Outcome of the Group Work (please select one)	
Further work needed by school	
Further work needed by CYPS Clinician	
No further work required	

**CYPS STROUD SCHOOL PILOT
TRAINING WITH STAFF FORM**

The form needs to be completed following each training session.

School Information	
School Name	
School Year	
Date of training	
Total No attendances	
Members of staff present (inc staff role)	

Type of Training (please specify)

Outcome agreed with school (select one)	
Further work needed by school	
Further work needed by CYPS Clinician	
Group Work	
Outcome achieve/ No further action	

Albert House
Quay Place
92-93 Edward Street
Birmingham
B1 2RA
United Kingdom

T +44 (0)121 212 8800
F +44 (0)121 212 8899
E Birmingham@uk.ecorys.com

www.ecorys.com

