

Research paper

Emotional health work with schools by primary mental health workers in Wales

Julia Terry

Primary Mental Health Lead in CAMHS with Pembrokeshire and Derwen NHS Trust, Wales, UK

ABSTRACT

Background Child and adolescent mental health services (CAMHS) have implemented the primary mental health worker role using a variety of models at the interface with primary care and education. There has been limited scope to develop emotional health initiatives in schools, due to less monetary provision for CAMHS in Wales. To address this gap, Welsh CAMHS services have utilised primary mental health workers to provide emotional health interface work with schools.

Method A 21-item survey questionnaire was sent to 28 primary mental health workers in Wales.

Results Eleven respondents reported providing emotional health provision in schools.

Conclusions Many primary mental health workers were positive about their interface work with schools, though concerns were raised about implementation difficulties and the need to evaluate the effectiveness of their work.

Keywords: interface models, primary mental health workers, schools

Background

The National Service Framework for Children, Young People and Maternity Services and *Every Child Matters* support the joining up of services, in order that agencies work together effectively regarding the mental health and wellbeing of children and young people.^{1,2}

The number of young people who have been excluded from schools has risen, in Wales in 2005/2006 there were 450 young people permanently excluded.³ In order to address this, greater funding is needed to combat risk factors and to provide early intervention programmes.^{4,5} The publication in 2001 of the All Wales Child and Adolescent Mental Health Service (CAMHS) Strategy, *Everybody's Business* stressed multi-agency working, and is being implemented across Wales over 10 years.⁶ Although increased funding has been received in England, this is not the case in Wales, where there has been little resource for developing CAMHS services.⁷ These inequalities of funding for CAMHS have resulted in serious concern among clinicians in Wales for

the wellbeing of children and adolescents and their families.⁸

In recent years there has been a mismatch in educational objectives, with a curriculum set out for academic abilities leaving a vacuum around emotional literacy,⁹ even though 10–20% of school-age children have mental health problems.^{10,11} Increased interest in mental health means educationalists need to move to a more inclusive model of emotional and social competence,¹² and mental health staff need a broader model to empower educationalists.¹³

Emotional literacy is about recognising the importance of emotions in all aspects of our lives.¹⁴ It is best defined as the capacity to register our emotional responses to situations and to acknowledge these, so we can recognise how they influence our thoughts and actions.¹⁵ Interventions supporting the development of emotional literacy need to be accessible and available in community localities,¹⁶ and school settings can be ideal.

The majority of child mental health problems may be addressed in primary care with specialist support from primary mental health workers (PMHWs), through consultation, supervision, training, and joint work,¹⁷ which may prevent referral to specialist CAMHS.¹⁸ The role of PMHWs is to help primary care staff build their confidence and skills through training, to assist in the recognition of child and adolescent mental health problems, and to assess and treat young people whose problems are considered appropriate for management in Tier 1 services.¹⁹

England has seen the introduction of behaviour educational support teams (BESTs), who provide schools with a multi-agency support network, to develop a range of strategies to promote emotional wellbeing, and to improve staff's skills and confidence in managing behaviour and school attendance.²⁰ Due to limited funding, BEST teams have not emerged in Wales, resulting in other professional groups supporting emotional health work with schools.

The Department for Education and Skills and the Mental Health Foundation (MHF) explored joint working between schools and CAMHS.²¹ The survey identified a positive impact on children, staff and relationships between parents and school. The MHF recommended more training be developed between CAMHS and education staff on promoting children's emotional health, and effective early intervention work, including whole school approaches to mental health.

Funding from the Department of Health for 24 CAMHS innovation projects provided the opportunity for services to include CAMHS in school settings. The City of York offered school-based support services for young people with emotional and behavioural difficulties, who were at risk of exclusion. In targeted schools, Tower Hamlets worked with Bangladeshi boys who were under-achieving and at risk of developing mental health problems; both these projects were found to be effective.²² Many of these initiatives have brought health and social care topics into personal, health and social education (PHSE) curricula in schools. The remit of primary CAMHS includes school-based child and adolescent mental healthcare, which can provide young people with better opportunities to access services, including therapeutic input in the school setting.²³ At the time, these CAMHS innovation grants were restricted to services in England only.

During the last decade the implementation of PMHW roles has grown throughout England,²⁴ with most research in this area being of a quantitative nature.^{25,26} Emerging findings of consultation have called for more joint work between CAMHS and schools,²¹ and acknowledged the value of emotional

health provision in school settings. Wales has received far less monetary provision than its CAMHS counterparts in England.²⁷

There is a lack of research concerning the PMHW role in relation to emotional health provision in school settings. Current literature highlights the lack of qualitative research, as little is known about the views of those involved in provision and benefits or limitations of emotional health work provided by these staff in schools. As previous surveys have omitted the picture in Wales, this small-scale study seeks to examine the nature of interface work in school and educational settings provided by PMHWs in Wales.

Method

The aim of the study was to establish the nature of interface work in school and educational settings in Wales provided by PMHWs, in order to:

- identify the different types of interface models used by PMHWs in school and education settings
- establish brief descriptions of the benefits and limitations of these interface models.

Study design

A cross-sectional study involving a 21-item postal questionnaire was used.

Sample

The sample population was those working in the role of PMHW worker in Wales, and they were contacted through the All Wales Primary Mental Health Worker Forum. This group was established in 2000, to promote good practice, and provide peer support and networking in the principality. Additionally, PMHWs were contacted through the CAMHS in each NHS trust.

Research tool

A copy of the questionnaire is included in the appendix.

Procedure

The postal questionnaire was accompanied by a letter of invitation, participant information sheet,

and consent form. Postal reminders, followed by a telephone call/email were used to follow up non-responders. The data for the study were submitted by participants between September 2005 and January 2006. Permission was obtained from the local ethics committee prior to sending out the questionnaires.

Analysis

The quantitative data were analysed using Statistical Package for the Social Sciences software (SPSS).²⁸ The qualitative elements were examined using content analysis, to search the narrative for emerging themes and concepts.²⁹ An editing analysis style was used, where the data were read in search of meaningful segments, which were identified and then categorised.

Ethical considerations

Respondents were informed at the outset that the study was being conducted anonymously, with confidentiality observed.

Results

There were 13/28 completed questionnaires; 11/13 respondents said they provided emotional health provision to school and educational settings.

Estimate the time you give to emotional health provision for each school/ educational age group

PMHs estimated the number of hours per month they spent on emotional health provision to a range of school and education settings. Out of the 11 PMHs involved in education, eight provided input to both primary and secondary schools, and six of these PMHs also worked in other settings as well (such as sixth form and early years). All four PMHs who worked with early years also worked in primary schools. Four PMHs provided input to colleges, pupil referral units or other educational establishments. No PMHs worked in one education setting exclusively.

Indicate the time you spend on different interventions offered in school and educational settings

PMHs estimated the time spent on different interventions; the most popular was consultation, with all 11 PMHs providing this service. Ten PMHs offered advice. Of the seven PMHs who provided training to staff, four also worked directly with clients, (with five PMHs offering training overall). The two PMHs who provided whole-class workshops also provided direct work and staff training. Three engaged in parent workshops, and one worked through peer education.

How were school and education settings in your area selected when emotional health provision was planned?

Participants recounted how the interface models were established, with eight PMHs stating this was in response to requests made by individual schools, and five of these identifying a particular need. Five reported that provision was in line with schools in areas of deprivation (with four of these identifying a particular need). Three said input was in conjunction with 'Healthy Schools' initiatives. Five out of 11 PMHs stated that the work they provided was established more than four years ago. All 11 PMHs said they experienced support and help from education staff in the setting up of this work.

Has the effectiveness of this emotional health work been measured?

Six out of 11 respondents reported that this had been measured, and five stated it had not. PMHs reported their perceptions of the effect of the interface model they were using, with five stating a reduction in referrals to specialist CAMHS. Five PMHs reported CAMHS teams having an increased knowledge of school staff, with four of these also stating that local schools now had an improved relationship with Specialist CAMHS. All PMHs who had not measured the effectiveness of their work with schools stated that a tool was in development.

Participation of schools and education settings in establishing interface model

When emotional health work was established with schools, nine out of 11 respondents noted a willingness

by school staff to be involved, and to work together using multi-agency approaches to projects. This was demonstrated by school staff being welcoming and allocating time to meet, and giving the work priority. Eight out of 11 PMHWs reported a wish from school staff to improve their own understanding of emotional health issues and a desire to manage problems in a more effective way. Few difficulties or barriers were highlighted in the establishment of emotional health provision, with one PMHW noting the different priorities and agendas that organisations strive to manage. One further PMHW stated they had met with barriers in certain schools.

Effectiveness of emotional health provision in schools

The six PMHWs who stated they had measured the effectiveness of their emotional health input to schools cited a number of outcome measures, including attendee evaluations, satisfaction surveys and strengths and difficulties questionnaires; with encouraging outcomes. This study did not collect detailed reports of these outcome measures, and this information is anecdotal.

‘Parents have been happy with the service because it has provided an intervention which has prevented escalation of behavioural problems in school and helped them manage behaviour at home.’

‘Children feel more in control after doing “dealing with emotions” work, e.g. anxiety/anger ... young people seem to enjoy and value the opportunity to discuss issues.’

Benefits of a PMHW interface model in place in schools

PMHWs reported on a number of benefits, such as an increased focus on emotional literacy (5/11 PMHWs). The benefits of early intervention and preventative work were noted by six respondents, also the increase in the confidence and skills in education staff in recognising and dealing with mental health issues (5/11 PMHWs). An increase in partnership working and joint approaches was noted by five respondents.

‘I think consultation reduces anxieties ... and is beneficial because it contributes to the development of skills, cascading ideas and knowledge to professionals who are working directly with families.’

Limitations of a PMHW interface model in place in schools

Participants noted that a number of staff felt *Everybody’s Business*⁶ pushes more work onto primary care staff, who feel unsupported and overwhelmed, mostly by a lack of time (5/11 PMHWs). The PMHW interface model is often not provided to all schools due to capacity:

‘We are only a small team so are not able to work in all schools in the same way ...’

Respondents also highlighted the needs of young people who are not in school, as they may be missed. Also, the subject of ‘emotional health’ may be viewed as just another topic:

‘In PHSE [personal health and social education] lessons, many schools have a lot of external professionals going in to do work with young people on a wide range of topics. How much info can young people take on board? ... the same applies to staff inset training.’

The most effective ways that PMHWs can provide emotional health provision in schools

All respondents emphasised consultation and training as key features of their interface models:

‘Staff need to be more aware/have understanding about what can affect young people’s emotional health and what can improve it ... teaching and support staff need to be aware that children’s behaviour is often related to their emotions and family influences.’

‘When considering the emotional and social wellbeing agenda for children and young people, it should be considered an essential to also demonstrate commitment to parenting ... If family mental health and wellbeing is the remit of PMHWs, the needs of parents/carers must be considered alongside the needs of the children and young people.’

Five out of 11 respondents recommended that PMHWs be involved in local strategy, by forging links and developing protocols with education regarding the provision of services around emotional wellbeing. Suggestions were made around the provision of emotional health promotion days for young people, parenting courses in schools, that all schools be allocated a PMHW, and that PMHWs link closely with other services (such as educational psychology and behaviour support).

Discussion

This small-scale study indicates that PMHWs are indeed working in a variety of school settings, providing consultation, training and joint work, in line with other studies.^{30,31} There was variation across the respondents in the educational settings they worked with; the majority worked in both primary and secondary mainstream schools. While four of these respondents also worked in early years settings, a further four worked with older young people in colleges, sixth form and pupil referral units. This implies there is no particular focus on age, and that mental health needs of children and young people are being identified across the board. The PMHWs working with early years and primary schools have identified the importance of mental health promotion and identification at an early age.

The most frequent type of interface model identified is the provision of consultation, with the aims of identifying mental health needs and considering ways of meeting these.^{30,31} The provision of training by PMHWs to education staff is a commonly occurring feature of the PMHW role; when carefully developed this can assist Tier 1 staff in identifying mental health problems at an early stage.³³ Consultation may reduce anxiety in workers, and increases understanding of staff about how to promote children's wellbeing. This implies that schools are interested in working in partnership with mental health services.

Where PMHWs commented on the establishment of their work with schools, they all gave positive reports of the support received from schools in the setting up of provision. The majority of schools, who either requested input or were situated in an area of deprivation, had identified a particular emotional health need for PMHWs to address (for example self-harm and eating disorders).

PMHWs highlighted the limitations of their work in relation to the different agendas that agencies own. Although partner agencies appear to be working more closely, how they collaborate has not been adequately conceptualised and no real model exists.³⁴ PMHWs noted the importance of being at the heart of strategy and development in their local areas,³¹ in order to ensure that emotional health provision in schools is not only on the agenda, but is a reality that is owned by education partners and service users alike.

PMHWs are providing education on emotional health and early intervention, in order to positively affect the emotional health needs of children and young people in the areas where they work, despite resources often being limited. Respondents described their work where programmes promote emotional

literacy. Early intervention programmes are most likely to succeed when they are long term, sustained by committed funding, supported by a wide range of public policy measures to reduce health inequalities, and where multi-agency involvement is encouraged.³⁵

Only half of respondents reported that they had evaluated the effectiveness of their interventions in schools, although their positive feedback was anecdotal, as this study did not collect detail regarding outcomes. For future practice, it may be helpful to schools if there is parity in the use of outcome measures, which may increase the uptake of emotional health provision, as schools become convinced about the benefits for pupils.³⁶ Many respondents highlighted positive feedback regarding the effectiveness of their interface models. The majority perceived a reduction in referrals to specialist CAMHS as a result of their ongoing intervention. In Wales, the Merthyr Tydfil PMHWs have already demonstrated an impact on the local specialist CAMHS team, with referrals to Tier 2 becoming far more appropriate, and a huge increase in attendance rates.³⁷

Although the study did not seek to identify PMHW attributes and skills, previous studies have noted the need for PMHWs to have autonomy, accountability, and the ability to utilise specialist knowledge to make decisions about a child's mental health.³⁰ Additionally, PMHWs require a range of therapeutic skills, need to be excellent communicators and networkers, to be able to design and deliver training programmes, and provide consultation and supervision to other professionals at a variety of levels. There has been concern that in order to develop PMHW services this has led to professionals leaving specialist CAMHS to take up these roles, thus depleting the CAMHS workforce.³⁰ While this would certainly have negative implications for specialist CAMHS, it is proactive to develop services more robustly at Tier 1 to avoid children and young people developing mental health problems in the first place.

It is important to remember that PMHW teams are often established with different remits, for example targeting health promotion, providing early intervention and uncovering unmet need have quite different aims, and will consequently have different outcomes and effects. Even if referrals increase, and more children are receiving a service, the outcome of this provision should be regarded as a significant success.³¹ A sustainable approach to emotional health in schools is a major challenge, and many initiatives fade quickly, particularly if they are not supported by permanent funding. As schools' priorities include the promotion of learning, and assisting in the management of challenging behaviours,¹³ they have an investment in the promotion of emotional literacy. Many PMHW posts are subject to

short-term funding, making the delivery of effective emotional health projects extremely challenging.

Further research is essential regarding the outcomes and effect on young people of emotional health provision in schools. This is best achieved by involving children and young people. They are already learning more about emotional health, and are becoming aware how to support each other, with many successful buddy and peer mentoring systems in place. If emotional health provision in schools demonstrates an improvement in attendance, exclusion rates, and behaviour, it would be crucial that this resource is recognised and owned by education. It would then be a high priority for both local commissioners and government agencies to ensure this work is properly funded.

Limitations

This was a very small-scale study, limited to the principality of Wales, an area which has often been omitted from previous research. The data provide a snapshot of current activities of PMHWs' emotional health work with schools in Wales, which was the aim of the study.

However, the ability of the research to answer questions about current service provision is limited to the knowledge of participants, and data regarding the effects of interface models were almost entirely based on professionals' reports and perceptions. It would be beneficial to research the effects and experiences of emotional health provision to schools from a wider viewpoint, including the views of education staff and specialist CAMHS teams.

The response rate to the questionnaire was low (13/28 = 54%). It is difficult to comment on the types of services that did not respond. Some may not provide a service to schools, and hold other service priorities. Another limitation may be that the questionnaire was considered too long, which may have affected the response rate. The All Wales PMHW forum is aware that many PMHW posts exist only through short-term funding, which leads to frequent changes in staff and the way in which services are provided. There was no significance found in the geographical areas that did not respond. The views of children and young people were not included in this study, and thus their crucial perspective has been omitted.

Conclusion

The nature of emotional health interface work provided in education settings by PMHWs in Wales is varied, but there is an increased focus on providing

consultation and training to school staff. These interventions are being welcomed in education, and it feels as if we have moved from the starting blocks as schools start to own their role in meeting the emotional health needs of children and young people.

Recommendations in the *National Service Framework for Children, Young People and Maternity Services in Wales* and *Every Child Matters* are likely to improve multi-agency collaboration.^{2,38} The effects of interface work should promote a 'can do' culture for education staff, as they are no longer restricted to merely 'holding' the challenging issues of mental health. Support and training provided by PMHWs can raise confidence, and promote the satisfaction of seeing new skills in education staff being effective, as early intervention work in schools develops.

In order to examine effective models of emotional health provision in education settings, further research including longitudinal studies would be advantageous in realising the true impact on young people, education staff and communities. This would significantly inform the debate regarding the most effective and efficient use of resources in implementing emotional health provision with schools.

While many PMHWs spoke positively about their work with schools, they did not see themselves as the only professional able to deliver this. Each school requires an allocated mental health worker, to ensure a whole-school approach to emotional health, systems for peer support, and early identification of problems, with training for staff and pupils on emotional literacy. Presently, a number of PMHWs in Wales have sought to fill this gap.

This research was conducted as part of an MSc in Interprofessional Practice (Child and Adolescent Mental Health) with City University, London in conjunction with YoungMinds.

REFERENCES

- 1 Department of Health. *National Service Framework for Children, Young People and Maternity Services*. London: HMSO, 2004.
- 2 Department for Education and Skills. *Change for Children – Every Child Matters*. London: Department of Health, 2003.
- 3 The Poverty Site. www.poverty.org.uk/W16/index.shtml (accessed 28 July 2007).
- 4 Buchanan A. *Promoting Children's Emotional Well-being*. Oxford: Oxford University Press, 2000.
- 5 Carr A (ed). *What works with Children and Adolescents? A critical review of psychological interventions with children, adolescents and their families*. London: Routledge, 2000.

- 6 National Assembly for Wales. *Child and Adolescent Mental Health Services: everybody's business*. Cardiff: National Assembly for Wales, 2001.
- 7 Department of Health. *Our Healthier Nation: mental health – children and young people's mental health services* (CAMHS). London: Department of Health, 2002. www.ohn.gov.uk/ohn/priorities/mental.htm
- 8 Lamb C, Riley S and Davies G. Strategic thinking. *YoungMinds* 2004;71. www.youngminds.org.uk/magazine/71/davies/php
- 9 Atkinson M and Hornby G. *Mental Health Handbook for Schools*. London: Routledge, 2003.
- 10 Meltzer H, Gatward R, Goodman R and Ford T. *Mental Health of Children and Adolescents in Great Britain*. London: The Stationery Office, 2000.
- 11 Weare K. *Promoting Mental, Emotional and Social Health, A Whole School Approach*. London: Routledge, 2000.
- 12 Weare K. Building bridges between mental health and education. *International Journal of Mental Health Promotion* 2001;3.
- 13 Weare K. *Developing the Emotionally Literate School*. London: Sage, 2004.
- 14 Orbach S. *What's really going on here?* London: Virago, 1994.
- 15 Orbach S. *Towards Emotional Literacy*. London: Virago, 1999.
- 16 Walker S. Social work and child mental health: psychosocial principles in community practice. *British Journal of Social Work* 2003;33:673–87.
- 17 Gale F. When tiers are not enough: the developing role of the primary child mental health worker. *Child and Adolescent Mental Health in Primary Care* 2003;1.
- 18 Health Advisory Service. *Child and Adolescent Mental Health Services: together we stand*. London: HMSO, 1995.
- 19 Bower P and Macdonald W. Developing Tier 1 services. In: Williams R and Kerfoot M (eds) *Child and Adolescent Mental Health Services: strategy, planning, delivery and evaluation*. Oxford: Oxford University Press, 2005.
- 20 Department for Education and Skills. *Behaviour and Education Support Teams*. www.dfes.gov.uk/best (accessed 28 July 2007).
- 21 Pettit B. *Effective joint working between Child and Adolescent Mental Health Services (CAMHS) and Schools' Mental Health Foundation*. Brief No. 412, 2003
- 22 Young Minds. www.youngminds.org.uk/magazine/54/kurtz.php Last (accessed 28 July 2007).
- 23 Ani C and Garralda E. Developing primary mental healthcare for children and adolescents. *Current Opinion in Psychiatry* 2005;18:440–4.
- 24 Gale F and Vostanis P. Case study: the primary mental health team – Leicester, Leicestershire and Rutland CAMHS. In: Williams R and Kerfoot M (eds) *Child and Adolescent Mental Health Services: strategy, planning, delivery and evaluation*. Oxford: Oxford University Press, 2005.
- 25 Bradley S, Kramer T, Garralda M *et al*. Child and adolescent mental health interface work with primary services: a survey of NHS provider trusts. *Child and Adolescent Mental Health* 2003;8:170–6.
- 26 Lacey I. The role of the child primary mental health worker. *Journal of Advanced Nursing* 1999;30:220–8.
- 27 CAMHS National Assembly Elections. *NCH Cymru, Barnardos Cymru, NSPCC, Save the Children, Tros Gynnal, Briefing Paper 2*. www.positifpolitic.co.uk/docs/manifestos/bp2.doc
- 28 Norusis MJ. *SPSS for Windows: Base System User's Guide*. Chicago: Statistical Package for the Social Sciences Inc, 1993.
- 29 Polit D, Beck C and Hungler B. *Essentials of Nursing Research: methods, appraisal and utilisation* (5e). New York: Lippincott, 2001.
- 30 Gale F and Vostanis P. The primary mental health worker within child and adolescent mental health services. *Clinical Child Psychology and Psychiatry* 2003;8.
- 31 Macdonald W, Bradley S, Bower P *et al*. Primary mental health workers in child and adolescent mental health services. *Journal of Advanced Nursing* 2004;46:78–87.
- 32 Dogra N, Parkin A, Gale F and Frake C. *A Multi-disciplinary Handbook of Child and Adolescent Mental Health for Front-Line Professionals*. London: Jessica Kingsley, 2002.
- 33 Gledhill J, Kramer T and Iliffe S. Training general practitioners in the identification and management of adolescent depression within the consultation: a feasibility study. *Journal of Adolescence* 2003;26:245–50.
- 34 Salmon G. Multi-agency collaboration: the challenges for CAMHS. *Child and Adolescent Mental Health* 2004;9:156–61.
- 35 Titterton M, Smart H and Hill M. Mental health promotion and the early years: the evidence base for interventions. *Journal of Mental Health Promotion* 2002;1.
- 36 Wolpert M, Foster B and Fletcher C. Regional Developments: Outcome Measures in CAMHS. *YoungMinds* 2004;69.
- 37 Whitworth D and Ball C. The impact of primary mental health workers on referrals to CAMHS. *Child and Adolescent Mental Health* 2004;9:177–9.
- 38 Welsh Assembly Government. *National Service Framework for Children, Young People and Maternity Services in Wales*. Cardiff: Welsh Assembly Government, 2004.

CONFLICTS OF INTEREST

None.

ADDRESS FOR CORRESPONDENCE

Mrs Julia Terry, 19 Rhosfa Road, Brynaman, Carmarthenshire SA18 1DF, Wales, UK. Tel: +44 (0)1269 822953; email: juliaterry@btinternet.com; Julia.terry@pdt-tr.wales.nhs.uk

Received ?????

Accepted ?????

Questions 4–6 relate to the establishment of emotional health provision in school and education settings.

- 4 How were school and education settings in your area selected when emotional health provision was planned?

Please tick all that apply

- | | |
|--|--------------------------|
| Request by individual school/education setting | <input type="checkbox"/> |
| School/education setting in area of deprivation | <input type="checkbox"/> |
| Particular need identified by school, e.g. self-harm | <input type="checkbox"/> |
| In conjunction with Healthy Schools Initiative | <input type="checkbox"/> |
| Schools invited to respond to advert/offer of intervention | <input type="checkbox"/> |
| Time apportioned equally to schools in area | <input type="checkbox"/> |
| Interventions offered to schools randomly | <input type="checkbox"/> |
| Unknown | <input type="checkbox"/> |

- 5 When were the links established with these schools/education settings approximately?

Please tick one box only

- | | |
|---------------------------|--------------------------|
| Less than 12 months ago | <input type="checkbox"/> |
| Between 1 and 2 years ago | <input type="checkbox"/> |
| Between 2 and 4 years ago | <input type="checkbox"/> |
| More than 4 years ago | <input type="checkbox"/> |

- 6 Have other people been supportive and helpful in the setting up of the local emotional health work in school/educational settings?

Please circle one only

Yes

No

If yes, which groups of people have been encouraging?

Please tick all that apply, and state any other helpful agencies/individuals

- | | |
|---|--------------------------|
| Young people | <input type="checkbox"/> |
| Parents | <input type="checkbox"/> |
| Staff in school/education setting | <input type="checkbox"/> |
| Link workers | <input type="checkbox"/> |
| Specialist Child and Adolescent Mental Health Service (CAMHS) staff | <input type="checkbox"/> |
| Other PMHWs | <input type="checkbox"/> |
| Other education staff | <input type="checkbox"/> |
| Other, please state | <input type="checkbox"/> |

In what way have these people been encouraging?

Questions 7–11 relate to the monitoring of, and effectiveness of emotional health provision in school and education settings.

- 7 Has the effectiveness of this emotional health work been measured?

Please tick one only

Yes (please go to Question 8a)

No (please go to Question 8b)

8a

(i) If yes, how was this measured?

(ii) Were the outcomes encouraging or discouraging? Please describe.

8b If no formal outcome measures have been used, please give a brief description of the feedback there has been so far from young people, parents, school/education staff and other agencies.

9 What do you see as the benefits of the type/types of interface model that are in place in these school/education settings?

10 What do you see as the limitations of the type/types of interface model that are in place in these school/education settings?

11 In your opinion, what do you think are the most effective ways that a PMHW can provide an effective emotional health service to young people in school/education settings?

Questions 12–14 relate to information about the PMHW provision in the area where you work.

12 How many PMHWs are there in your area?

Please state

13 How are PMHWs in your area are funded?

Please state how many

- NHS trust
- Social services
- Part NHS/part social services
- Voluntary sector (please state which)

.....

- Local health board
- Other (please state)

.....

14 What is the ratio of PMHWs per head of population?

Please state how many PMHWs, compared to the population (i.e. census amount, including adults) e.g. 3:70,000

Questions 15–16 relate to the known effects of emotional health provision in school and education settings

15 What effect do you think the PCMHW interface model in school and education settings has had on your local specialist CAMHS team?

Please tick all that apply

- A reduction in referrals to Specialist CAMHS
- An increase in referrals to Specialist CAMHS
- Local schools/education settings have increased contact with specialist CAMHS
- Local schools/education settings have decreased contact with specialist CAMHS
- Local schools/education settings have an improved relationship with specialist CAMHS
- Local schools/education settings have a decreased relationship with specialist CAMHS
- CAMHS team have an increased knowledge of school/education staff
- Effects on local specialist CAMHS team not known
- Other, please state

16 What effect do you think the school interface model had on young people attending that particular school/education setting?

Please tick all that apply

- Changes in behaviour of young people
- Changes in behaviour of staff
- Changes in attendance patterns
- Changes in young peoples educational ability/achievements
- Changes in local self-harm rates
- Other, please state

Please give a brief description of these effects:

17 Is there anything else that you would like to add?

Thank you for taking time to complete this questionnaire

