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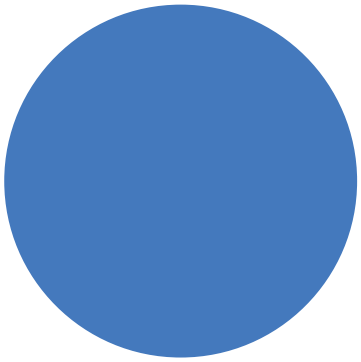

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- All Participating TaMHS Schools (appendix)
- The TaMHS Leads within Participating Schools (appendix)
- The TaMHS Steering Group (appendix no)
- Intervention Leads (appendix no)
- Operational Group
- Evaluation group
- Carmen Cadgwan TaMHS Administrator

Report and data compiled by

- Michelle Pye – *TaMHS Programme Lead*
- Liv Kleve – *Evaluation Lead*
- Ben Hooper – *Assistant Psychologist*

If you require further information or detail relating to either the TaMHS Programme or the evaluation then Michelle or Liv are happy to be contacted via email:

- Michelle Pye
  TaMHS Programme Lead & Primary Mental Health Specialist
  CAMHS
  Marina Health Care Centre
  2 Haven View
  Portishead BS20 7QA
  Email: m.pye@nhs.net
- Dr Liv Kleve
  Avon and Wiltshire Mental Health Partnership trust.
  Consultant Clinical Psychologist
  North Somerset Specialist Children's Services
  CAMHS
  Drove Road
  Weston-super-Mare
  North Somerset BS23 3NT
  Email: liv.kleve@nhs.net

Contributions:

Gabrielle Stacey for conducting staff surveys

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Abstract

This report details the evaluation of the North Somerset TaMHS programme during the time span April 2010 to April 2011. A brief introduction identifying important reasons for early mental health interventions and the key areas addressed during this project is followed by the method section. An outcome evaluation approach has been used; measuring changes at group, whole school and inter agency levels comparing presentations before and after TaMHS interventions using both quantitative and qualitative methods. This is followed by descriptions and results for each group intervention and training programme including FRIENDS, Season for Growth, SEAL, Breakthrough, Dreamwall, Go-peutics, Mental Health workshop and ELSA. Results highlight positive trends for all interventions and statistically significant changes for some. Whole school and interagency measures showed significant changes in staff perception following TaMHS on a range of school practices related to mental health, but there were no differences in outcomes comparing TaMHS and Non TaMHS schools in relation to student absence, exclusion rates and managed transfers. Qualitative feedback from schools highlights a positive view of the TaMHS project and a wish to continue several of the interventions. Value was linked to having a clear project lead, support to implement interventions and many appreciated using independent programme facilitators instead of school staff. Challenges included the sheer volume of activities implemented during a short time frame and aspects of the evaluation. TaMHS results are reviewed and discussed in the last chapter. Recommendations include more staff training in the understanding and identification of mental health problems, ensuring that school staff take on the delivery of early mental health interventions and that mental health work is supported by school seminar leadership teams. We recommend that supervision is integral to any mental health provision delivered within schools.

1

Background

Overview of TaMHS

The Targeted Mental Health in Schools Programme (TaMHS) was devised by the labour government following a review by the DFES & Treasury 2007: Aiming High for children & supporting families.

This review identified that there was a lack of capacity in "lower level" mental health support which presented a barrier to delivering Early Intervention for children and young people at risk of developing mental health problems.

This was further supported by findings following a National Review of CAMHS (Children Adolescent Mental Health Services) 2008, the development of the Nice Guidance : social and emotional wellbeing in Schools, alongside delivery strategies such as PSA 12 : Delivery strategy focusing on health promotion, ill-health prevention, early intervention and effective support from practitioners

The response was for TaMHS to become part of the Governments Child Health Strategy promising:

> A commitment to provide funding to ensure local areas can build on and roll out effective practice in supporting children & young people with social and emotional difficulties in schools

For this to be delivered, the Department for Children Schools and Families, (DCFCS, now known as the DFE following the change of Government) agreed to invest £60 million during the period of 2008-11.

This was to be delivered in 3 phases:

- Phase 1 – 25 pathfinder local authorities (3 years funding)
- Phase 2 – a further 55 local authorities (2 years funding)
- Phase 3 – remainder of local authorities (1 years funding)

Developing evidence based models of mental health support in schools

- For children & young people aged 5-13 yrs and their families
- Who are at risk of and/or experiencing mental health problems
- Builds upon existing universal work in schools to promote pupils social & emotional development.
- Compliments Healthy Schools and Social Emotional Aspects of Learning (SEAL) Programmes
- Provides targeted support which can be run by school staff for those pupils needing enhanced support

North Somerset became a Phase 3 authority initially in Sept 2009 by providing information as a control group to earlier phases by partaking in the "Me and My Schools" National Evaluation, providing data and information relating to what approaches work best to help children in schools with mental health problems and identifying the best ways to help schools implement these.

The TaMHS Programme came with a one year grant, with funding commencing in April 2010 until April 2011. Initial planning took place with the schools and the TaMHS Programme between March and September.2010. Interventions within most of the schools commenced between September 2010 – March 2011. Some schools have staggered their interventions and as a result some interventions have only recently commenced activity

The TaMHS model has a significant role to play in ensuring the mental health needs of Children and young people are appropriately considered and that strategic and operational plans across all services reflect this. It has sought to ensure continuity, integration and collaborative practice when planning interventions or services.

It has afforded an opportunity and framework to enhance universal and targeted interventions, pulling together key strategies through the utilisation of existing partnerships and the children's workforce to deliver a more flexible, responsive, and innovative service to young people and their families.

We have attempted to address key areas of concern within schools through:

- Implementation of a range of interventions to meet the needs of the children and young people experiencing or at risk of developing mental health problems
- Provide a comprehensive training, support and supervision programme for teachers/support staff in mental health issues building capacity and confidence in dealing with vulnerable young people in school. (This remains ongoing at time of writing this report.)
- Opportunity to develop cohesive pathways for identified mental health issues resulting in Early intervention and appropriate referrals to Specialist Services
- Comprehensive mapping of needs, service delivery and gaps in provision within the (TaMHS) schools.
- Joined up working in order to deliver positive outcomes for young people as highlighted in PSA 12.

Our main focus has been to create sustainability beyond the scope of TaMHS. Within this the decision was taken early on not to separately employ a TaMHS workforce but to utilise the skill, expertise and knowledge within existing services. Our primary aim has been to build capacity, expand the good practice that already exists within our schools.

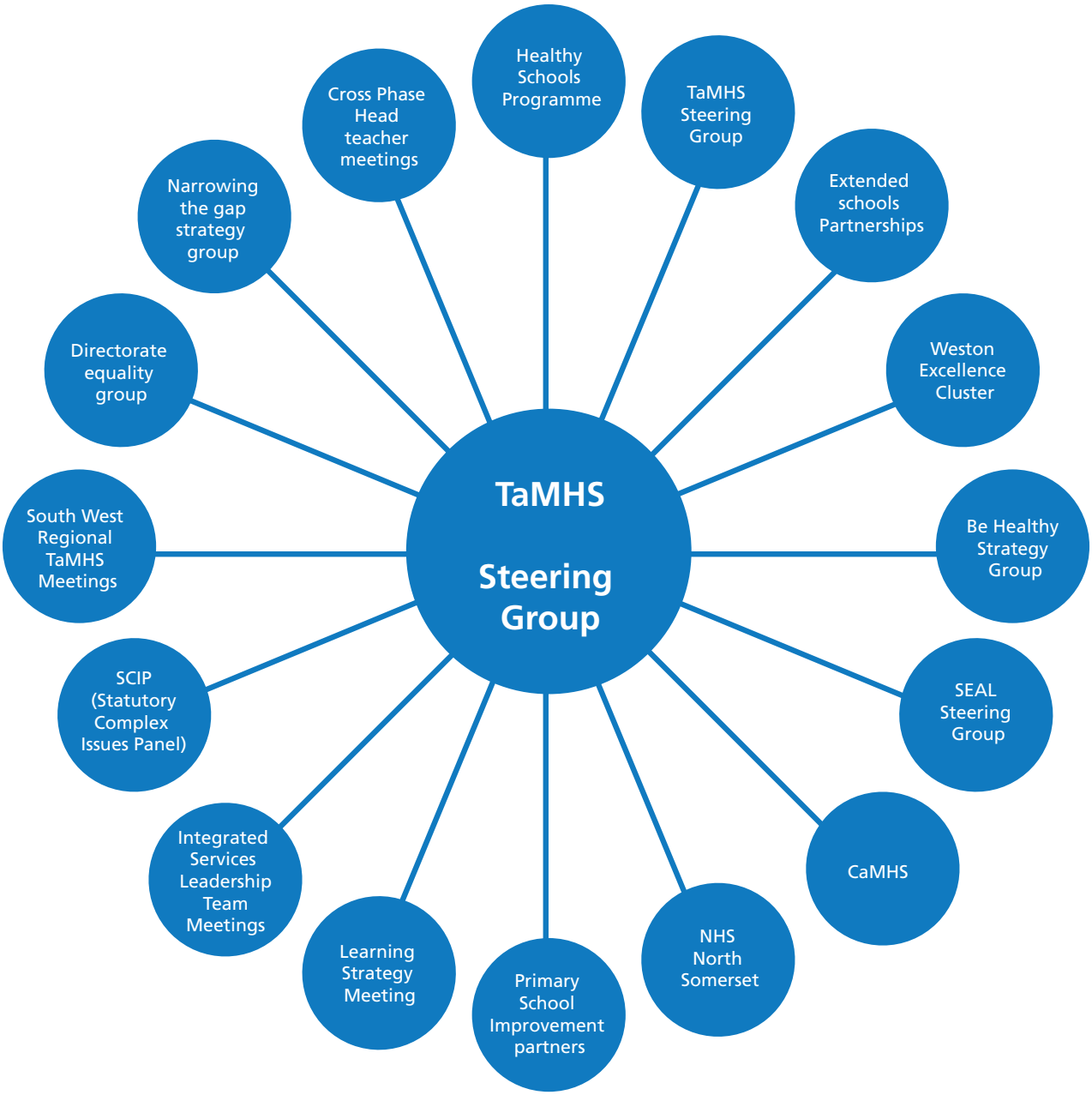
In order for this approach to work it was clear we would need a strong collaborative approach to the steering of the TaMHS Programme and in particular a commitment from service managers to ensure that the existing workforce would be able to deliver the operational model and support the school based staff.

Members of the Steering group were selected from a wide base of expertise, knowledge and availability across Health, Education and CYPS. Others were also selected to feed into the programme's infrastructure and together with the main steering group were responsible for the delivery and long term sustainability of the identified model of mental health to Children and Young People in North Somerset.

The purpose therefore of this report is to share the findings of the North Somerset Targeted Mental Health in Schools Programme, to share best practice to improve the outcomes for all children and young people, their Mental health* and emotional wellbeing.

* *This report has been limited to providing information related to the TaMHS findings. We have been unable to explore mental health in any depth within the remit of this report. If you require any further information we are happy to be contacted.*

TaMHS Links

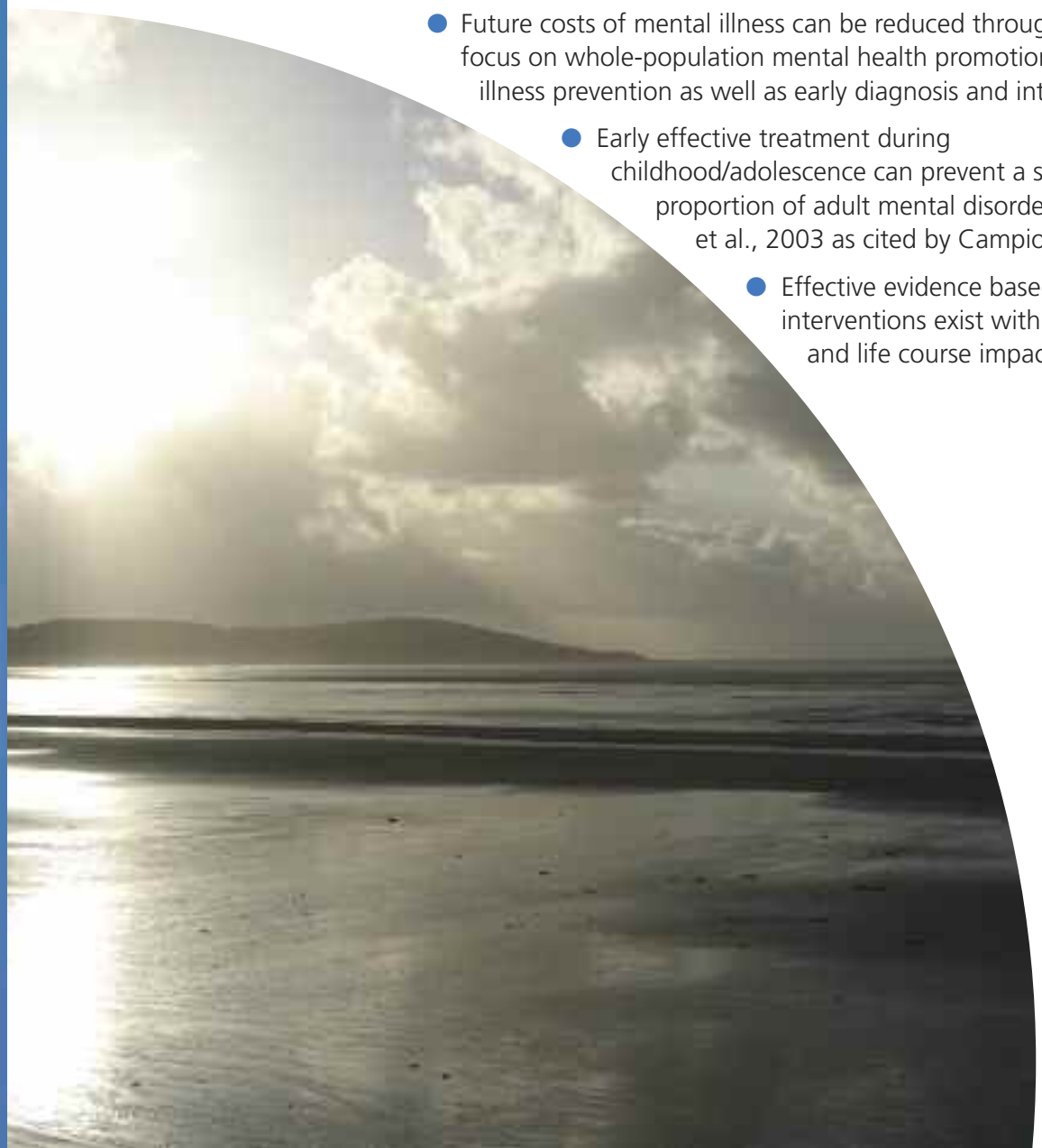


- *This diagramme seeks to demonstrate the integrated and collaborative practice that has taken place by TaMHS Steering Group members .It shows how members of the steering group have acted as a conduit for TaMHS ensuring the key considerations for children and young people are considered.*

Some facts about mental health

"Mental health is a state of well-being in which an individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and is able to make a contribution to his or her community. In this positive sense, mental health is the foundation for individual well-being and the effective functioning of a community," (WHO, 2011).

- The United Kingdom is ranked bottom on children's emotional wellbeing compared with North America and 18 European Countries (UNICEF, 2007) and ranked 24th out of 29 European countries in a more recent survey (Bradshaw and Richardson, 2009).
- 10% of children and young people have a clinically recognisable mental disorder (Green et al., 2005).
- 50% of lifetime mental illness starts by the age of 14 years and 75% by mid-twenties (Kessler et al., 2007).
- Poor mental health is linked to poor educational attainment; increased health risk-behaviour and physical illness, increased anti-social behaviour and crime.
- Mental illness is the single largest cost £10.4 billion (10.8%) of the NHS budget (Centre for Mental Health, 2010).
- Future costs of mental illness can be reduced through greater focus on whole-population mental health promotion, mental illness prevention as well as early diagnosis and intervention.
- Early effective treatment during childhood/adolescence can prevent a significant proportion of adult mental disorder (Kim-Cohen et al., 2003 as cited by Campion, J, 2010).
- Effective evidence based interventions exist with both short and life course impact.



"By Promoting good mental health and intervening early, particularly in the crucial childhood and teenage years, we can help prevent mental illness from developing and mitigate its effects when it does"

No Health without Mental Health: A cross Government strategy (DOH, 2011)

The mental Health of children and young people is increasingly recognised as being fundamental to the wellbeing and future prospects of individuals and communities. We know that Children who are emotionally healthy achieve more, are able to participate fully with their peers, engage in less risky behaviour and are better able to cope with adversities they may face. (DOH, 2004)

Mental health has been defined as:

> "A state of wellbeing in which the individual realises his or her own abilities, can cope with the normal stresses of life can work productively and is able to make a contribution to his or her own community"

Emotional Wellbeing has been defined as:

> "A positive state of mind and body, feeling safe and able to cope, with a sense of connection with people communities and the wider environment"

When we talk about mental health problems we are talking about different degrees of difficulty. There is no one divide between mental illness and mental health. We all sit at different times and in different ways along what can best be called a continuum of mental health (Wilson, 2004)

Whatever language we use there is increasing evidence to suggest that if mental health issues are not addressed during childhood that this may have serious implications for health and social outcomes in adulthood. National Service Framework for Children Young People and Maternity Service (DOH, 2004) makes reference to mental health problems in childhood being associated with youth offending, failure in achieving academic success, anti social behaviour and problems within families.

Despite this most Children and Young People are part of happy healthy families with parents & family members providing for their emotional development. However not all children are able to access this from their parents or extended family members and are reliant on other positive influences and everyday experiences to develop their Mental Health and emotional well being e.g. Schools, voluntary groups, community activities; e.g. sports clubs, drama groups, peer group and social networks.

A mentally healthy child has the ability to:

- Initiate, develop and sustain mutually satisfying personal relationships
- Use and enjoy solitude
- Become aware of others and empathise with them.
- Play and learn
- Develop a sense of right and wrong
- Resolve (face) problems and setbacks and learn from them.
- Develop psychologically, emotionally, intellectually and spiritually

We know that a significant proportion of young people will experience issues with their emotional health and wellbeing during their childhood and adolescent years. Most will be able to contain and overcome these with the support of family and friends. However a number of young people, due to their personal circumstances, may be more vulnerable and may present a higher risk * in the development of mental health issues and as such may require additional support (NCSS, 2011)

* *not all young people who fall within a vulnerable group will necessarily go on to develop mental health problems. Many will have a range of protective factors that will provide them with some resilience.*

Vulnerable groups at greater risk of developing mental health problems:

- Children Looked After
- Living with specific disabilities e.g.: chronic health problems, learning disabilities
- Children whose parents have a mental health problem
- Hidden Harm e.g. Drugs, alcohol, domestic abuse
- From a black and other ethnic minority group
- From low income families
- Travelling Communities
- Who may be Lesbian, Gay, Bisexual or Transgender

Government policy over recent years has been to introduce a range of strategies and policy documents which support the need for an integrated workforce, working collaboratively with core values and common goals to address the mental health needs of children young people and their families. Some of these drivers have become embedded in strategic planning across all agencies and service providers e.g.: Every Child Matters, Change for Children programme (DCFS, 2004), The Children's Plan, Building Brighter Futures, (DCFS, 2007), and Healthier Lives, Brighter Futures (DFCS 2008).

In order to improve outcomes for children young people and their families the Governments current approach is to develop Early Intervention and Prevention Programmes. The strategic vision for this is evident in: the public health white paper: *Healthy lives, Healthy People, and in the more recent mental health strategy - No Health without Mental Health*. Graham Allen's Review of Early Intervention makes a recommendation that the Targeted Mental Health in Schools Programme be considered as a model of mental health support when commissioning Early Intervention Programmes.

Interventions chosen by North Somerset TaMHS

The population served by North Somerset is 206,800 with 42,440 children and young people under the age of 18. Weston-super-Mare contains the highest areas of deprivation in North Somerset and is one of the most deprived in the UK.

In total 13 schools participated (*Appendix A*) with children being 4 years of age (Reception) to 14 Years of age (Year 10). Each school identified a TaMHS Lead who had direct responsibility for the implementation of TaMHS interventions within their school. Regular support and guidance was given by the TaMHS Programme lead in addition to the Intervention Leads who had a responsibility in liaising direct with schools in order to ensure that the individual programmes delivered were able to be implemented effectively.

A significant proportion of the interventions had supervision of staff as an intrinsic part of the support offered by TaMHS ensuring the development of skills and knowledge and sustainability beyond TaMHS in addition to developing a working model of support and embedding of supervision to schools as core work between Specialist agencies e.g.: Primary Mental Health Specialists, Educational Psychologist, Inclusion Advisory Team and SEAL Programme Lead and schools.

Using information taken from North Somerset Children and Young People's Joint Needs Assessment (Dec 2009) and the CAMHS Self Assessment Matrix, the TaMHS Steering Group decided that North Somerset would build on already established and successful interventions to provide enhanced support for children, young people and their families' experiencing:

Emotional disorders
e.g.: Anxiety, Depression and Attachment Disorders

Interventions chosen:

- FRIENDS (Barrett, Lowry-Webster & Turner, 1999)
- SEAL (Lendrum, Humphrey, Kalambouka et al., 2009; Hallam, Rhamie & Shaw, 2006)
- 'Go-Peutics' – a Lego© play based intervention (Legoff & Sherman, 2006; Owens, Granader, Humphrey et al., 2008)
- Mental health workshop

Loss and Bereavement:

To include children experiencing loss through parental separation, parental mental health concerns, and domestic violence etc.

Interventions chosen:

- Seasons for Growth (SFG) (DHA, 1999; South Australian Department of Human Services, 2004; UOM, 2005 and the UCQ, 2008).

Conduct disorders

Working with vulnerable and challenging children whose behaviour interrupts their own and others learning.

Interventions chosen:

- Breakthrough
- Dream-wall.
- ELSA (Humphrey et al, 2008; Burton, 2004 & 2008).

Workforce Development

An important component of TaMHS has been to devise a Core training Programme that will support staff in schools and other settings by building up their skills set and confidence in promoting the mental health needs of all young people and to provide support and supervision for staff wellbeing within schools.

In order to deliver a core training programme the following agencies are pivotal in the delivery, EPS, PMHS, and CAMHS. Other agencies will be approached to provide enhanced training around specialist areas in line with current CPD Practice. Joint training between agencies is good practice and therefore recommended.

Each school has been offered a core training programme to include:

- MH Awareness
- Attachment
- Risk & Resilience
- Stigma and the use of language
- Information about specific disorders/mental health conditions e.g.: anxiety, depression, eating disorders etc.
- Staff wellbeing
- Whole school approach- what makes a difference & how – Katherine Weir.

All schools have received training and supervision in order to deliver identified interventions within their schools. 5 Schools have identified an action plan for core training based on their individual needs. The remaining 8 schools will be offered a core training package in Sept 2011. All training delivered will be offered cross phase as appropriate.

For enhanced training, schools have been asked to identify need and agencies will be approached to provide the training as necessary or if training is currently delivered as part of the North Somerset CPD Programme schools will be encouraged to access this.

Schools have been offered a range of training options: whole day, twighlights, and morning or afternoon sessions and or in clusters if preferred.

Core training offered will be delivered to different tiers of staff within the schools e.g.:

- members of the SLT, Year Heads and Heads of House
- SEN Team
- Teachers
- LM's & TA's

Action Planning

The process in which the schools have been asked to follow in order to determine their training programme is as follows:

1. Schools to identify need based on their data set e.g.:

- PASS Survey
- FSM
- Behaviour & Attendance
- SEN
- FSM
- FFT

Focus to be on needs of vulnerable groups and linked to the SEF.

2. Initial planning meeting to take place with TAMHS Lead (School based) and member of the SLT if different to TaMHS lead. And two members of the TaMHS Steering Group. (TaMHS Lead & one other)
3. Model of delivery and dates for CPD Programme to be agreed at the initial meeting any enhanced training to be identified.
4. Ongoing support for policy development and embedding the language of emotional literacy throughout the whole school thereby creating a whole school ethos and understanding of emotional health.
5. Identification of staff support and supervision framework/model.
6. Regular review of training programme matched against outcomes.

2

Method

2.1 Evaluation strategy

Evaluation is the process of making judgements based on criteria and evidence.

By conducting a systematic evaluation we are in a better position to

- Inform practice.
- Build evidence of what works.
- Choose the best and most effective interventions.
- Learn how best to implement interventions within and across organisations.

The overall aim of this evaluation has been to identify "what works" in helping children and families with or at risk of experiencing mental health problems. An OUTCOME EVALUATION approach has been used, measuring changes in presentations before and after interventions. The evaluation has taken into account outcomes at different levels including *group, whole school and interagency changes* as a result of TaMHS.

More specifically *objectives* sought to answer the following questions:

Group level

- Are the selected approaches (described under result section 3) effective in helping children with mental health issues?
- What are student and staff perceptions of the different interventions?
- Do training programmes (described in section 3) help raise student and staff ability and confidence in addressing mental health issues?

Whole school level

- What number of young people and staff have been involved in TaMHS? (assessment, individual and group interventions)?
- What number of supervision and consultation sessions were delivered to staff?
- What are the changes in staff perception of their school's ability to address mental health issues following TaMHS?
- What effect does TaMHS have on school absence, exclusions and managed transfers?
- What are school perceptions of facilitating factors and obstacles to engagement and implementation of TaMHS?

Interagency level

- Does TaMHS have an effect on staff perceptions of access to CAMHS?
- Does TaMHS affect referrals to specialist support services (including Education Other Than Schools (EOTAS), Behaviour Improvement Programme (BIP) and Pupil Referral Unit (PRU)?
- How does North Somerset schools compare with national data on levels of emotional problems, behavioural problems and school climate? (Information from 'Me & My school' 2010 report).

2.2 Measures

All interventions were quantitatively measured and supported with qualitative measures where appropriate. All quantitative measures were evidence based, ensuring good reliability (stability in measure over time) and validity (that the test measures what it claims to measure e.g. anxiety).

Pre & post questionnaires were completed for: MHW, FRIENDS, Breakthrough SFG, Go-Peutics & SEAL, ELSA – with 6-month follow up as well. Dreamwall was qualitatively evaluated by interview and feedback.

All questionnaires were anonymous and students were requested to indicate on a cover sheet their age, gender, school and the first two letters of their street name.

Group intervention measures used:

- **FRIENDS for life** – included The Spence Children's Anxiety Scale (SCAS) (Spence, 1998).
- **Seasons for Growth** – Used the Strengths and Difficulty Questionnaire (Goodman, 1997 & 2001) and Short-Moods and Feelings Questionnaires (SDQ and SMFQ) (Costello & Angold, 1988; Angold, Costello, Messer et al. 1995).
- **'Go-Peutics'** – Using the teachers SDQ (Goodman, 1997 & 2001) comparing presentations before and after intervention.
- **SEAL and Silver SEAL** – Emotional Literacy was measured using Emotional Literacy Questionnaire (ELQ) Southampton Psychology Services (SCC, 2003). The checklists covers the five SEAL dimensions, creating a profile showing areas of strength and weakness across these dimensions: Self awareness, Managing emotions, Motivation, Empathy and social skills (DfES, 2005a; DfES, 2005b; Lendrum, Humphrey, Kalambouka et al., 2009 ; Downey & Williams, 2010)
- **Breakthrough project** – Used the self-completed Strengths and Difficulty Questionnaire (SDQ) (Goodman, 1997 & 2001).
- **Dream-wall** – A predominantly qualitative approach was taken to the evaluation of Dream wall's intervention for North Somerset. This is because it is a high intensity programme delivered to a small number of participants, making it possible to interview a large proportion of those involved, and obtain their perceptions of effectiveness and the experiences of the young people attending. Three semi-structured interviews were designed to be used with the three target groups of:
  - The boys themselves,
  - Their parents and
  - School staff.

The interview schedules followed a similar structure with all three groups asked to describe how the boys were before the Dreamwall initiative began and how they had been since. Although ideally all participants and their parents and school staff would have been interviewed, within the limited time constraints it was decided that the evaluation would focus on the school with the larger number of participants, which was four. In addition, the students' positive and negative marks, detentions and exclusions over the period were compared to provide some quantitative data.

Measures in relation to this intervention are both qualitative and quantitative and have involved semi-structured interviews of pupils, teachers and parents, measuring both pre and post intervention with regards to attitudes and behaviours.

- **Mental Health Workshops (MHWs)** – Measures were conducted using a Likert-scale measure with self-reported ratings of '1' (strongly disagree) to '5' (Strongly agree) across three statements of interest:
  - *"The majority of people are likely to have known a friend or family member(s) who have experienced a mental health problem."*
  - *"A wide range of stressful events (e.g. exams, relationship difficulties, family problems) could all have a negative impact on a young person's mental health."*
  - *"If I, or someone I know, were to experience mental health difficulties, I would know where to go for support."*
- **ELSA** – This training programme used a Likert-scale measure with self-reported ratings of '1' (strongly disagree) to '5' (Strongly agree) across four questions of interest:
  - *"I feel confident about helping children improve their behaviour".*
  - *"I feel confident about helping children improve their social skills."*
  - *"I feel confident about identifying children who need support to improve their behaviour and social skills."*
  - *"I feel confident about monitoring progress in children's behaviour and social skills."*

Whole school measures

A **Semi structured questionnaires interview conducted with staff before and after TaMHS**

- Staff in each participating school were issued with a questionnaire early in the programme (September 2010) and again towards the end of the programme (March 2011).The questionnaire consisted of 16 statements focused on a number of themes:
  - Whole school practices and policies
  - Understanding of mental health and identification of mental health difficulties
  - Referral to mental health professionals
  - Intervention with pupils
  - Staff well being
  - Involvement of pupils and parents

For each item, participants were required to indicate on a 5-point Likert scale the extent to which they agreed with the statement. A score of 5 indicated that the participant 'completely agreed' with the statement. A score of 1 indicated that the participant 'completely disagreed' with the statement.

Each participating school was asked to select 5 members of staff to complete the questionnaire as follows:

- Head Teacher
- Special Educational Needs Coordinator (SENCo)
- TAMHS Coordinator
- Teacher (selected at random)
- Learning Support Assistant (LSA) (selected at random)*

** LSA and teachers were randomly selected*

B Telephone interview towards the end of TaMHS programme with school heads and senior staff within schools.

C School absence and exclusion rates comparing data from term 2 & 3 in 2009/10 to term 2 & 3 in 2010/11 between TaMHS and non-TaMHS schools.*

Interagency measures

A Semi-structured questionnaires conducted with school staff before and after TaMHS, focussing on access to CaMHS. (see above)

B Referral rates to specialist support services (including EOTAS, BIP, PRU) comparing term 2 & 3 2009/10 to term 2 & 3 2010/11 between TaMHS and Non-TaMHS schools.*

C Managed transfers comparison of data from term 2 & 3 2009/10 to term 2 & 3 2010/11 between TaMHS and Non-TaMHS schools.*

** The selection criteria for comparison of non-TaMHS schools with TaMHS schools in these measures were based on numbers on roll and percentage of pupils receiving free school meals.*

2.3 Implementation strategy

The implementation strategy for TaMHS has ensured that several tiers and agencies have worked in an integrated manner *(see page 7 for how these individuals have been linked to key services)*.

In order to ensure that the aims and objectives were delivered several strategy and working groups were set up including:

- **TaMHS steering group,** meeting six-weekly and responsible for developing and delivering the overall strategy.
- **Evaluation group**, meeting six-weekly and responsible for developing the evaluation strategy and coordinating the evaluation of TaMHS.
- **Operational group**, meeting bi-monthly and responsible for planning and implementing the different interventions
- **Intervention lead group,** meeting bi-monthly facilitating information, support and coordination of all group leaders.

3.1 Group changes

Q: Are the selected approaches effective in helping children with mental health difficulties?

Q: What are student and staff perceptions of the different interventions?

3

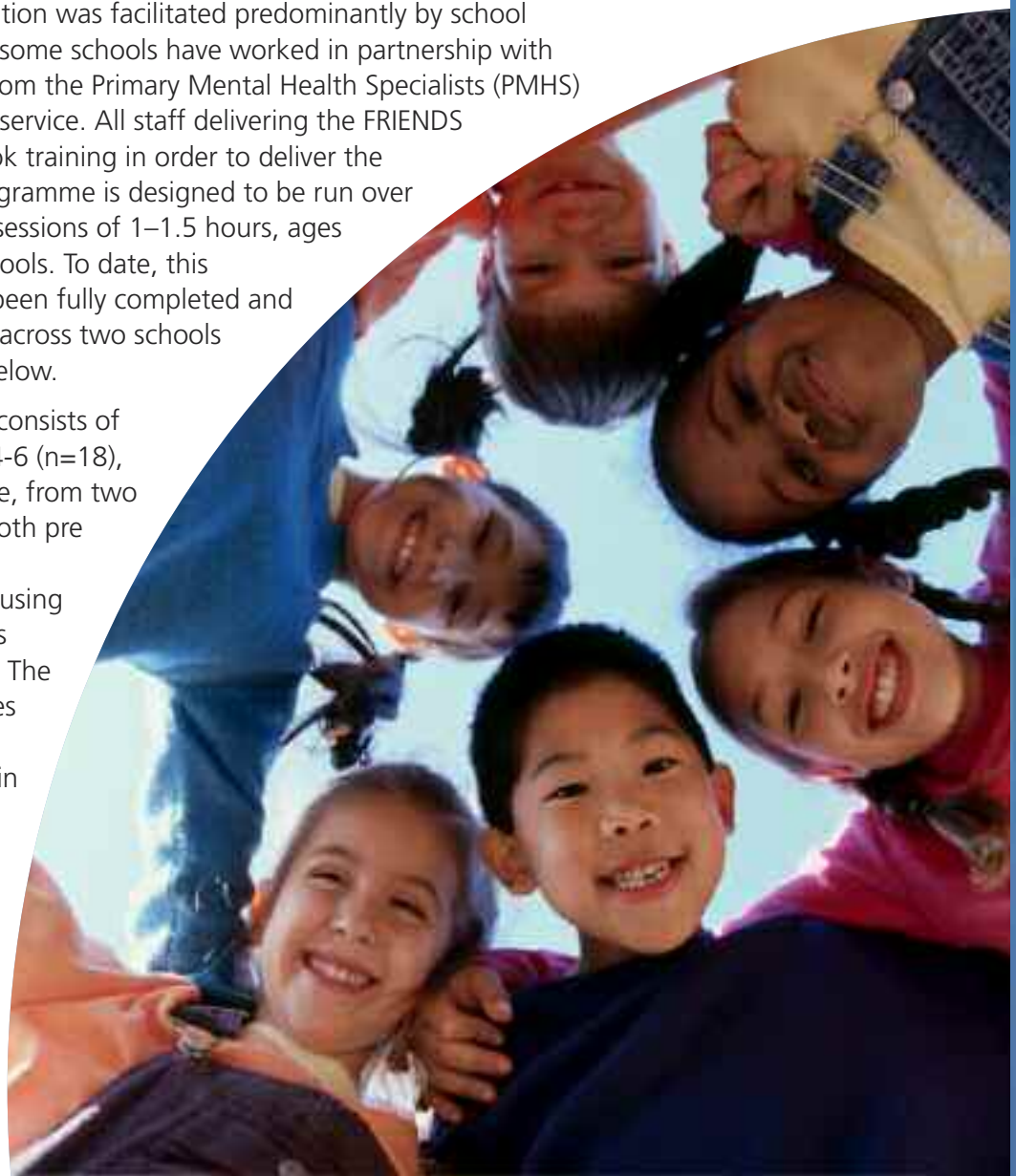
Results

"FRIENDS' programme

FRIENDS for LIFE – is a universal 10 session cognitive behaviour therapy (CBT) programme designed to promote children's emotional resilience (Essau, Muris & Ederer, 2002; Stallard, Simpson and Anderson et al. 2005 & 2007). FRIENDS utilises behavioural, physiological and cognitive strategies teaching children to identify their anxious feelings; to learn to relax; to identify unhelpful anxiety provoking thoughts to replace these with more helpful thoughts and develop problem solving skills.

Research evaluation of the FRIENDS programme has shown that it is effective in reducing anxiety across age ranges and over time (e.g. Miller, Laye-Gindhu, Liu et al, 2011; Pahl & Barrett, 2010; Stallard, Simpson, Anderson et al., 2007 & 2005; Taylor & Stanley, 2002). Some studies have suggested that it is more successful for the lower age groups (Barrett, Lock & Farwell (2005) and for children with more severe emotional problems (Stallard et al 2011).

The FRIENDS intervention was facilitated predominantly by school based staff although some schools have worked in partnership with external facilitators from the Primary Mental Health Specialists (PMHS) & the school nursing service. All staff delivering the FRIENDS programme undertook training in order to deliver the intervention. The programme is designed to be run over a 10-week period in sessions of 1–1.5 hours, ages 7–16 years, in 10-schools. To date, this programme has not been fully completed and measures conducted across two schools only, are presented below.



Data presented here consists of students from years 4-6 (n=18), 10-male and 8-female, from two primary schools for both pre and post intervention measures as collated using The Spence Children's Anxiety Scale (SCAS). The results for the changes in total SCAS anxiety scores are presented in Figures 1 & 2 below.

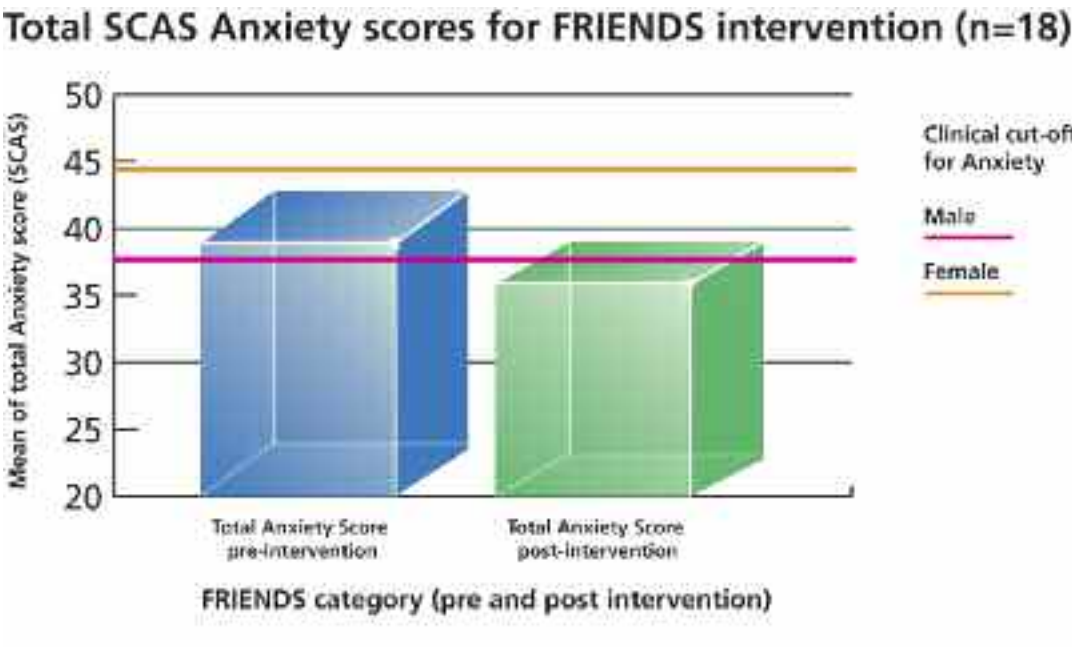


Fig.1 – Total anxiety scores for pre and post FRIENDS intervention. The graph also shows clinical cut-off for both male and female pupils (n=18).

N.B. – Additional detailed data is available on request

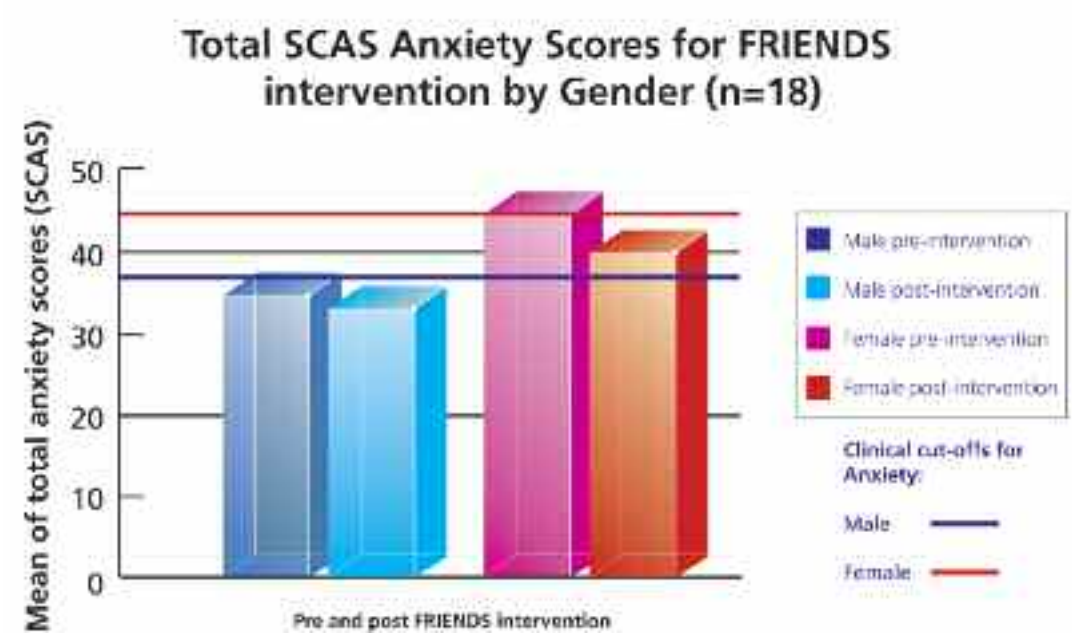


Fig. 2 – demonstrates the total SCAS anxiety scores by gender, for pre and post FRIENDS intervention. It also shows clinical cut-offs for male and female anxiety scores (n=18).

Figure 1 & 2 show that. boys scored below clinical cut off before intervention but girls scored just above clinical cut off indicating that they experienced mild levels of anxiety prior to engaging in Friends. The figures also show that there is a trend for anxiety to reduce following Friends for both boys and girls. However, a repeated measure ANOVA found no statistically significant difference between the mean scores pre and post (*Social Phobia* intervention: *Panic/Agoraphobia*

(P = .889); *Separation anxiety* (P = .297); *Physical Injury Fears* (P = .547 (P = .457); *Obsessive Compulsive Behaviour* (P = .544) and *Generalised Anxiety Disorder/OAD* (P = .458); *Total Anxiety* (P=.644).

The above outcomes differ from previous findings such as Stallard et al., (2007) whose participants scored similarly low prior to intervention but made significant improvements. It needs to be noted that their sample size (N= 89) was significantly larger than the present one.

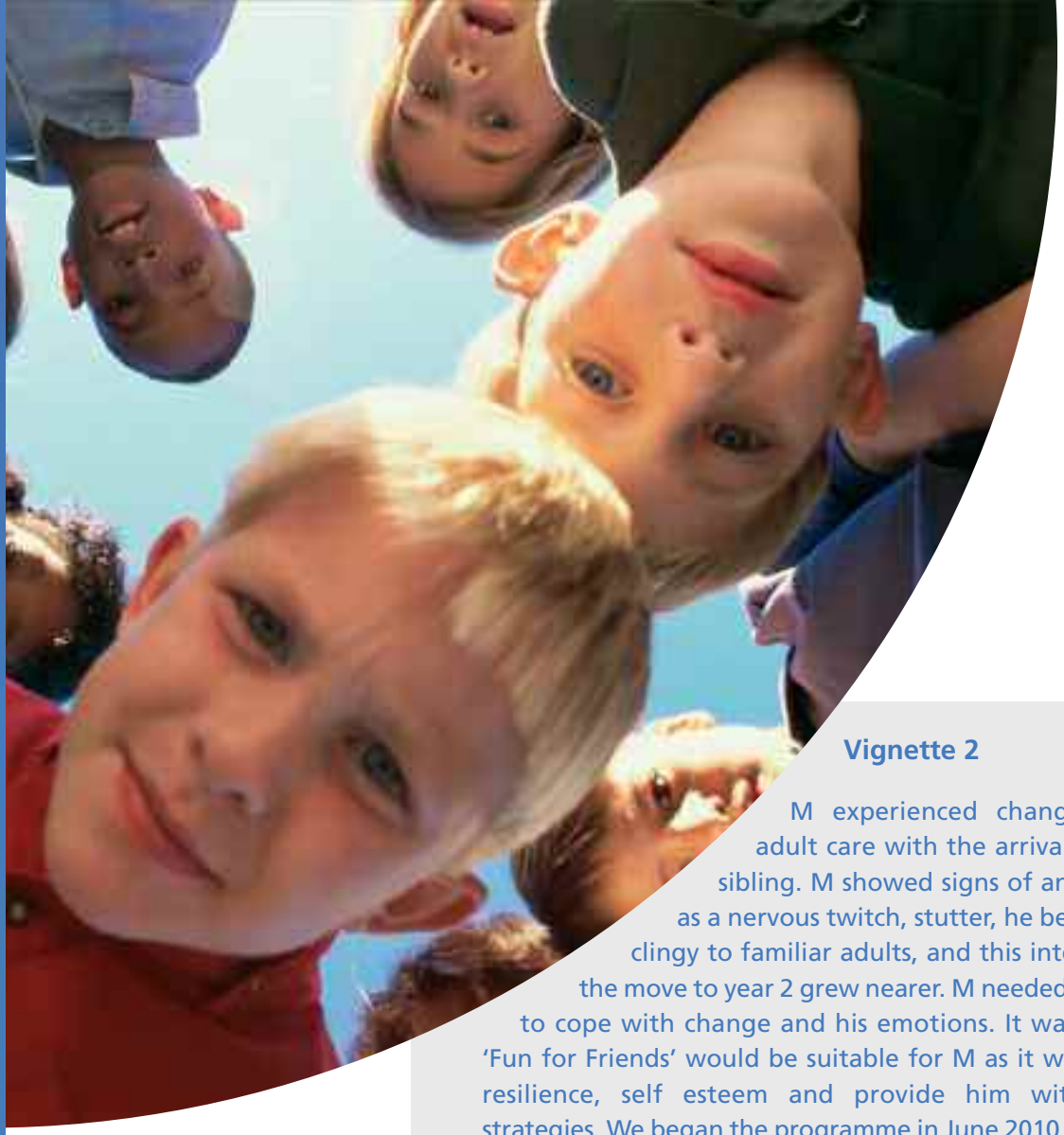
Our sample size was unfortunately too small, (and some data sets incomplete), to examine whether the results were more favourable for different age groups or for children scoring above clinical threshold prior to intervention.

Vignette 1

"My group was a mixed year 4 and 5 group. The teacher nominated one of the children. He was an 8-year old boy, with very supportive parents, but who was painfully shy. He was of low ability. I only knew him by sight."

"In the group setting he seemed anxious about being asked questions so I purposefully allowed everyone to contribute but was not insistent that they did. I was also careful to affirm every contribution made. Slowly, he lowered his guard and by week 4 or 5 he was offering answers and making comments. On the final session, whilst we were all colouring out bookmarks and 'adverts', he was very chatty and relaxed. The head teacher offered to give out their certificates in assembly. I was unsure of how this boy would feel about being up the front with 300 other children in the room. But he said that he was fine. He did go up to collect his certificate and I was very proud of him for making so much progress,"

T' – Learning mentor.



Vignette 2

M experienced changes in his adult care with the arrival of a new sibling. M showed signs of anxiety such as a nervous twitch, stutter, he became very clingy to familiar adults, and this intensified as the move to year 2 grew nearer. M needed strategies to cope with change and his emotions. It was felt that 'Fun for Friends' would be suitable for M as it would build resilience, self esteem and provide him with coping strategies. We began the programme in June 2010 to support his transition.

The Fun Friends programme gave the main carer the opportunity to share positive and past experiences with M and the class teacher incorporated some of the language into the classroom. The carer observed and commented that M had generalised some of the intervention strategies to the home situation. M coped well with the move to year 2 and his carer commented that he was much calmer at home and was able to recognise and cope with difficult feelings. Relationships with peers improved. M's coping strategies enabled M to attend the TaMHS Conference at a local Secondary school where he stood in front of an audience and explained how 'Fun for Friends' had helped him.

QUOTES

'It makes you stand up tall and be brave' & 'I was feeling cross but I used milkshake breathing….feel better now.'

'I try to have green thoughts not red thoughts.'
'I listen to my body, it is my friend.'

'FRIENDS' Key findings:

A There is a positive trend indicating a general reduction in anxiety levels for both boys and girls following FRIENDS intervention.

B The reasons for the lack of statistically significant findings may include small sample size and normal levels of anxiety in many of participants prior to intervention.

Seasons for Growth

Seasons for Growth is a programme for children and young people who have experienced a significant change or loss in their life, perhaps due to a death, divorce or separation. It is based on the belief that change, loss and grief are a normal and valuable part of life. The programme is based upon Worden's theoretical model of 'Task's of Grief' and uses the imagery of the four seasons to illustrate the cyclical nature of grief. Each of the four tasks is matched to a season thereby illustrating a natural progression from task to task and emphasising how a person can be active in their grief experience.

The core intentions of the programme are the development of resilience, self-esteem and emotional literacy to promote social and emotional well-being. It aims to educate participants about the grief process, help them to understand and manage current feelings relating to their grief and apply what they have learned to future experiences of loss.

This manualised programme runs for 8 weeks with groups of between 6–8 children facilitated by a trained 'companion'. The children have the opportunity to share their experiences and support and learn from one another through a variety of activities, including discussion, artwork, music, and recording in their personal journals.

SFG is suitable for children between the ages of 6–18 years and was delivered in 10 schools, either by school-based staff or support agency staff (e.g Educational Psychology Service (EPS), Primary Mental Health Specialists (PMHS), Behaviour Improvement Programme (BIP) who had all received prior training in the implementation of the programme.

The programme was developed in Australia by education, health and welfare professionals and forms part of the curriculum of Kids-matter and Mind-Matters, both of which are Australian government initiatives to promote mental well-being in schools. It has also been positively evaluated by the South Australian Department of Human Services (2004). These reviews demonstrated an overall positive response to the programmes with over 80% of parents and teachers agreeing that the programme is good; aides pupils in dealing with loss and that 86% of pupils responded positively to learning outcomes (UOM, 2005). These ideals have been supported by Frydenburg & Muller (2005) who found safety and reassurance in location and rapport led to better disclosure of loss, and therefore, management and learning of such feelings, thoughts or emotions.

To the best of our knowledge, no outcome evaluation, exmining the effectiveness of the intervention has been published to date.

Due to school time constraints and commitments many of the SFG groups have only recently commenced, many programmes continue to run at the time of write-up and insufficient number of completed programmes have made it impossible to conduct a meaningful analysis of the quantitative data. **Results are therefore limited to qualitative information and case vignettes as presented below.**

> "I like this group because I didn't get to talk to my dad before he died and now I can talk to kids who have been through it"

> "They all said it had helped them understand their feelings more and they found it a great support to spend time with other students experiencing similar problems. Most felt that when they experience further loss/difficulties in the future they would cope better having attended the course," 'A'- Learning Mentor.

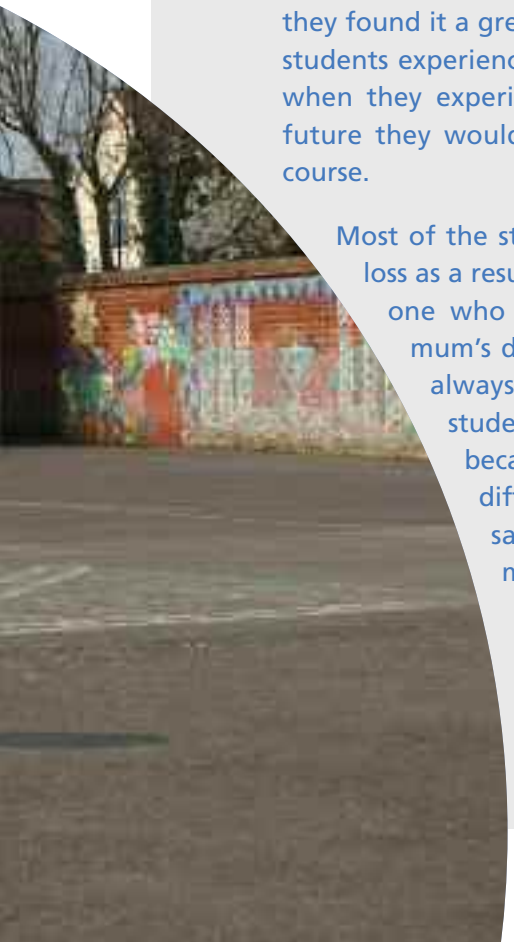
> "There are some people with the same feelings so you are not the only one"

Vignettes for Seasons For Growth

1. A pupil lost her mother last year and her maternal grandmother. Mum and dad were divorced but dad has returned to look after our student, bearing in mind they don't know each other that well. Dad reported that he could not stop her crying and that he couldn't get her to school. She was in the inclusion unit here on a daily basis when she was in. She began seasons for growth and attended school every week and was virtually back to normal lesson. She was reportedly more cheerful. The hopeless crying has gone but towards the end of the course she missed a few sessions. In fact her attendance has dropped again. However, I feel she has made a connection with the school and she feels they understand her through her 'seasons for growth' sessions.

2. A thirteen year old who had lost contact with her mum attended all sessions. She has displayed a lot of anger throughout the sessions in writing and verbally. She has now started to reveal her past in sessions with the counsellor. This is a difficult time for her but it has helped to bring her issues to the fore.

3. Although there wasn't a particular student who made amazing progress as a result of the course, this was partly due to the fact the most of them still have difficult things going on in their lives. However, they all said that it had helped them understand their feelings more and they found it a great support to spend time with other students experiencing similar problems. Most felt that when they experience further loss/difficulties in the future they would cope better having attended the course.



Most of the students who attended had suffered loss as a result of family break-ups but I did have one who wasn't coping very well after her mum's death. On reflection, I think I would always try to include at least one other student in this situation on further courses because I think she felt her situation was different. Another student suffering the same type of loss would have been more supportive.

I would like to run further Seasons courses in the future when there is enough demand and will use some of the material when working 1:1 with other students,"

Case study - Seasons For Growth

"Through my SFG group there was one child in particular that stood out. Her dad died suddenly. Her mum and dad were separated. Before she started the group she was complaining of headaches and tummy aches, had a bit of a temper, lacked confidence and self esteem and was often unhappy and tearful in school especially at break times and lunchtimes; needing a lot of adult time, support and attention.

As a Learning Mentor, I had been working with this child weekly but this had increased to 2–3 times a week.

The first few sessions were quite difficult for her. She was quiet, withdrawn and found it difficult to share her thoughts and feelings. By the 3rd session I felt she was more able to open up and express her feelings through the safety and security of the group setting. During two of the sessions she sobbed uncontrollably as she shared memories and items that were special to her in relation to her dad. She even shared them with her class. I found that the group were very supportive and gave her the encouragement and time she needed.

As a Learning Mentor I also supported her after some of the sessions and was able to, with her consent, pass information on to her mum. This helped their relationship as it was starting to become strained; she struggled with the fact that her mum didn't have the same feelings for her dad as she did. On session 4 she was able to express her guilt in front of the group; I felt this was a positive step forward. This was a very powerful session.

After the sessions she became less dependent on myself and the class teacher, coming in less to talk to me, dealing better with situations in and out of school and was generally happier during the school day. At home she said she was happier as she was sharing more thoughts with her mum and her mum understood more about how she was feeling now.

In school her self esteem and confidence grew, she was able to talk in front of the class, which she found difficult and even sung in front of them. When she was upset at school, it was usually her SFG friends that she went to for support or that came to her.

In her evaluation she said she had learnt that it was ok to feel sad and was able to cope better with her feelings.

I feel she has gained immensely from this programme as she was given the time and support to grieve, acknowledgement of her feelings and the support and acceptance from her peers which should help her in her transition to secondary school."

'Season's For Growth' Key findings:

A Due to time constraints there was insufficient data available to measure quantitative changes in presentation following the Season for Growth intervention.

B Qualitative feedback from group leaders indicates that SfG can offer valuable help to children who experience loss and grief.

Breakthrough Mentoring

The Breakthrough project is an activity based mentoring scheme. The benefit of similar programmes have been evidenced by MandBF, (2010); DuBois et al., (2002); Herrera, Sipe & McClanahan, (2000); Guetzloe, (1997). Previous studies found that mentoring support increased self-esteem and confidence in social interaction (MandBF, 2010). Increased school attendance and improved behaviour with peers, parents and teachers was also seen (Tiemey, Grossman & Resch, (1995).

Breakthrough has been run across 13 schools. Skilled mentors offer weekly, one-to-one support to a range of vulnerable young people who have been identified by an agency as being in need of support. The project uses activities and rewards to help mentees build positive relationships with adults and peers as well as interests and skills that can be sustained in the longer term. In some placements, short and long term.

Activities can include sporting activities, arts and crafts, voluntary work or helping mentees apply for a job. Sessions are usually a minimum of one hour.

The aim of Breakthrough is to create positive experiences and relationships in order to help young people achieve, grow, develop skills and realise their full potential.

Due to the tight time schedule of implementing programmes and the extension of the length of this intervention to 50 weeks, it was decided to use data from the 'Breakthrough' mentoring programme run for 25-weeks across 13 schools in 2010 (n=15).

> "There has already been a steady and consistent improvement in BA's attitude to school since taking part in Breakthrough. BA has developed positive and healthy friendships in his new school with boys and girls. Overall it (Breakthrough Project) has been a fantastic experience for my son. The mentor came along at just the right time ... worked positively with my son and I cannot thank you enough for the amazing and positive benefits this scheme has brought. Thank you so, so much. We were so lucky to have Andy's (mentor) input and support via Breakthrough. A brilliant scheme, long may it continue".

Overall scores were recorded from the self-report Strength and Difficulties Questionnaire (SDQ) and mean scores were calculated under the following categories, both pre and post-intervention: *Total difficulties, conduct problems, Pro-social behaviour, hyperactivity, emotional symptoms, peer problems and impact score of difficulties on the young person's life.* The findings are summarised below *(Fig.3)*.

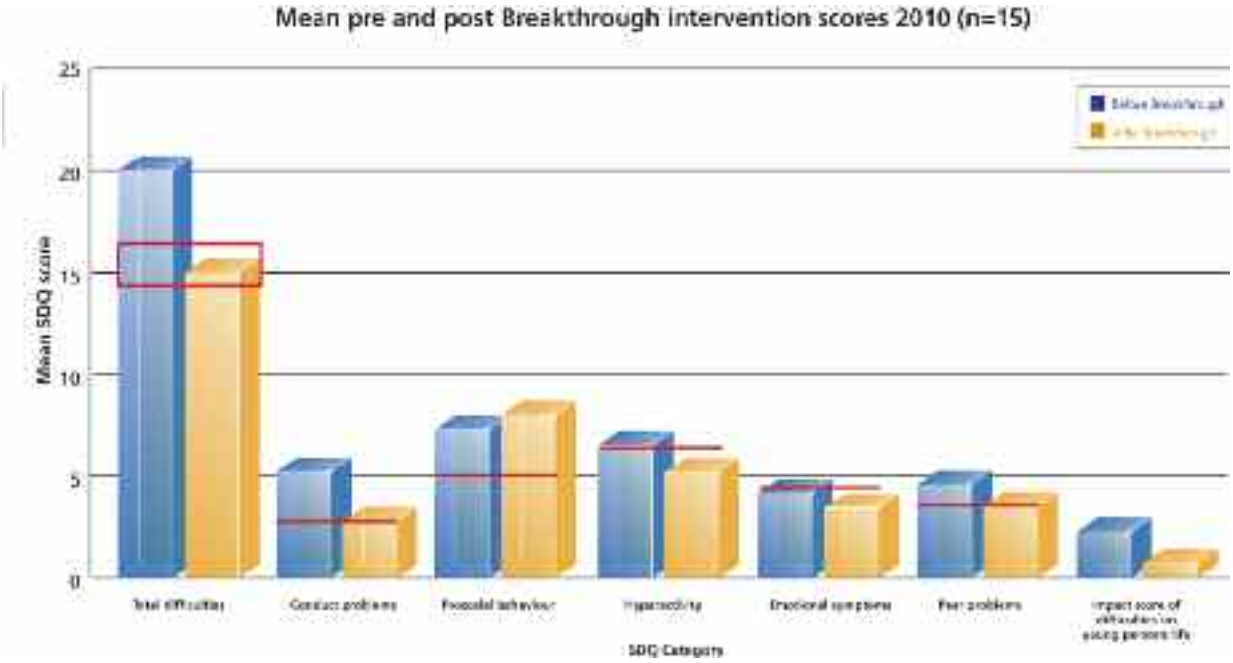


Fig. 3 – (n=15) above shows the mean SDQ scores before and after their Breakthrough mentoring in 2010.

**NB: further and more detailed data is available on request*

Positive trends in the mean SDQ scores comparing results before and after mentoring were found for all categories, but an ANOVA repeated measures analysis found the following mean changes in SDQ scores between pre and post Breakthrough intervention to be the only statistically significant changes:

Total difficulties - Pre-intervention mean = 19.73 / Post intervention mean = 15.00 (P <.05);

Conduct problems – Pre-intervention mean = 5.33 / Post intervention mean = 3.33 (P < .05) and

Impact score of difficulties on young persons life Pre-intervention mean = 2.77 / Post intervention mean = 0.91 (P <.05).

'Breakthrough Case Study'

"A pupil was referred by his school teacher and Learning Mentor to help improve his behaviour in school and at home. He lived with an older couple as he had been separated from his mum, brother and sister. He was referred due to his love of sport and the project being activity based. The project worked by seeing him once a week for an hour and using activities as a way of building trust and confidence with the mentor and speaking to him when he was most comfortable.

He was often very angry, uncooperative and disruptive and found it impossible to take blame for his actions. One of his interests was football and he wanted to get better, become more of a team player as well as play within a team. Activities such as designing his own outdoor game, a bat and ball target game, swimming, beach walk, designing comic books, football, basketball and a bike ride were just a few of the activities undertaken during the placement.

The mentor was there to listen and guide the pupil to make the right choices and speak about his past as well as his hopes for the future. He has continued his enjoyment of being a team player by attending a local city football summer school, something of which he and his adopted family are very proud of.

He now has a male teacher and no longer needs one to one teaching support and is thriving in his new class and a new start."

'Breakthrough' Key findings:

A 'Breakthrough' is effective in significantly reducing *overall problems*, *conduct problems* and the impact score from above clinical levels to below clinical levels. Impact score relates to the combined scores of social impairment and overall distress.

B There is a positive trend for reducing peer problems, emotional symptoms and hyperactivity.

Dreamwall

Summary of Quantative Evaluation

The aim of this evaluation was to identify what impact the Dreamwall initiative has had so far on the attitudes and behaviour of four Key Stage 3 students at risk of disaffection and for some exclusion from their secondary school.

Dreamwall is a third sector organisation that specialises in providing residential activity breaks to promote social and emotional development in disaffected young people. Participants are grouped by interest so that the activities offered are suited to their motivation. Dream wall's long-term involvement with Southampton City Council has been independently evaluated and shown to produce improvements in Looked After children's foster placement stability and GCSE results (Dreamwall, 2008; Holroyd & Armour, 2003; Riley & Rustique-Forrester, 2003).

For North Somerset, Dreamwall is delivering a programme of four residential weekends comprised mostly of challenging physical activities to meet the needs of the 7 boys selected. Research literature provides some evidence of the effectiveness of physical activity interventions aimed at improving young people's

social and emotional development, as long as they meet certain criteria, such as using facilitators who are enthusiastic, fair and respectful, create a sense of community and build resiliency in the participants. The first residential weekend was held in October 2010 and the second in January 2011. At the time of writing two more are expected to take place (Please see section 2 for a full description of methodology)

Results and Discussion ***

School's Achievement and Behaviour Data was collated (n=4) 6-months pre-intervention and four months post-intervention for: average achievement marks, average behaviour negative marks, number of detentions received and number of exclusions. Four male pupils had been selected for the programme due to their histories of disruptive behaviour in school. They were at risk of exclusion because of their high scores on the school's negative marks system. Three had difficult circumstances to deal with at home due to acrimonious parental separations and the fourth had long-standing difficulties in controlling his anger, for which he had received help from CAMHS. Two of the boys had been involved with the Youth Offending Team.

The parents of two of the boys were also interviewed (the others did not take up the invitation) as were three members of the school's staff deemed to be best able to make meaningful observations.

In response to the interviews all four boys were exceptionally polite and helpful, appearing to give considerable thought to their answers. They all clearly valued the experience of attending Dreamwall, spoke

respectfully of the course leaders and had bonded well with each other and with the boys from the other school.

The students', parents' and school staff's responses were analysed and are presented as themes and illustrative quotations in the full report. Overall, there seems to be quite a lot of evidence that the boys have made improvements to their behaviour since the first Dreamwall weekend. The majority are working harder in lessons, have improved friendships and are getting on better with their families. However, there are areas, for each student, where there appears to be little or no improvement.

The students' positive and negative marks, detentions and exclusions are also presented, but these data are of insufficient quantity to enable robust comparisons to be made. All four boys received an increased average number of positive marks in the four months following their first Dreamwall weekend compared with the six months before. There was a less favourable pattern in the negative marks as while those for two of the boys had gone down, a third student's negative marks stayed the same while the fourth's increased considerably.

Conclusion

In conclusion, explanations are offered in the main report for why there are only limited improvements in behaviour in some areas, for instance, that when the interviews took place the intervention was only half-way through. Similarly, alternative explanations for improved behaviour in other areas are also identified, such as that the family circumstances for some of the boys had become more settled prior to the Dreamwall intervention starting, and that three of the four boys are at an age (Y9) when maturation is commonly observed.

Overall, this study's findings suggest there has been an improvement in the four students' attitudes and behaviour, in at least some aspects of their lives, since they started the Dreamwall programme.

> It is worth noting that all four residentials have now taken place. All the boys who took part in the Dreamwall programme (seven in total) remain within mainstream school and there are no plans for managed transfers or the exclusion of any of the boys to date.

*** *NOTE: Further and more in-depth report details can be obtained on request*

Qualitative feedback:

> "The students', parents' and school staff's responses were analysed and are presented as themes and illustrative quotations in the full report. Overall, there seems to be quite a lot of evidence that the boys have made improvements to their behaviour since the first Dreamwall weekend. The majority are working harder in lessons, have improved friendships and are getting on better with their families. Significant

observations made about individual students include that two are "better able to see other people's points of view", while two said they could now see that the way they behave at present will affect their futures, for better or worse. They also said that they found it easier now to talk to other people about their feelings, rather than bottling them up. One student, who is generally seen as having made the least progress of the four, is described as being better at waiting for the right time to speak, rather than always acting impulsively. However, there are areas, for each student, where there appears to be little or no improvement. This is perhaps not surprising as the intervention was only half-way through at the time the data was collected."

Dreamwall case vignette

"C said that he had messed about a lot during Years 7 and 8, been given lots of negative marks and was on the verge of being excluded. He explained that he had been upset by the breakdown of his parents' relationship and had brought his sadness and anger about this into school with him, taking his feelings out on everyone around him. He also finds school-work difficult and is aware that other students do better than him in tests, even when he has tried really hard and they haven't."

"Since starting on the Dreamwall programme he has realised what he wants to do when he leaves school, and that he needs to behave well and do his best in his GCSEs. He has started to work harder in lessons, to keep up with his homework, and to listen to the advice that teachers and other adults give him. He also says that in break-times he plays football with his friends instead of winding them up. Although there are still tensions in his family he has realised that there are some members he can talk to about his feelings. Although he still has difficulty conforming to the requirements of certain teachers he is developing insight into this, saying "when they are cross with me it feels like it's their fault, at the time, but I realise later that it was mine."

"He says that Dreamwall has helped him see that he must not give up when things are difficult."

Dreamwall Key findings:

A All four students interviewed rated their experience of attending Dreamwall highly, understood its purpose and valued the input from the course leaders and other adults involved (the TaMHS Programme Lead and Deputy).

B All four students are judged by their parents and staff to have made improvements in their attitudes and behaviour in at least some areas. They are all getting on better with other members of their households. They have improved relationships with peers.

C Some of the students have started to think about their futures and to recognise that they need to behave well and work hard at school in order to have the jobs they want when they leave.

D All of the 7 students taking part in Dreamwall remain within mainstream education.

SEAL (Social and Emotional Aspects of Learning)

SEAL is a whole school approach which aims to develop the qualities and skill which help promote positive behaviour and effective learning. SEAL offers a framework to develop emotional, social and behavioural skills, taught as a discrete skill set within the curriculum and embedded as part of the whole school ethos of personal and emotional literacy.

The five domains of SEAL which are taught as part of the universal provision in both primary and secondary schools are:

- Self-awareness
- Managing Feelings
- Motivation
- Empathy
- Social skills

In secondary schools the targeted work, delivered in small groups, is personalised and provides a basis for student target setting, Individual Educational Plans (IEP) and Personal Support Plans (PSP).

The resource materials which deliver on Seal learning outcomes are based on these five domains This is supported by previous studies which not only recommend the use of SEAL in small group work (Lendrum et al., 2009) but also found that facilitator knowledge and skills were crucial. Increases in pupil emotional literacy (EL), were found in addition to a decrease in peer problems, improved social skills and self-regulation in social interactions.

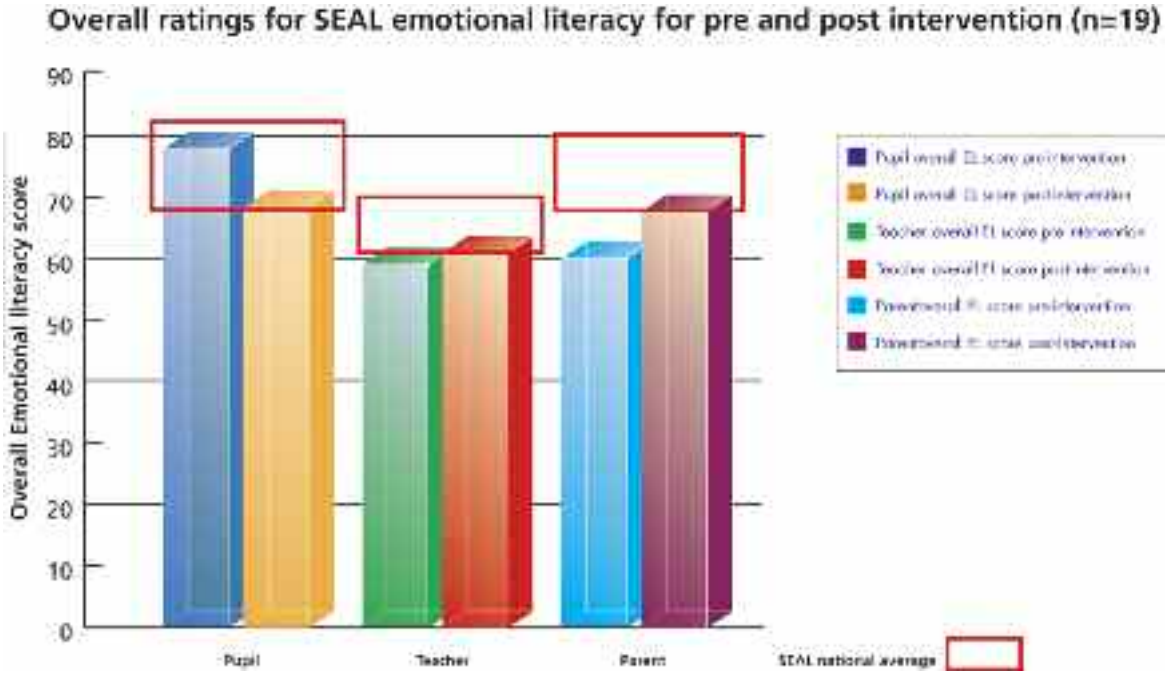


Fig. 4 – Demonstrates overall ratings in emotional literacy for pupil, teacher and parent pre and post- SEAL intervention.

Additionally, pupil rated peer problems have been seen to reduce along with improved social skills/interactions (Lendrum et al., 2009; Humphrey et al., 2008; Hallam et al., 2006).

Having collected all the data available at this time on pupils (n= 19; 10 male and 9 female) analysis was conducted to examine the overall scores of pupil emotional literacy (EL), including assessment by teacher, parent and self-report by the pupil. This was measured both pre and post-intervention and the analysis can be seen *Fig.4*.

Figure 4 shows a positive trend indicating a small increase in child emotional literacy across all three observations following SEAL intervention. However, further analysis was using ANOVA and found no statistical differences in the mean changes from pre to post intervention: *Pupil overall EL score* – pre SEAL (mean = 76.63, SD = 13.981) and post SEAL (mean = 80.42, SD = 9.143) (P=.329); *Teacher overall rating of EL score* – pre SEAL (mean = 58.79, SD = 12.546) and post SEAL (mean = 62.05, SD = 11.232) (P=.404) and *Parent overall rating of EL score* – pre SEAL (mean = 59.74, SD = 27.817) and post SEAL (mean = 70.21, SD = 17.962) (P=.176).

Silver SEAL

This programme provides targeted, small group work as an early intervention for pupils who need additional support in developing their social, emotional and behavioural skills. In primary school this programme is delivered as six 1hr sessions in small groups (6 to 8 pupils), usually delivered by a member of the support staff. The materials based on the SEAL curriculum themes, allow pupils to explore and practice new skills in a safe environment, developing ways of relating to others and learning more about self.

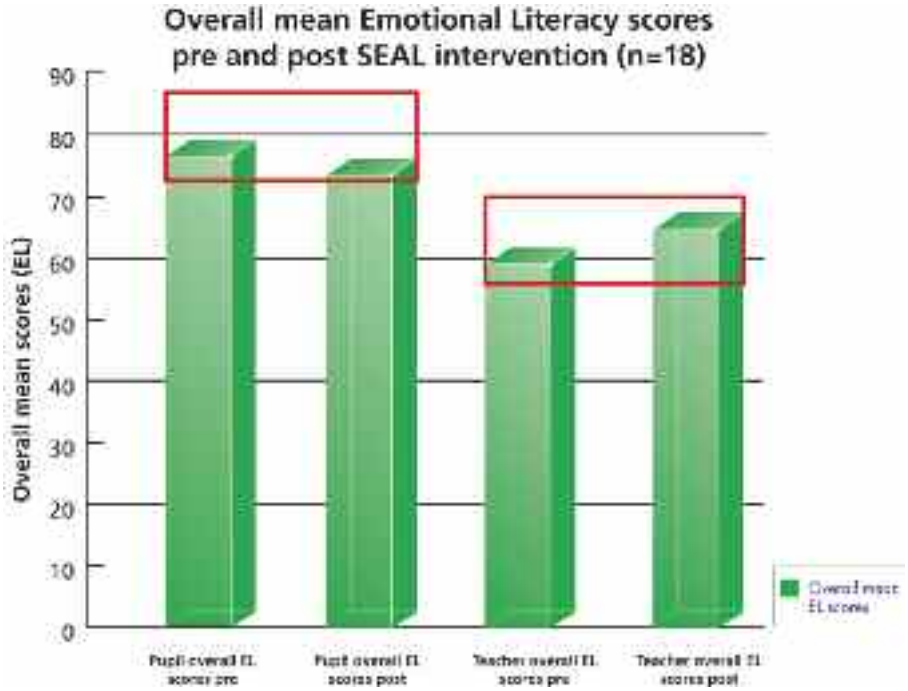


Fig 5 – above shows a mean trend in pupil EL increase from pre to post-silver SEAL, indicating improvement in both the opinion of the pupils themselves and teachers ratings.

Silver SEAL was delivered in 5 schools with 22 groups, and having collected data available at this time (n=18; 10 male and 8 female) analysis was conducted to examine the overall scores of pupil emotional literacy (EL), including assessment by teacher and self-report by the pupil. This was measured both pre and post-intervention and the analysis can be seen in *Fig.5*.

"It's helped me understand what to do to solve problems"

Further analysis was conducted using a repeated measures ANOVA and found the following changes in mean from pre to post intervention overall EL scores: *Pupil overall EL score* – pre SEAL (mean = 76.44, SD = 11.959) and post SEAL (mean = 78.44, SD = 12.197) and *Teacher overall rating of EL score* – pre SEAL (mean = 58.33, SD = 10.782) and post SEAL (mean = 64.22, SD = 12.112). None of the above mean changes were statistically significant (P= .409).

SEAL vignette and quotes

"It helped me because I didn't like J but we get on now … we don't have a full conversation, we just say hi."

The first group that I worked with was selected because they were quiet and reluctant to speak up in class. The children bonded well as a group from the very beginning. They loved working together and I still see them supporting each other now, a whole term after their group ended. They spent more sessions together than the plan (1 additional half hour during assembly) and I believe this made a big difference. A task I gave them at the end of their group was to model some role play facial expressions to the rest of the class. They all did this with confidence and I was extremely proud of them, I don't believe that any of them would have

volunteered before silver seal. They also say how much they enjoy 'sitting around and talking about their feelings!'

A further group was selected because they all had a family member with health issues, they have made a very positive start to the group and seem to be benefiting. They are a very different, louder group and I am adapting the sessions more than with the previous group.

A few comments made on Silver SEAL by those involved: – "….makes me get on better with my brother" – "me and you are getting on better aren't we…" – "I think me & J get on better, we hardly fall out now…."

'SEAL' Key findings:

A There was a small positive trend to indicate an increase in Emotional Literacy ratings in the school and home setting following SEAL intervention.

B Following Silver Seal there was a small positive trend indicating that Emotional Literacy, (assessed by student and teacher) increased following intervention.

C The fact that a large proportion of students scored well within the normal rage for Emotional Literacy prior to intervention is likely to have had an impact on several of the outcomes.

"There was an Individual recognition for students and a great sense of achievement, especially with whole school involvement. And particularly, in smaller schools when the group receive their portfolios in assembly…."

'Go-Peutics'

Go-Peutics is a locally developed programme which works with identified pupils in small groups, maximum of 8 children, using LEGO® bricks. Previous studies have demonstrated that using Lego with autistic children (n=60, mean age 9.3yrs) over a three-year period significantly improves social interaction. Benefits were also evident in control groups (non-autisno n=57) (Legoff & Sherman, 2006). Maladaptive behaviour has been seen to decrease in autistic children (n=31) over children in non-clinical and non-intervention groups (age range – 6–11 years) (Owens, Granader, Humphrey et al., 2008). Go-Peutics is based on an 8 session block, the first of which is staff/carer led to discuss specific focus and circumstances of the children. Different activities take place for the next six sessions, each with a separate focus adapted to the needs of the group or individuals. A constant rapport is maintained with the staff/professionals involved as it is paramount that any information is treated confidentially.

The intervention is aims to address; minor behavioural problems, lack of motivation, becoming withdrawn, background of domestic abuse or

trauma, lack of nurture and varying issues that cause disruption to their thought processes and ultimate achievements.

Using LEGO as an intervention aims to develop motivation, self esteem and belief, bonding communication as well as teamwork skills and peer support. By providing a safe and familiar environment for children, they are able to build on existing skills and recover after or during life's traumas. Importance is placed on making children feel valued and that they *are* able to achieve.

The final session is returning to the designated staff member, feeding back and highlighting any significant issues and progress.

The 'Go-Peutics' intervention data was collated from 4 schools between years 3 and 8, 21 males and 7 females (n=28). Year 7 was excluded due to the nature of students moving from primary to secondary school and instability that often accompanies this transition. Overall scores were calculated across the five categories of the Strengths and Difficulties Questionnaire (Ford, Hutchings, ByWater et al. 2009; Kaptein, Jansen, Vogels et al. 2008): *Conduct problems, Pro-social behaviour, Hyperactivity, Emotional symptoms and peer problems for students both pre and post intervention* and the results can be seen below ***(Fig.6)***

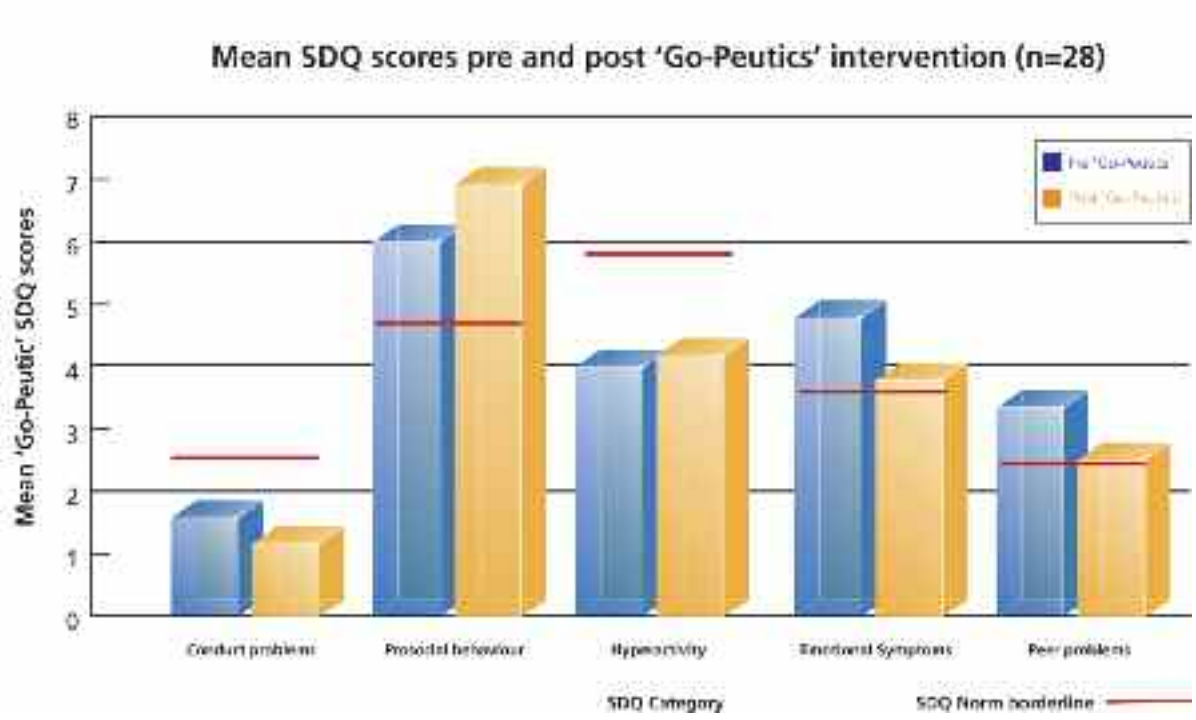


Fig. 6 – shows the mean changes in teacher reported strengths and difficulty ratings before and after the Go-Peutics intervention.

Figure 6 above demonstrates an overall positive trend for improvement from pre to post intervention. Specifically, it shows that pro-social behaviour is positively above the norm; both pre and post-intervention whilst peer problems at pre-intervention were observed to be abnormal but post-intervention were seen to be within normal limits. Conduct problems and Hyperactivity were both within the normal rage prior to intervention. There is a reduction in conduct problems following intervention but a marginal increase in hyperactivity.

"She has gained a real sense of achievement.
I highly recommend it!"

However, a repeated measures ANOVA analysis found that these changes were not statistically significant, as follows:

Conduct problems pre-intervention mean = 1.86 and post-intervention mean = 1.25 (P = >.05);

Pro-social behaviour pre-intervention mean = 6.00 and post-intervention mean = 6.79 (P = >.05);

Hyperactivity pre-intervention mean = 4.04 and post-intervention mean = 4.21 (P = >.05);

Emotional symptoms pre-intervention Mean = 4.68 and post-intervention mean = 3.71 (P = >.05);

Peer problems pre-intervention mean = 3.36 and post-intervention mean = 2.54 (P = >.05).

Figure 7 shows gender differences in outcomes. A mean increase in female pro-social behaviour between pre and post intervention measures were found.

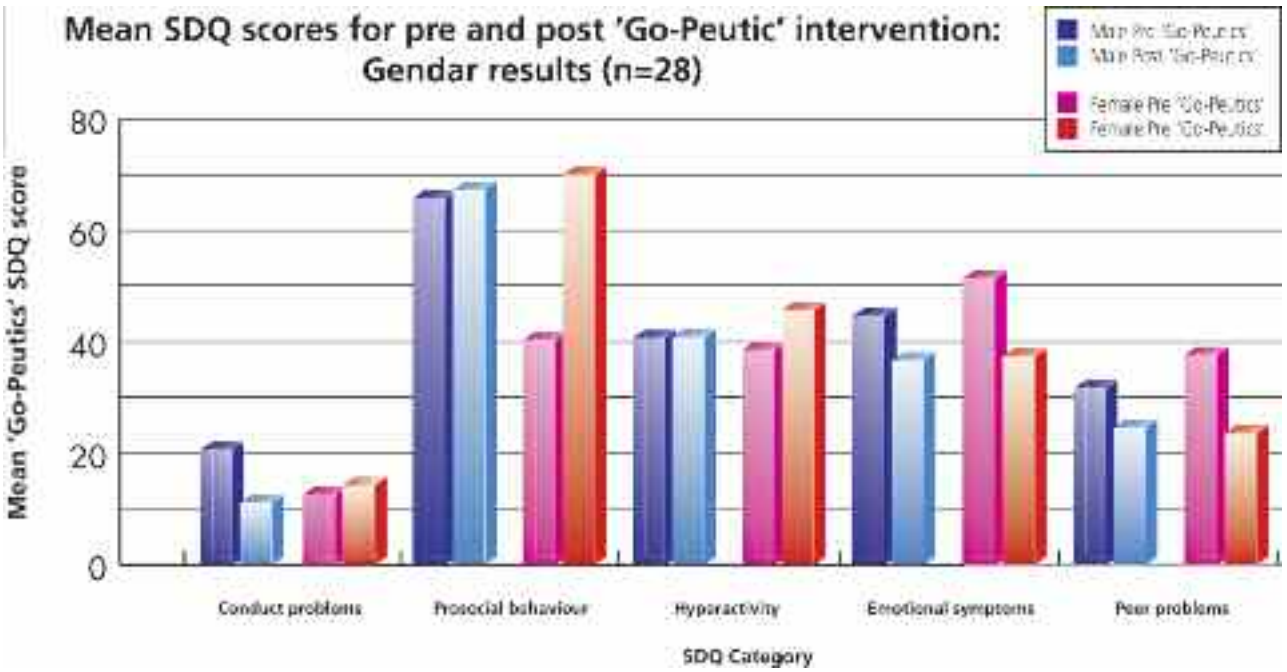


Fig. 7 – Demonstrates the mean SDQ scores by gender for both the pre and post measures of the 'Go-Peutics' intervention.

Of note, males show a decrease in conduct problems between pre-intervention (mean rating = 2.05) and post-intervention (mean rating = 1.19) whilst females show increase from pre-intervention (mean rating = 1.29) to post-intervention (mean rating = 1.43.) Neither of these were significant mean changes. However, females show a greater mean improvement in pro-social behaviour from pre-intervention (mean rating = 4.00) to post-intervention (mean rating = 7.00) and this was a statistically significant change (P = .019).

'Go-Peutics' vignettes

' Play together Learn together'

Having decided on the appropriate children, I ran an hour long session each week for 6 weeks. The children involved enjoyed the sessions and were always keen to get started. Activities varied from individual, pairs or group builds, developing social interaction and confidence as the programme progressed. One parent said that her son had "had the best day at school ever."

A pupil recalled, "It was fun interesting and challenging. It was fun because I like Lego and I liked working with my friend. It was interesting because it's stuff I don't normally do and it was challenging because it got harder and more complicated each time."

The SENCO at one Secondary school commented that it was such a successful intervention because it was short term and instant. "It was so successful because you were so pro-active." A mother said of her daughter's experience: "… She has gained a real sense of achievement. I highly recommend it!!"

'Go-Peutics' Key findings:

A There was a statistically significant increase in girls' pro-social behaviour following 'Go-Peutics' intervention.

B There was a trend in emotional, peer problems and conduct problems reducing following intervention.

3.2 Results for education and training programmes

Q Do training programmes help raise student and staff ability and confidence in addressing mental health issues?

Mental Health Workshops

The Mental Health workshops are delivered as a universal early intervention and prevention programme. The aims were to increase young people's awareness of mental health and the stigma associated with it; explore how different life events can impact on a person's mental health; and increase their knowledge of the support available to young people within their school and local community.

The two 50 minute workshops were delivered as whole class interventions during PSHE lessons, to the whole of Year 10, over the course of three months. They were facilitated by Primary Mental Health Specialists with the class teacher present to observe and to support the learning of the students during small group exercises. Prior training had been provided to the PSHE lead teacher with the intention of them facilitating the workshops in the future and therefore, the sustainability beyond TaMHS.

The workshops used a variety of teaching methods including: graffiti wall/posters, whole class discussion, individual stress scales, case studies and a 'true life' DVD of two young people living with parents experiencing mental health difficulties. They also provided details of local and national support and help lines as well as identifying the students support available within their own school and local community.

The mental health workshops were originally developed in 2005 by Jo Scott (Primary Mental Health Specialist) and Michelle Pye (Mental Health Lead for Healthy Schools) as an intervention for Year 9 pupils and were piloted in Worle secondary school in 2005 and St Katherine's secondary school in 2006. The evaluation of these pilots was very positive with pupils' self-evaluation following the intervention showing: 89.8% had a better understanding of mental health; 95.3% a better understanding of how life events could impact on a young person's mental health; and 92.1% a better understanding of where to go for support.

During the course of TAMHS the mental health workshops were delivered to the whole of Year 10 in Backwell School and further workshops are planned in Priory and Wyvern to be delivered to Year 9 and 10 students, respectively.

The Mental Health Workshop (MHW's) intervention was measured in one school across year 10 students (age range approximately 14-15 years) over the course of four months (n=183).

Overall, scores were calculated across the three categories of the MHW Likert-scale for both pre and post-intervention (using a Likert-scale of '1' strongly disagree – '5' strongly agree) ***(Fig.8)*** and a second analysis was conducted using repeated measures ANOVA. Results are as follows:

(1) *'The majority of people are likely to have known a friend or family member(s) who have experienced a mental health problem'* – Pre-intervention (mean = 3.44) and post-intervention (mean = 3.41). These changes in mean ratings were not statistically significant (P>.05).

(2) *'A wide range of stressful events (e.g. exams, relationship difficulties, family problems) could all have a negative effect on a young person's mental health'* Pre-intervention (mean = 3.96) and post-intervention (mean = 4.02). These changes in mean ratings were not statistically significant (P>.05).

(3) *'If I, or someone I know, were to experience mental health difficulties, I would know where to go for support,'* Pre-intervention (mean = 2.69) and post-intervention (mean = 3.44). These changes were statistically significant (P <.001), indicating that pupils were more confident post- MHW's in where to go for support if they or someone they knew were to experience mental health difficulties.

No statistically significant differences were found between gender and this may have been due to the number of unspecified 'gender' responses on questionnaires (n=79).

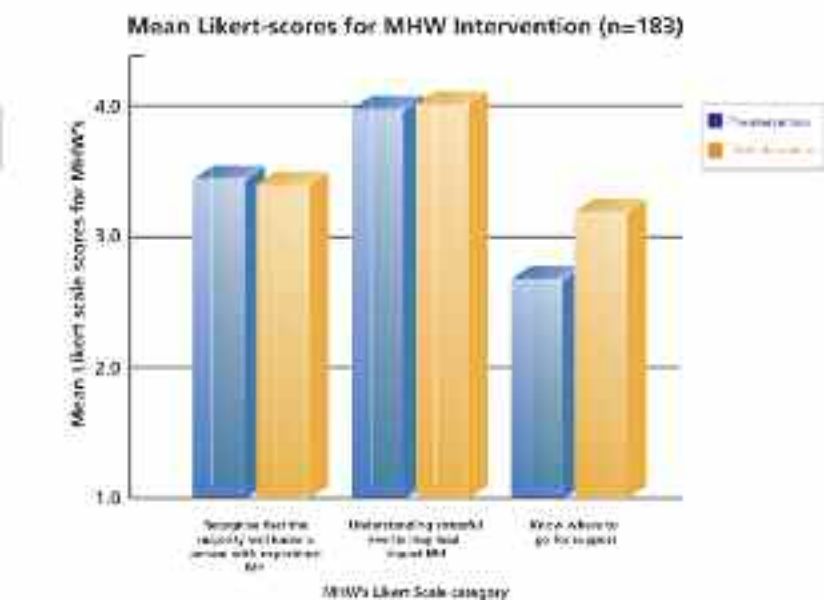


Fig. 8 – Demonstrates the mean changes in MHW Likert-scores between pre and post-intervention

MHW vignette

The MHW were used for yr 10 following a discussion by the SLT at a Secondary school who were keen to be proactive following increasing concerns re: pupils engaging in risky and self harming activities.

The workshops were used as part of a collaborative approach to provide support, early intervention & prevention to pupils who may be at risk or already experiencing mental health difficulties. It was acknowledged that as a universal intervention there may be a number of young people who were experiencing mental health difficulties that were not known to the school but would benefit from the workshops.

The assistant head teacher also ran assemblies in parallel to the workshops that gave information relating to support networks available within the school. A number of young people approached the PMHS following the workshops to discuss their concerns and subsequently self referred into the CAMHS service for issues that required specialist support.

The workshops were identified by teachers as having had a positive impact on knowledge and understanding of young people and has enhanced cross curricular learning.

MHW Key findings:

- Following training, there was a statistically significant improvement in student knowledge of where to access support if they or anyone they know experience mental health difficulties.
- No changes were identified in students' recognition that they are likely to know someone suffering from mental health problems or that stressful events are likely to have an effect on an individual's mental health. The reason for lack of significant changes in these areas may be that student level of understanding was quite high prior to undergoing the MH workshops.

ELSA

Emotional literacy is generally thought of as the ability to recognise, understand, manage and express one's own emotions productively, as well as the ability to listen to others and empathise with their feelings. It is a concept which, therefore, includes competencies in both self-awareness and inter-personal relationships. The Emotional Literacy Support Assistant (ELSA) programme is based on the Hampshire (Burton & Shotton, 2004) piloted initiative aimed at supporting the emotional literacy of children and young people in more targeted ways.

The approach was designed to equip Learning Support Assistants (LSA) with the skills and knowledge needed to deliver a range of individual and small group interventions for children and young people with challenging behaviour and social communication difficulties. This took the form of 5 days' training for LSAs and / or Learning Mentors (up to a maximum of 2 per school) which covered the following areas: emotional literacy and raising emotional awareness; self-esteem, active listening and communication skills; managing angry feelings and working with puppets; social skills, social communication difficulties and social stories; friendship skills and writing therapeutic stories. Groups then ran in 8 schools, with termly clinical supervision sessions.

Previous studies have demonstrated that teacher perception of pupil motivation and peer engagement improves following training. Also, pupils working together with teachers on emotional literacy programmes showed significant reduction in behavioural problems, hyperactivity and in peer related problems (HEPS, 2010). Further, support for the training in emotional behaviours of pupils for Learning support assistants and teachers is evidenced by Kassem (2002) who found that this had a positive effect on classroom environment, reducing behavioural problems and creating stability amongst peer groups.

"Learning only happens when well-being is right"

Measures were conducted with participants across all 8 schools both pre, post and 6 months following training (n=9) and examined the participant's confidence using a Likert-scale of '1' (strongly disagree) – '5' (strongly agree). Analysis was completed of ratings for pre, post and follow-up interventions under the statements below ***(Fig.9)***. Mean changes and all four statistically significant results are as follows:

- *"I feel confident about helping children improve their behaviour" – pre-training (mean = 3.466) and post-training (mean = 4.200) with (P<.05).*
- *"I feel confident about helping children improve their social skills," – Pre training (Mean = 3.466) and Post- training (Mean = 4.266) with (P <.001).*
- *"I feel confident about identifying children who need support to improve their behaviour and social skills," - Pre-training (Mean = 3.333) and Post- training (Mean = 4.466) with (P<.001).*
- *"I feel confident about monitoring progress in children's behaviour and social skills," – Pre-training (mean = 2.800) and Post-training (mean = 4.066) with (P<.001).*

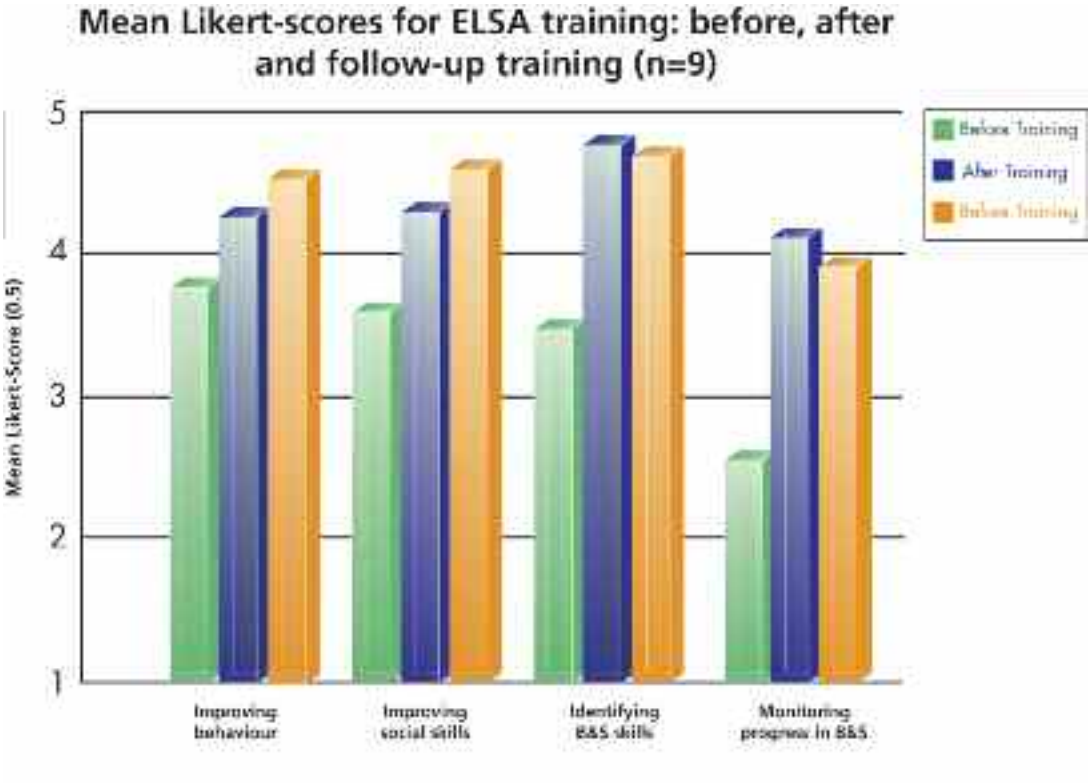


Fig. 9 – demonstrates the mean-Likert cores of pre, post and 6-months follow-up of ELSA training.

Figure 9 shows that there is an improvement in all areas measured including confidence in improving child behaviour, child social skills as well as in identification and monitoring.

A further analysis reveals that the mean differences between before, after and follow-up training measures are statistically significant ($P<.001$) indicating the ongoing progression of staff ability and confidence across the four area's stated above, 6-months after concluding training. A post-hoc Bonferroni measure shows that within the four measured categories, the mean difference is specifically between 'before' and 'follow-up' training ($P<.05$).

Qualitative feedback:

- Skills of staff and confidence have been developed by ELSA intervention – fantastic!
- ELSA was difficult to run due to cost and/of staff release within school and TaMHS ELSA staff should be more supportive of the school and communicate effectively.

'ELSA' Key findings:

A Results show statistically significant changes on all measures indicating that ELSA is effective in improving staff confidence in:

- Identifying children needing intervention
- Monitoring progress
- Improving child behaviour
- Improving social skills

B The changes are maintained at 6 months follow up.

ELSA Case Study

I worked 1:1 with a Y5 girl – M.

M presented with anger problems and was often aggressive towards others; I became involved when she ran away from after school club one evening because an incident had led her to put herself and others at risk. M and I agreed to work on helping her to manage anger by understanding and becoming aware of the physiological symptoms, identifying the feelings which trigger her angry outburst and developing some strategies to help her cope when she was angry.

At the beginning of our work together she rarely smiled, was often seen alone around school and felt disliked by "everyone", she was very unhappy and did not enjoy school. Her ability to establish and maintain friendships was poor, she was confused about the reactions her peers had to her and she took no responsibility for her actions. We initially discussed the option of doing a circle of friends and agreed that could be the next stage of our work together.

We worked on the "fight or flight" response and she began to notice the physical signs of her anger. We practiced calming down techniques. We identified feelings of frustration, annoyance, anxiety and sadness as being present before she felt angry. We established her understanding of what triggered those feelings and explored her perception of situations. We challenged her preconceived judgments and enabled her to take responsibility for her contribution. We recognised how difficult it was for her to make different choices and identified ways which could help – one of which was an anonymous class circle time during a PSHCE lesson that raised this topic and incidentally three other pupils shared with their class teacher how they had found this really useful too.

At the end of our work together I asked M how she felt she told me she felt happier, that school was better, she had more friends, felt like she was more in control and enjoyed her lessons. We have not done the circle of friends yet as M feels for the moment it is not necessary.

Summary of group intervention and training outcomes

Positive trends were found for all interventions but statistically significant changes were only demonstrated for some including; improvement in pro-social behaviour in girls following Go-Peutics; several behavioural improvements following Breakthrough; increased student awareness of where to seek help following mental health workshops; improvements in LSA's ability to identify, monitor and intervene in relation to social skills and behaviour problems following Elsa training.

It is however important to keep in mind that sample sizes on the whole were small and some interventions may have been run by newly trained staff. In several instances many students also scored well within the normal range prior to intervention All of these factors may have affected the outcomes.

3.3 Whole school and interagency impact of TaMHS programme

Q What number of young people and staff have been involved in TaMHS? (assessment, individual and group interventions)?

Q What number of supervision and consultation sessions were delivered to staff?

Q What are the changes in staff perceptions of their ability to address mental health issues?

Activity data

Children attending initial individual assessments:	703
Number of children attending group sessions;	1487
Number of supervision and consultations to staff:	227
Staff attending training	49

(Separate to the CPD programme)

Semi structured staff questionnaire

To look at the impact of TAMHS at a whole school level, staff in each participating school were issued with a questionnaire early in the programme (September 2010) and again towards the end of the program me (March 2011). (A full description of the sample is available in the method section)

- 11 schools returned questionnaires at the beginning of the programme (49 questionnaires in total).
- 8 schools returned questionnaire at the end of the programme (33 questionnaires in total).

Results from the pre-TAMHS and post-TAMHS questionnaires were compared using a T-test analysis to identify any significant changes in whole-school approaches to mental health *(Table 1 & 2).*

Overall, comparison of the responses in the autumn and spring indicated that staff was significantly more positive about their school's approach to mental health after participating in the TAMHS program.

Table 1 – Demonstrates the result as being highly significant at P<0.001.

Mean rating pre-TAMHS	Mean rating post-TAMHS
4.27	4.53

Table 2 - demonstrates ratings for individual statements before and after the programme

	Statement	Mean rating Pre-TAMHS	Post-TAMHS		Probability
1	We support our pupils' mental health effectively through policies and practices at a whole school level	4.35	4.48	Not significant	
2	We support our pupils' mental health effectively by targeting supporting to groups of children who may be at risk of mental health difficulties	4.24	4.70	Significant	<0.001
3	We support our pupils' mental health by intervening when we identify that a child is experiencing mental health difficulties	4.53	4.76	Significant	<0.05
4	We recognise the importance of staff well being and take steps to ensure that the mental health needs of staff are met	4.04	4.52	Significant	<0.005
5	We have a clear understanding of what is meant by mental health	4.08	4.15	Not significant	
6	We understand the role that different support services and professions (including specialist CAMHS) have in supporting mental health for our pupils	4	4.50	Significant	<0.005
7	We know how and when to carry out a CAF if we have concerns about a child's mental health	4.27	4.58	Significant	<0.05
8	We know how and when to refer to different support services and professions (including specialist CAMHS) if we have concerns about a child's mental health	4.29	4.59	Significant	<0.05
9	We know and understand how different factors in a child's life can make them more at risk of mental health difficulties	4.67	4.69	Not significant	
10	We intervene effectively when a child appears anxious	4.61	4.75	Not significant	
11	We intervene effectively when a child appears to have a persistent low mood, or to be depressed	4.33	4.53	Not significant	
12	We intervene effectively when a child has difficulties forming relationships with others	4.35	4.72	Significant	<0.005
13	We intervene effectively when a child has experienced a loss or bereavement	4.63	4.73	Not significant	
14	We intervene when a child's behaviour interrupts their own and others' learning	4.57	4.70	Not significant	
15	We work effectively with parents to support pupils' mental health	4.39	4.55	Not significant	
16	We have asked the pupils about mental health and have acted on their ideas for how to improve	3.04	3.55	Significant	<0.05

These results would suggest that perceptions of a number of specific aspects of school practice had changed significantly by the end of the TAMHS programme. No clear consistent themes were apparent in the aspects of school practice most affected by the programme, although it is worthy of note that the 'core content' of the CPD programme for TAMHS schools due to be delivered after the end of the programme focuses on many of the areas where changes noted failed to reach significance.

Semi structured staff questionnaire - Key findings:

A By the end of TaMHS there was a significant positive change in staff perceptions on a number of school practices such as:

- The provision of effective mental health support to students
- Recognising and addressing staff wellbeing
- Knowledge of how to help improve relationship difficulties
- Understanding the role of different support services, including specialist CAMHS
- Knowledge of how to carry out a CAF

B The areas that have not changed much include policy development to support practice; having a clear understanding of mental health issues; being able to support experiences of low mood, bereavement and anxiety; behaviour management and working with parents to support students. These are areas which will be addressed as part of the core CPD Programme.

Absence managed transfer and exclusion data

Q What effect does TaMHS have on schools 'ability to address absence, managed transfers and exclusions?

Q Does TaMHS affect referrals to specialist support services (including Education Other Than Schools (EOTAS), Behaviour Improvement Programme (BIP) and Pupil Referral Unit (PRU)?

Q How does North Somerset schools compare with national data on levels of emotional problems, behavioural problems and school climate? (Information from 'Me & My school' 2010 report).

Analysis was conducted across 13 schools originally signed to partake in the TaMHS project and compared with equal number of schools (n=10 primary and n=3 secondary) in North Somerset based on *"Numbers on roll"* and the *%* of school meals provided by the school.

Data collected related to the following categories: Summary Absence *(SA)* - % of sessions missed of the total number of sessions available; Persistent absence (PA) - % of pupils who have missed 20% of sessions available; Fixed Term Exclusions *(FTE)* and Permanent Exclusions (PE) and these are recorded as numbers (*Fig.10 & 11).*

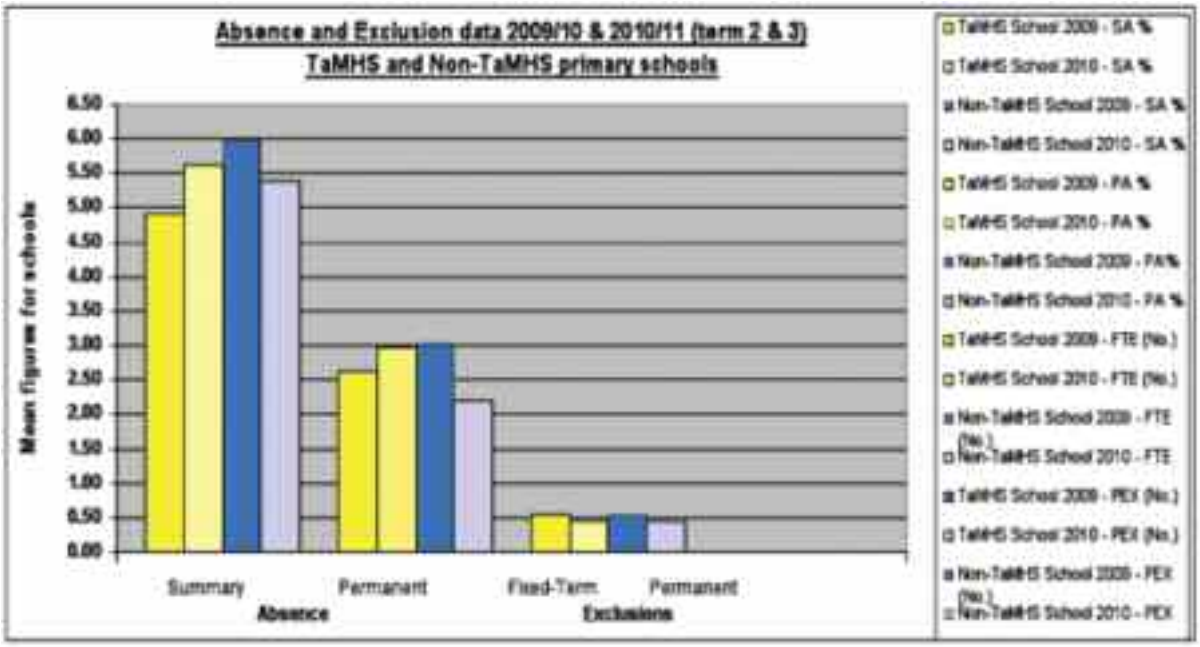


Fig.10 – Comparison of pre and post data for TaMHS primary schools against non-TaMHS primary schools on rates of summary absence, persistent absence ,fixed-term and permanent exclusions. This data relates to terms 2 & 3 of academic years 2009/10 and 2010/11.

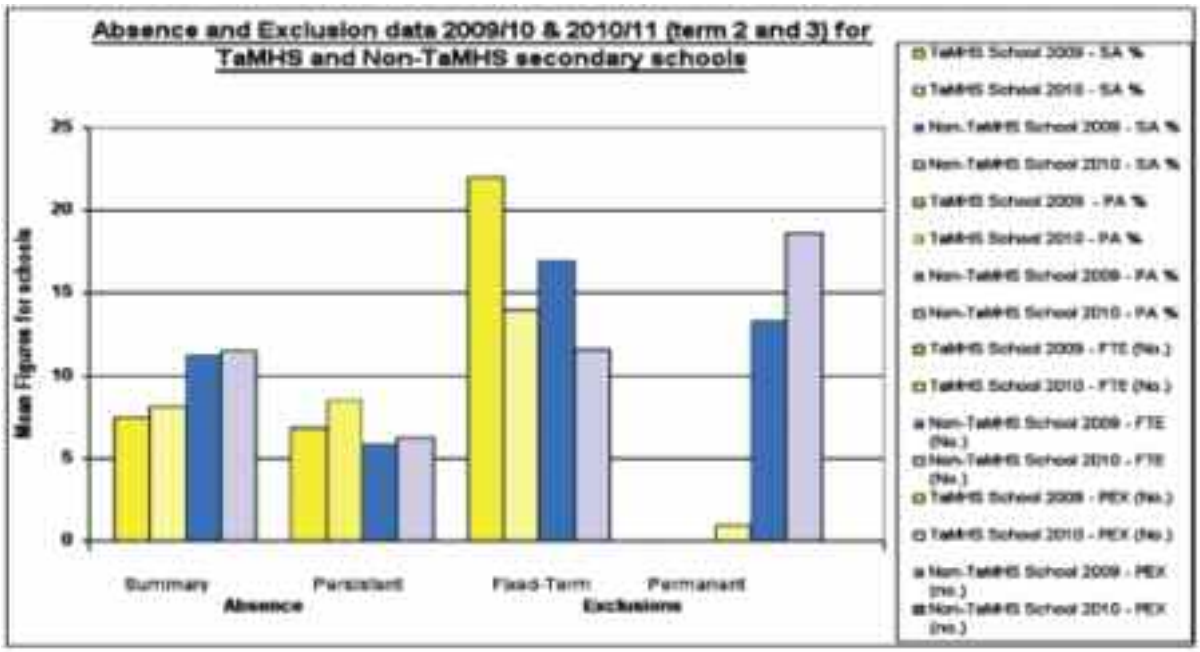


Fig. 11 – Comparison of pre and post data for TaMHS secondary schools against non-TaMHS secondary schools in relation to rates of summary and persistent absence, fixed-term and permanent exclusions. This data relates to terms 2 & 3 of academic years 2009/10 and 2010/11.

As can be seen from figure 10 there appears to be slight increases in summary and persistent absences for TaMHs primary schools compared to the non TaMHS primary schools where there appears to have been a decrease across these measures. There seems also to have been a small decrease in fixed term exclusions for both TaMHS and non TaMHS schools.

The results from secondary schools, presented in figure 11 appear to show a similar trend for both TaMHs and non TaMHS schools with a small increase in both summary and persistent absence but a decrease in fixed term exclusions. An increase can be seen in permanent exclusions.

Analysis conducted using ANOVA found however no significant differences in mean changes across any of the four categories by either year (2009/10 – 2010/11 - terms 2 & 3), or between TaMHS and Non-TaMHS schools (P>.05). Mean data were as follows:

Primary schools (n=11):

- TaMHS 2009/10 SA (mean = 4.91, SD = 2.066) and 2010/11 (mean = 5.62, SD = 1.236). Non-TaMHS 2009/10 SA (mean = 5.98, SD = .733) and 2010/11 (mean = 5.38, SD = .876).
- TaMHS 2009/10 PA (mean = 2.62, SD = 1.956) and 2010/11 (mean = 2.97, SD = 2.626). Non-TaMHS 2009/10 PA (mean = 3.02, SD = 1.433) and 2010/11 (mean = 2.20, SD = 1.462).
- TaMHS 2009/10 FTE (mean =.545, SD = .934) and 2010/11 (mean = .454, SD = .687). Non-TaMHS 2009/10 FTE (mean = .5455, SD = 1.213) and 2010/11 (mean = .454, SD = .820)
- TaMHS 2009/10 PEX (mean = 0.00, SD = 0.00) and 2010/11 (mean = 0.00, SD = 0.00). Non-TaMHS 2009/10 PEX (mean = 0.00, SD = 0.00) and 2010/11 (mean = 0.00, SD = 0.00).

Secondary Schools (n=3):

- TaMHS 2009/10 SA (mean = 7.55, SD = 2.116) and 2010/11 (mean = 7.53, SD = 2.592). Non-TaMHS 2009/10 SA (mean = 11.23, SD = 4.992) and 2010/11 (mean = 11.50, SD = 5.655).
- TaMHS 2009/10 PA (mean = 6.80, SD = 3.953) and 2010/11 (mean = 7.03, SD = 5.519). Non-TaMHS 2009/10 PA (mean = 5.83, SD = 2.203) and 2010/11 (mean = 6.23, SD = 2.753).
- TaMHS 2009/10 FTE (mean = 22.00, SD = 4.582) and 2010/11 (mean = 12.66, SD = 7.371). Non-TaMHS 2009/10 FTE (mean = 16.93, SD = 19.977) and 2010/11 (mean = 11.56, SD = 9.287).
- TaMHS 2009/10 PEX (mean = 0.00, SD = 0.00) and 2010/11 (mean = 1.00, SD = 1.000) and non-TaMHS 2009/10 PEX (mean = 13.33, SD = 21.385) and 2010/11 (mean = 18.66, SD = 25.716).

Referrals to specialist support services

Requests for referral data to specialist support services were made, but unfortunately this was not made available in time for this report.

North Somerset schools comparison nationwide

The *'Me and My schools'* (2010) report shows that North Somerset schools are comparable in emotional and behavioural difficulties, and school climate – atmosphere within the school – with participating pupils nationally but only at primary school level. Unfortunately, there was insufficient secondary school data for comparison (*See Appendix D).*

Absence managed transfers, exclusions, referrals to support services and 'Me and My School' - Key findings:

A There were trends to indicate a slight increase in summary and persistent absence for TaMHS primary schools compared to non TaMHS primary schools but a reduction in exclusions for both categories during the time that TaMHS were running. These differences were, however, not statistically significant.

B For secondary schools there were trends to indicate a small increase in summary and persistent absence for both TaMHS and non TaMHS schools. There were reductions for both school categories in fixed term exclusions, but a small increase in permanent exclusions. The differences were not statistically significant.

C No data were obtained to identify changes in referrals to specialist support services.

D 'Me and My schools' findings indicate that North Somerset primary schools do not differ significantly from schools nationally in relation to emotional and behavioural difficulties and school climate (atmosphere).

Q What are school perceptions of facilitating factors and obstacles to implementing TaMHS?

3.4 Qualitative feedback from telephone interviews

A qualitative analysis was conducted following telephone interviews across TaMHS schools (n=13) *(Appendix C)*. However, only ten took part (77% response) and the following themes emerged:

- Differences TaMHS has made to our school:
  Staff confidence and whole school awareness/understanding of pupil emotional well-being and mental health issues have been enhanced. This has assisted staff to identify, focus on and assist those who require additional support in the classroom. In turn, this has helped to raise self-awareness, self-esteem and confidence in pupils.
- Main successes of the programme in school and factors which helped bring about these successes:
  Having an independent facilitator for particular interventions helped to reduce costs in terms of staff and resources. Further, TaMHS has fed into other school interventions/initiatives. In particular, several schools mentioned the ***visible*** *success of Breakthrough and 'Go-Peutics'. Having one single point of contact has proved useful in some schools.*
- Aspects of the TAMHS programme less successful in school and why this may be:
  Reasons of disruption, incomplete data collection or interventions not having been run tended to be attributed to lack of staffing time, costs and the resources required to run multiple interventions in one school at the same time. In particular, Breakthrough and ELSA were repeatedly mentioned as resource consuming and difficult to maintain as was communication of these interventions with TaMHS staff/facilitators, and training was negatively viewed by some schools as a result. Breakthrough not

Case Whole School Study

Backwell and TaMHS

The implementation of the TaMHS interventions was led by the Assistant Head teacher with responsibility for inclusion. This gave the programme both a high profile within SLT and ensured that one person had a clear overview of what was being put in place. In addition to the Assistant Head teacher, two of our Learning Mentors played an important role by leading several of the interventions.

The programmes that we selected were designed to both build on the work that we were already doing with our vulnerable students but also to bridge any gaps that we had indentified. In the end we used seven programmes (Dreamwall, PASS, Breakthrough, FRIENDS, and Seasons for Growth, ELSA and the Mental Health Workshops) from the TaMHS 'menu'. The selection process of students for specific programmes was a group effort between the Heads of House, the Learning Mentors and the Assistant Head teacher. In addition, the PASS survey results fed into this selection process.

Some programmes, such as the Mental Health Workshops, we adapted a little to focus on specific issues that we had recognised within the school. This flexibility was important as it allowed us to use the programme for our own specific needs.

The TaMHS programme undoubtedly has left a legacy for the school. At present we are creating a Vulnerable Child Policy and the TaMHS interventions are feeding directly into this policy. Likewise we are targeting our gap between FSM and non-FSM students and the PASS survey data is playing an important part in targeting strategies to improve both the academic progress and attitude towards education of some of the students in this cohort

Nick Lind – Assistant Head teacher
Behaviour and Inclusion

being continued into secondary has led to relapse in behavioural issues of 1 in 4 pupils and PASS and SEAL questionnaires were not child-friendly in their layout or with regards to those with reading difficulties and visual impairment.

- Intervention(s) schools want and feel equipped to continue running:
  FRIENDS, ELSA, MHW, SEAL and SFG were mentioned as interventions schools would most like to develop further in collaboration with TaMHS support. In particular, FRIENDS as it can be tailored to specific support needs and is very good at tackling resilience issue; ***"you could say it is invaluable in doing so."*** *'Go-Peutics' was very successful in engaging pupils instantly but not considered long enough for children to maintain benefit as they have only just settled at 6-weeks.*

- Outside support and Resources to continue/commence running future interventions (cost, staffing, logistics, facilitation space):
  Would like to continue to run 'Breakthrough' or 'Go-Peutics' but funding is the issue. A single point of contact, good-in house training for school staff to aid in autonomy and intervention tailoring would also be necessary. A final theme was TIME – to plan, resource, devise and assess pupils for participation and continued TaMHS support for supervision and guidance in structure and running of ELSA's and MHW's.

- Things learnt in this evaluation and future recommendations for interventions and TaMHS:
  Common themes were to simplify procedures and data collection for TaMHS evaluations. Provide more training for school staff to give autonomy in running their own interventions yet having a single point of contact in TaMHS for supervision, guidance and ongoing questions/support.

"Interventions are a brilliant concept, but we need good feedback to build confidence in conducting them; and for the children as in 'Go-Peutics' they too require feedback such as the photo-book, mini-reports. Also, it is vital to have a project lead such as MP who has assisted us greatly with her knowledge and understanding of schools and the interventions – she has been fantastic!

In future, set-up time is required and evaluation should be considered in terms of timing also."

"Professionally, both the lead and TaMHS team were outstanding!"

"We understand how important evaluations are but in future time and size of content should be a priority. Schools were already stretched with interventions running and multiple other evaluations for Academy status, National strategies etc…."

"Overall, this was a very positive experience with staff and systems. Interactions, networks and support were all there and managed well…."

Summary of whole school and interagency outcomes

A Following TaMHS there was a significant positive increase in staff perception on a range of school practices in relation to mental health. The areas that did not change relate to areas that have just recently been introduced (eg interventions for grief and loss) and a better understanding of mental heath (eg a training programme is due to be implemented).

B TaMHS did not have any significant effect on absence managed transfer and exclusion data.

C There was a significant increase in staff perception of how to access support services, including specialist CAMHS

D Qualitative feedback from schools highlight that having a clear project lead and using independent group leaders are perceived as facilitating the implementation of TaMHS. Pressure on staff, time constraint and paperwork for some of the evaluations (Pass and SEAL) were seen as obstacles for successful implementation.

4

Conclusions and Recommendations

Summary of results

An overwhelming positive and enthusiastic response has been received for the North Somerset TaMHS programme. Within the programme core work from colleagues in CAMHS, Mental Health Specialists, Inclusion Advisory Team and Educational Psychology alongside third sector organisations and North Somerset sports partnership, have contributed to the development of mental health support with 13 TaMHS schools. This model has developed a cohesive, collaborative approach and commitment to mental health, enabled the pooling of resources, joint working and evidence based practice. Specialist support and supervision has enabled schools easy access in order to meet the needs of their pupil population. A significant number of children, young people and staff have been involved with the TaMHS programme. The interventions provided have given schools an opportunity to 'sample' good practice and the TaMHS model seems to have given them the confidence to develop emotional health and well being work. Increased awareness and skills in both staff and students have been reported in relation to mental health issues and schools have valued not only the opportunity to be involved , but also to be part of a collaborative workforce.

Positive trends and feedback have been evident for all interventions. Small sample sizes may account for the lack of significant results found for some of the group interventions. Other reasons include the finding that students selected scored well within the normal range for mental health problems prior to intervention. Although these findings are not totally surprising given that TaMHS is a universal service, it may nevertheless indicate a need for improving identification and assessment skills in staff. For instance, previous studies have found that children with high scores of anxiety prior to FRIENDS intervention showed more significant improvements than children who scored within normal range pre-intervention (Stallard et al., 2005 & 2007). The excellent results from ELSA which demonstrated significant improvements in staff identification and monitoring skills is therefore worthy of note. We recommend that this training is rolled out to a wider group of staff.

Overall the best outcomes for the group interventions and training were for

Breakthrough, ELSA and specific aspects of the Mental Health Workshop. However schools were positive about most of the interventions but particularly valued groups run by independent facilitators as this was perceived as easier and more time effective for staff. However, caution should be noted as government policy has indicated a move for schools to provide early interventions alongside support by specialist services. The original remit of TaMHS was to build capacity within schools by developing interventions that could be facilitated by school based staff. Research findings support the benefit of teaching staff being trained in the delivery of universal interventions as demonstrated by Kassem (2002) who found that this had a positive impact on classroom environment, behaviour and peer relationships. In our experience a collaborative approach has been particularly valuable in facilitating best use of resources, knowledge and skills.

In order to sustain this level of mental health support and provision it is therefore recommended that sufficient priority be given to the development of mental health awareness for all school staff, underpinned by whole school policies. Further, that this is supported by specialist services in the guise of supervision, training and consultation.

On a whole school and interagency level there were positive changes in staff perception on a number of school practices in relation to mental health following TaMHS and an increased understanding of how to access specialist support services. There was however no identifiable benefits from TaMHS in relation to school managed transfer or exclusion rates. It could be argued that a more ongoing commitment to the TaMHS model needs to be embraced before organisational change can realistically be expected to occur. Continued leadership and co-ordination is therefore vital to ensure that schools adhere to a clear model which helps them to identify and address the needs of vulnerable groups.

Having a project lead and regular contact points for the different interventions were seen as key facilitating factors for the success of TaMHS.

There was however considerable variation between the schools in their engagement with TaHMS, as some schools managed to deliver a wide variety of interventions whilst others changed very little in their practices. Some of this variation has also been evident in the absence of evaluation data from specific schools. There may be several explanations for this. An impression formed by the TaMHS steering group has been that a strong commitment from the school senior leadership team has generally resulted in better overall participation.

Kidger(2008) found that unless teachers have the support and understanding from managers within school, initiatives to support the mental health needs of young people were often "hampered". Given that the senior management team set the tone for the school it is crucial that they embrace and model good practice in relation to mental health. Ideally, to ensure that strategies are integrated and sustainable within the school ethos and culture it is essential to identify

a member of this team with clear leadership in creating and managing a positive environment which enhances emotional health and wellbeing in school.

The fact that the North Somerset TaMHS only had 1 year to deliver a highly ambitious programme including training, assessments, implementation and evaluation should however be kept in mind. Anecdotal evidence from other authorities has highlighted that in areas where funding was given for a three year period, there was more time for planning, learning and consolidation but this did not necessarily result in more activities. Therefore it is important to note that given the very short time frame, the expectations placed on staff in relation to time commitment, learning and motivation have been extremely high.

North Somerset TaMHS has also unfortunately coincided with significant political changes for schools, many of which have been in the process of developing into Academies during the last year. This has among other things involved considerable changes to structural and procedural operations, staff roles and the requirement to comply with a range of new assessments and paperwork.

The evaluation process was highlighted as particularly taxing by some. This was mostly evident for evaluation systems requested by outside agencies (e.g. PASS which has not been addressed in this evaluation and Seal which is requested to comply with national audits). Ideally sufficient time should have been given prior to the start of the programme to discuss with staff the potential complexities of data gathering and evaluation tools should have been controlled by one source and streamlined where possible.

Although this TaMHS project has taught us that a significant amount of progress can be achieved within a very short time frame, it must nevertheless be acknowledged that the level of intensity sustained over the past year has had its limitations and ideally those involved would have preferred more time.

This would have created more opportunities for reflection and planning prior to implementation of programmes and ensured a more graded introduction of tasks. This may have facilitated ongoing feedback, necessary adjustments and more support and time for schools to absorb and consolidate new learning. It is possible that this would have served to minimise staff overload and confusion whilst maximising engagement, confidence and cooperation.

More funding would also have enabled the training of more external facilitators as well as school staff to improve provision in schools.

In considering the whole school outcomes, it is evident that there was limited change in staff understanding of mental health conditions following TaMHS. It is acknowledged that a teaching programme which aims to improve staff conceptualisation and understanding of different mental health conditions may have been better placed at the beginning rather than at the end of the programme. This may also have improved the understanding of the aims of interventions, the ability to select relevant students for groups as well as the need for evaluation.

Schools provide an ideal setting in which to reach large numbers of children and young people. Fergusson et al. (2003) suggests that there is evidence that indicates various school related factors in particular,

peer relationships, academic success and the way in which a student feels contained and connected to the school can have an impact on a young person's mental health and well-being.

Universal and early intervention in schools provides a firm foundation upon which to build capacity to support school improvement and engage in direct work developing student resilience and skills in managing their own mental health. The TaMHS programme has clearly demonstrated the commitment and enthusiasm from schools and specialists agencies to work in a collaborative cohesive and structured way in order to deliver targeted support to children and young people.

Whilst the needs of our most vulnerable groups should be given particular attention, we should not underestimate the need for a comprehensive model of emotional health and wellbeing support for all young people within North Somerset. This would provide a tiered approach offering enhanced support to our most vulnerable groups whilst acknowledging that there are many factors which can affect young peoples' mental health. In particular those who may require some short term intervention and support that do not fall within the category of being "vulnerable" and therefore the ethos should be Mental Health for All. In this current climate where the emphasis and focus is on attainment we know this is not possible without an underpinning of good mental health.

Summary of recommendations

- To improve staff skills in identification and assessment of mental health needs. One suggestion is to make Elsa training available to more staff.
- To further improve universal and targeted mental health awareness for all school staff, underpinned by whole school policies. An identified CPD Programme for staff within schools would address these issues.
- Ongoing coordination and commitment from school senior leadership teams to a model of care which helps staff to identify and address the needs of vulnerable students.
- Supervision, training and consultation to be provided by specialist services in order to address both staff and student well being and to improve access to specialist services.

That North Somerset identifies a strategic and operational lead with a commitment to ensuring that an early prevention and intervention strategy is implemented. One possibility could include a continuation of a multiagency steering group

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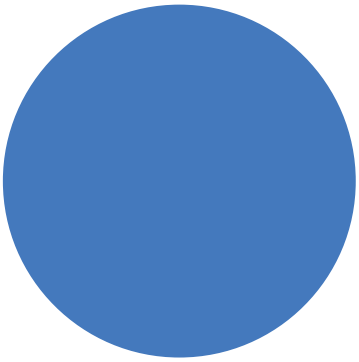


APPENDIX A

Participating Schools and School Lead /s

Ashcombe Primary School Earlham Grove Weston-super-Mare North Somerset BS23 3JW	Peter Turner Head teacher & Kathie Light Learning Mentor
Backwell Secondary School Station Road Backwell North Somerset BS48 3BX	Nicholas Lind Assistant Headteacher Behaviour & Inclusion
Castle Batch Community Primary School Rawlins Avenue Worle Weston-super-Mare North Somerset BS22 7FN	Edwina Whitwell Inclusion Leader & Senco
Christ Church C of E Primary School Baker Street Weston-super-Mare BS23 3AF	Tracey Harrington Yr 5 Teacher
Court De Wyck Bishops Road Claverham North Somerset BS48 4NF	Nick Riddiough Head teacher
Flax Bourton C of E Controlled Primary School Station Road Flax Bourton North Somerset BS48 1UA	Jane Bennett Head Teacher & Senco
Heron's Moor Community Primary School The Campus Highlands Lane Locking Castle Weston-super-Mare BS24 7DX	Julie Fox Head teacher & Rachel Cotterrill Year 5 Teacher
Kewstoke Primary School Kewstoke Road Weston-super-Mare North Somerset BS22 9YF	Lynn Yelland Head Teacher

Oak Hill + Tuition Services North Centre (Short stay school) Pound Lane Nailsea BS48 23NN	Andy Pryor Acting Head Teacher
Priory Community School Queensway St Georges Weston-super-Mare North Somerset BS22 6BP	Jane McBride Assistant Vice Principal
Windwhistle Primary School Kingsley Road Weston-super-Mare North Somerset BS23 3TZ	Natalie Sweet Senco
Wyvern Community School Marchfields Way Weston-super-Mare North Somerset BS23 3QP	Christine Johnson Head of Inclusion
Yatton CoE Junior School High Street Yatton North Somerset BS49 4HJ	Marion Clements Senco

APPENDIX B

Members of the TaMHS Steering Group

Michelle Pye	TaMHS Programme Lead & Chair
Jo Scott	Deputy Programme Lead & Primary Mental Health Specialist CAMHS
Liv Kleve	Evaluation Lead & Consultant Psychologist CaMHS
Sue Harding	CANs – Inclusion Advisory Team Manager
Gabrielle Stacey	Professional Lead for Educational Psychology
Maggie Dickinson	Senior Leader SEAL
Peter Turner	Head Teacher Ashcombe Primary School
Helen Caldwell	Strategic Commissioning Officer – (Equality, Access and Achievement)
Heather Kapeluch	CaMHS National Support Service, South west development Centre.
Marie Malferiol-Force	Assistant Locality Lead
Sheila Harding	Specialist Nurse Children Looked After
Chris Rush	Director Weston Excellence Cluster
Sue Walker	Teaching and Learning Adviser: PSHE and Citizenship

Intervention Leads

Silver Seal, Targeted Seal, Family Seal & SEAC
Maggie Dickinson, Sonia Hulejczuk, Sue Williams

Seasons for Growth
Jo Scott, Michelle Pye

Go –Peutics
Sarah Turnbull

Dreamwall
Ian Gosling, El Jenks, Sam stokes, Michelle Pye

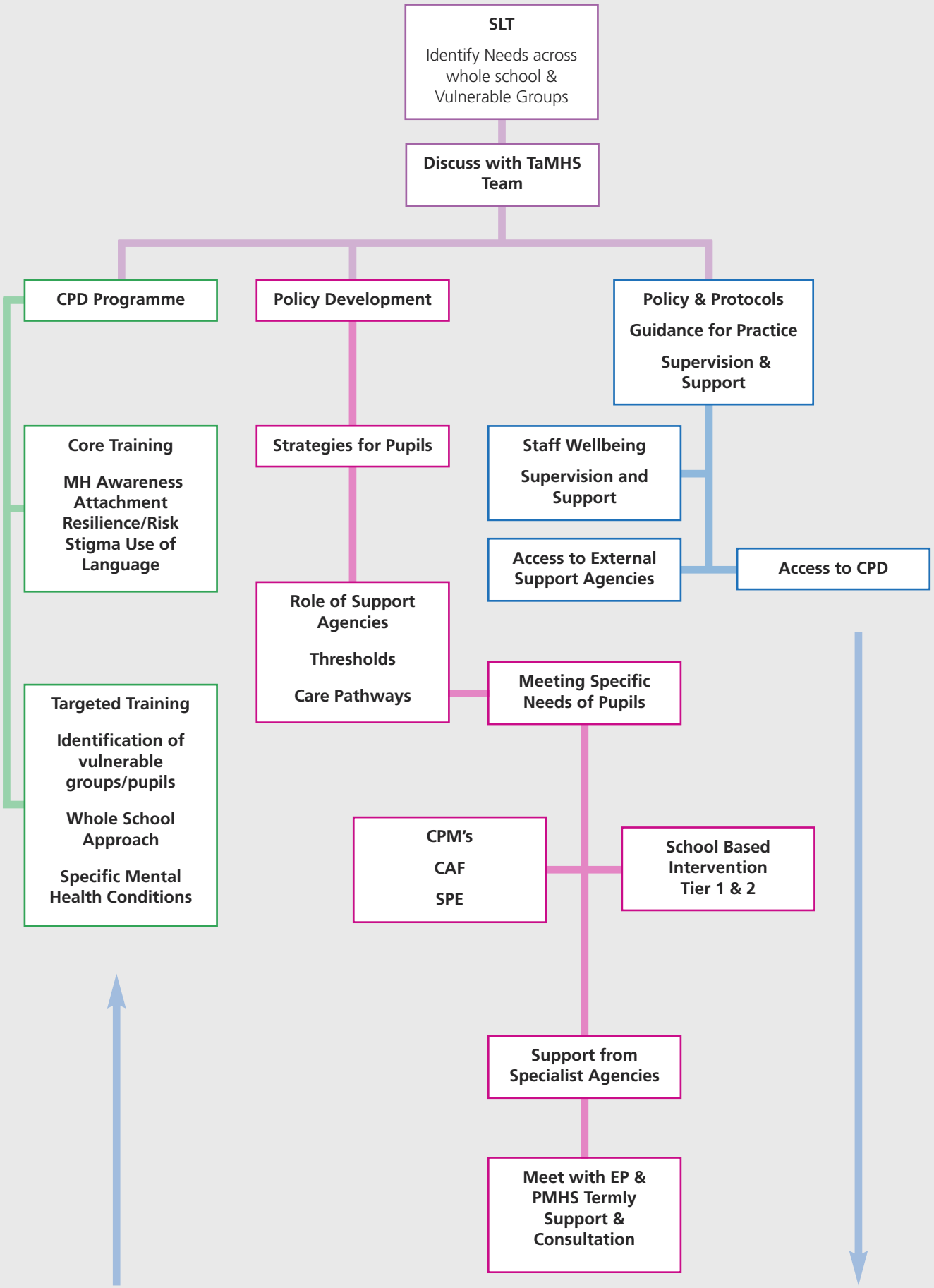
ELSA
Dave Jenkins

Mental Health Workshops
Michelle Pye, Jo Scott

FRIENDS for Life
Vince McLaughlin

Breakthrough
Rebecca McCormack

Diagramme of CPD Programme and Mental Health Support to schools



APPENDIX C

TAMHS Interview schedule for phone interviews with HTs/Senior staff

Introduction:

Thank you for spending time with me to answer these questions. As part of the TAMHS evaluation we are looking at not only what difference the programme made to pupils and staff but also what factors might have influenced the success of the program.

1. What difference do you think being involved in the TAMHS project has made to your school over the last year?
2. What (if anything) do you see as the main successes of the programme in your school and what factors do you think helped bring about these successes?

   School factors: (i.e. ethos, organisation, relationships in school/ with others outside school, staff skills or attributes, involvement of parents or children/ wider community)

   Features of the program: (i.e. interventions, collaboration with other schools, external agency involvement)

   Logistics: (i.e. time, funding, other)
3. What aspects of the TAMHS programme (if any) have been less successful in your school and why do you think this may be?

   School factors: (i.e. ethos, organisation, relationships in school/ with others outside school, staff skills or attributes, involvement of parents or children/ wider community)

   Features of the program: (i.e. interventions, collaboration with other schools, external agency involvement)

   Logistics: (i.e. time, funding, other)
4. What, If any, intervention(s) would you want to and feel equipped to continue running?
5. What, if any, outside support would you require in continuing this intervention?
6. Is there anything else you think we could learn for the future from how the TAMHS programme has happened in your school?
7. Briefly, please describe your experience of working with TaMHS, CaMHS and the evaluations?