Royal Borough Windsor and Maidenhead

Children's Services

Wellbeing Team Evaluation Report

November 2015 - July 2016

"The Royal Borough of Windsor & Maidenhead is a great place to live, work, play and do business supported by a modern, dynamic and successful Council"

Our vision is underpinned by four principles:

Putting residents first
Delivering value for money
Delivering together with our partners
Equipping ourselves for the future

In Children's Services, our highly skilled workforce is committed to meeting residents needs as quickly and early as possible. We know that the more children, young people and families we help early, the more successful citizens they become.

Achieving our ambition of supporting all residents to be successful is dependent on us working together with a wide range of partners.

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Section 1: Summary

Table 1: Summary of Wellbeing Service Casework November 2015 – July 2016

Outcome	Type of work	Totals
Outcome 1: To support children, young people (C/YP) and/or their families at the earliest stage to understand and effectively manage (where appropriate) mental health concerns.	Total individual referrals from the EHH	85
	Total Number of schools supported	22
	Total number of individuals supported (EHH)	49
	Short term individual interventions (<5 weeks)	13
	Long term individual interventions (5-20 weeks)	36
	Total Number of therapeutic groups Total Number of Children/Young People in groups	3 19 C/YP
	Total Number of C/YP in individual and group interventions	68 C/YP
Outcome 2: To improve knowledge and understanding of mental health and emotional wellbeing amongst students and staff, creating an open and supportive culture around mental health in schools.	Anti-Stigma Workshops Total number of C/YP	11 schools 79 C/YP
	Whole Class Mindfulness Groups Total number of C/YP	5 schools 130 C/YP
Outcome 3: To improve knowledge and confidence of school staff and parents when working with children and young people with emotional and mental health difficulties.	Mental Health First Aid Training for professionals working with children and young people Total number of delegates	11 schools 22 delegates

Section 2: Background and Service Delivery

2.1 The Wellbeing Team was set up in response to increasing concerns about the mental health and wellbeing of children & young people (C&YP) and was specifically identified by school audits as an area of need. It is, at minimum, a three year programme to focus on children and young people's mental health and wellbeing. The purpose of the team was to support children and young people and their families at the earliest stages to understand and effectively manage (where appropriate) mental health concerns. This was to ensure schools and other professionals feel supported with the aim to reduce the need to escalate to specialist services both in CAMHS and Social Care.

2.2 Support from the team was open to all children and young people in RBWM schools (5-18 years). It was agreed that this team would offer both direct work such as consultation and initial assessment, time limited focused interventions, such as CBT informed strategies and group work/workshops with children and young people and indirect work such as training, TAC meeting support and signposting. Three main areas of focus for the team were:

1. Social communication difficulties
2. Attention and hyperactivity and
3. Low mood and anxiety.

The period between November 2015 and December 2015 was used for team set up and liaison with schools. Early Help Hub referrals were received by the team from January 2016.

2.3 The Wellbeing Practitioners were assigned a number of link schools and carried out meetings with each to discuss services available and the referral process. During November 2015 – July 2016 a total of 85 individuals (Mean age 12.4, SD 2.4; 42 females and 48 males) were referred to the Wellbeing Service through the Early Help Hub. This included referrals from 8 secondary schools, 8 primary schools, 2 first schools and 4 middle schools (see Table 2 below). 49 of these cases received an individual intervention from a member of the Wellbeing Team; all others had an initial assessment and were successfully signposted.

Table 2: Breakdown of Early Help Hub Referrals by School 2015 – 2016

Secondary Schools	Primary Schools	First Schools	Middle Schools
Altwood	Cookham Rise	Dedworth First	Dedworth Middle
Charters	Courthouse	The Royal (Crown Aided)	St Peter's CE Middle
Cox Green	Furze Platt Junior		St Edward's Royal
Desborough College	Holy Trinity CE Sunningdale		Trevelyan Middle
Furze Platt Senior	Knowl Hill CE Primary		
Newlands	Larchfield Primary		
Windsor Boys	St Edmund Campion		
Windsor Girls	Woodlands Park		

Table 3: Summary of Difficulties referred to the Wellbeing Service 2015-2016

*It should be noted that some cases had more than one area of concern, following initial assessment and consultation a primary need was identified and appropriate intervention was suggested.

Section 3: Interventions, Measures and Desired Outcomes

Primary Concerns on referral	Number of Pupils
Anxiety	32
Anger Management/Behavioural Difficulties	11
Low Mood	11
Depression	11
Self-Esteem/Confidence	8
School Refusal	7
Self-Harm	3
Substance mis-use	2

3.1 The impact of interventions delivered by the Wellbeing Service, and the quality of the workshops and training were evaluated using a mixture of evidence based and purposefully developed measures. Table 4 below outlines the interventions, measures and outcomes.

Table 4: Evaluation Measures and Outcomes of the Wellbeing Service 2015-2016

Intervention	Measure	Respondent	Outcome
School Anti-Stigma Workshops	Summary Questionnaire	Child/Young person	Students will have benefitted from the workshop with an increase in knowledge and awareness of mental health. Students will make a change in their own lives and in school with regards to promoting positive mental health.
Mindfulness Groups	Child and Adolescent Mindfulness Measure (CAMM)	Child/Young person	Improvement in ratings of acceptance and mindfulness skills.
	Summary Questionnaire	Child/Young Person	Students have learned new skills, enjoyed the sessions and will consider the use of these in the future.
Staff Training (Mental Health First Aid Training)	Evaluation Youth MFHA form	Staff Delegates	Improved ratings in staff confidence, understanding and knowledge of how best to support young people with mental health difficulties.

Psycho-Education Group	Strengths and Difficulties Self Report Questionnaire SDQ (4-17)	Child/Young Person	Reduction in difficulties experienced and an increase in pro-social behaviour.
	Session Rating Scale (SRS)	Child/Young Person	Improved ratings on the individual's experience of the therapeutic relationship/alliance.
	Outcome Ratings Scale (ORS)	Child/ Young Person	Improved ratings in life functioning as a result of therapeutic intervention.
Emotional Resilience Group	SDQ Self Report Questionnaire (4-17)	Child/Young Person and Parent	Reduction in difficulties reported and an increase in pro-social behaviour.
CBT	Revised Children's Anxiety and Depression Scale (RCADS) and RCADS-P	Child/Young Person and Parent	Increased understanding of young person's difficulties and a reduction in symptoms.
	SDQ (4-17) Self Report and Parent measure	CYP and parent	Reduction in difficulties experienced and an increase in pro-social behaviour.
	Outcome Rating Scale	Child/Young Person	Improved ratings in life functioning as a result of therapeutic intervention.
	Session Rating Scale	Child/Young Person	Improved ratings on the individual's experience of the therapeutic relationship/alliance.
	CHI-ESQ	Child/Young Person	Individual can review their experience of therapy and help practitioner to appraise their own and their service's practice, to improve what they do.
Filial Therapy	SDQ (4-17) Parent measure (where appropriate)	Parent	To improve social and emotional mental health and behavioural outcomes for children and young people.
Attachment Focused Therapy	SDQ (4-17) Parent measure (where appropriate)	Parent	To help children and young people repair attachment trauma and strengthen attachment relationships.
Play and Creative Arts Therapy	SDQ (4-17) Parent measure (where appropriate)	Parent	To help children to make sense of their feelings and find ways of coping with and managing them.
Person Centred Counselling	Client Contract	Therapist and Child/Young Person	Children and young people to overcome specific problems, improving self-awareness and esteem.

3.2 It should be noted that for all groups and individual work the data set is relatively small, and hence any findings from quantitative measures used should be interpreted with caution and considered in combination with qualitative feedback from children and young people, their parents and teachers. We will regularly review how we collect the outcome measures for the Wellbeing Service to best reflect the impact of interventions

Section 4: Outcomes

OUTCOME 1: To support children, young people (C/YP) and/or their families at the earliest stage to understand and effectively manage (where appropriate) mental health concerns.

List of Interventions offered:

- Individual assessments and consultations
- Targeted therapeutic groups based on identified needs of group members
- CBT informed strategies for low mood and anxiety
- Person Centred Counselling
- Filial Therapy
- Attachment Focused Therapy
- Play and Creative Arts Therapy

Group Interventions

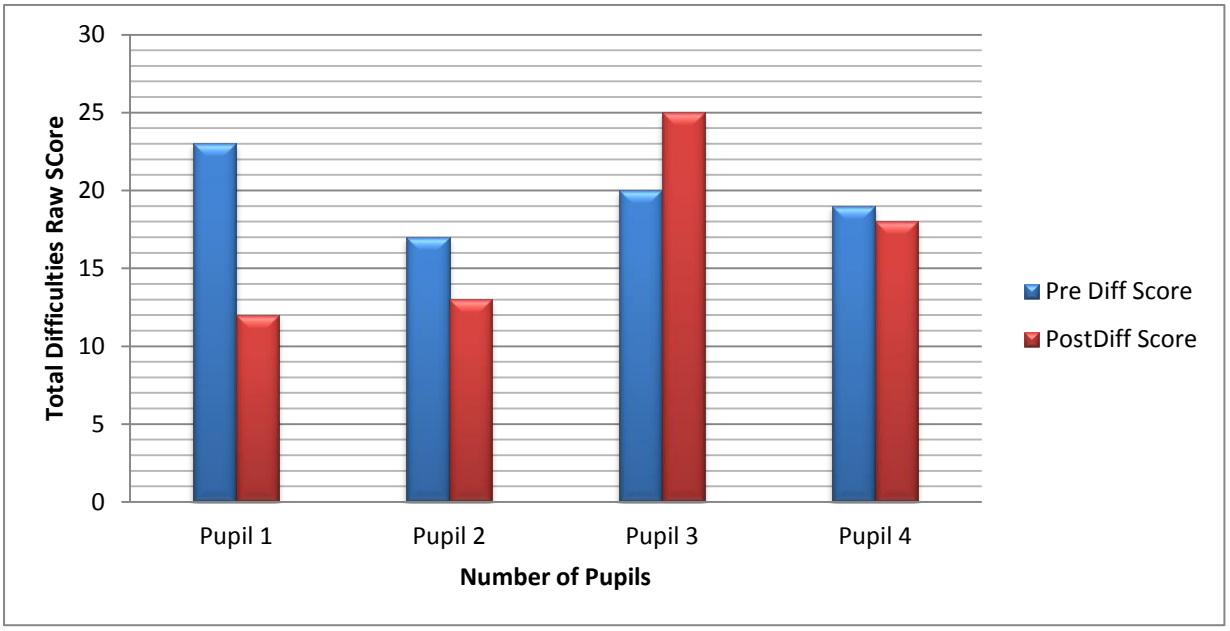
Emotional Resilience Group

4.1 Following an initial needs analysis at a planning meeting at Windsor Girls School in December, three girls from year 9 and one from year 10 were identified by key staff as having poor attendance and associated anxiety. From this, it was decided that an emotional resilience group could be offered by the Wellbeing Team to support these young people and their parents. The group format was for 10 sessions of 60 minutes duration, running after school from December 2015 to February 2016.

4.2 For the purpose of evaluation SDQs (4-17) were completed by the young people and their parents (where possible) both pre and post intervention, as well as weekly session rating scales (SRS) and outcome rating scales (ORS) to ensure the young people could provide immediate feedback on the intervention.

4.3 Each session focussed on improving young people's resiliency skills under 5 core themes 1) Basics 2) Belonging 3) Learning 4) Coping and 5) Care. The results presented below summarise the change in raw scores for total difficulties experienced pre and post intervention.

Graph 1: Self Report SDQ (4-17) - Raw Scores for total difficulties pre/post intervention



4.4 Self reports suggested an overall improvement in experience of difficulties for three out of the four young people as well as an increase in pro-social skills. Ratings for emotional difficulties, behavioural difficulties, inattention and problems with peers decreased for the same three students, but were rated higher for Pupil 3. This young person's scores were in contrast to what would be expected following an intervention, this may be due to contributing factors such as the impact of a recent diagnosis of ASD and the young person's suitability to the group, as well as the severity of the young person's anxiety.

4.5 Individual Outcomes:

- Pupils 1 and 2 re-engaged with education and their attendance began to steadily improve. Parents were encouraged to develop an understanding of their young person's situation, and to improve their skills when supporting their mental health and wellbeing.
- Pupil 4 was able to engage with a family worker from the Intensive Family Support Service, which resulted in a significant disclosure and social care involvement.
- Following the group, Pupil 3 re-engaged with education through an alternative provision and attended a small group community based setting from March to July 2016.

<u>Psycho-education Group</u>

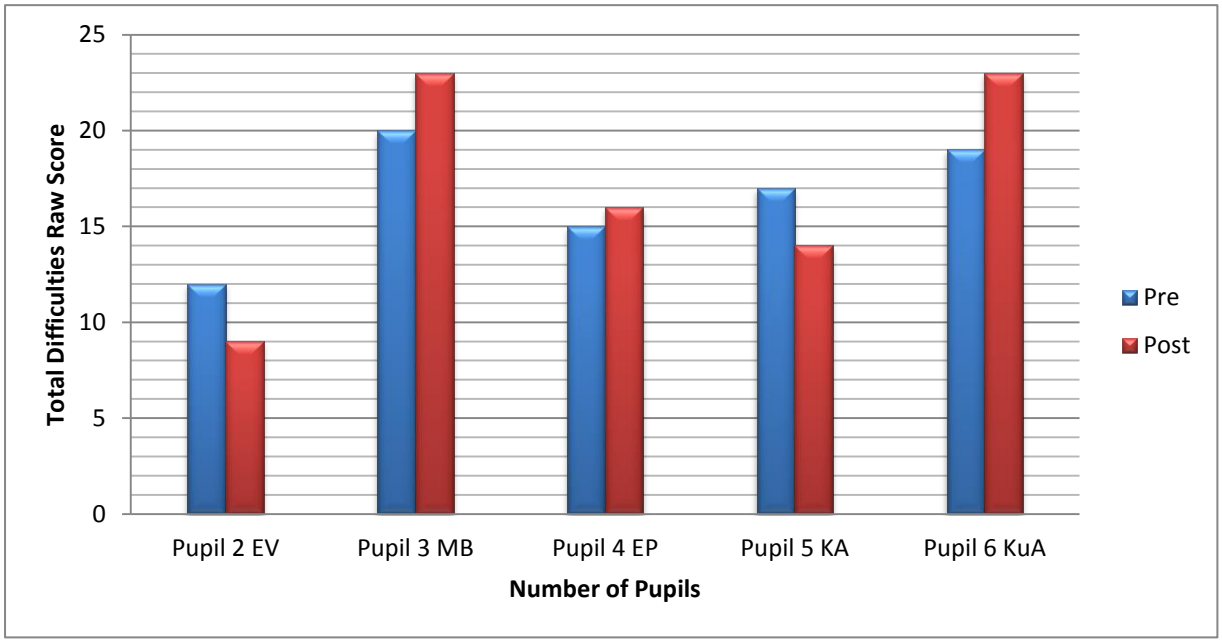
4.6 The programme was developed to provide psycho-education to those who may benefit from one-to-one therapeutic intervention, but were not ready to engage. The aimed for outcome was for the young people to be able to identify their needs and to inform adults what interventions would work for them. The group was developed in collaboration with key staff at Windsor Boys School and built around 6 students who were at risk of permanent exclusion because of presenting behavioural difficulties. Inclusion criteria were: 1) Young people displaying disruptive behaviours; 2) Mild anxiety; 3) Low self-esteem; 4) Facing difficulties at home, for example parents with mental health difficulties, alcohol and/or drug abuse.

4.7 The Developing Youth Practice's tool kit on 'Choice Theory and Reality Therapy' was used to provide an 8 week programme grounded in concepts and techniques from Choice Theory originally developed by William Glasser. Choice Theory contends that all our motivation and behaviours are an attempt to meet our specific desires and universal human needs of 1) Love and Belonging, 2) Self- Worth and Power, 3) Freedom, 4) Fun and Enjoyment and 5) Survival and Health. Reality Therapy is a method of psychotherapy based on Choice Theory which enables individuals to clarify how they can best fulfil their needs, to evaluate their own behaviours and to make more effective and satisfying choices without infringing on the needs of others.

4.8 The results below are based on measures returned from group members. Data was collected both pre and post intervention using the SDQ (4-17) Self Report Questionnaire, Outcomes Rating Scale and Session Rating Scale.

4.9 There were mixed results from ratings received pre and post with 2 out of 5 young people recording an improvement in total difficulties experienced.

Graph 2: Self Report SDQ (4-17) - Raw Scores for total difficulties pre/post intervention



4.10 This unexpected result may be explained by the fact that the aimed for outcome of the group was for young people to be able to identify their needs and evaluate their own behaviour, therefore their self-awareness of their difficulties may have increased post intervention.

4.11 Individual Outcomes (Group Interventions)

- Pupil 2 learnt that he had control over his behaviour, and was learning to take time out when he was feeling angry. He was beginning to identify and understand his triggers and what led to his disruptive behaviour. In light of this he put forward strategies within school that he felt would work for him. He decided that school support would be preferable at this time.

- Pupil 3 expressed a desire to change his behaviour, as he didn't want to be excluded from school. His emotional maturity held him back and was an area of need identified by his practitioner to explore in one-to-one counselling which it was agreed would start in September 2016.

- Pupil 4 said that he had learnt more about depression and anxiety through the group, the fight/flight response and the body's physical reaction. He was able to identify that he became angry quickly when people goaded or annoyed him. He is beginning to recognise the signs when he is getting angry and has said that he must think about the consequences and leave the situation before he lashes out.

- Pupil 5 had a diagnosis of ADHD which appeared to be impacting on his education and home life. He showed recognition of his impulsive behaviour, and his tendency to see red in certain situations.

- Pupil 6 was able to identify that he became angry when he was not being listened to. He also said that he becomes angry if people talk about his family in a disrespectful way. He identified that he needs to find a way to "let his anger out." He also said that he thought that it

would be helpful to talk to someone about his “loss of control.” He was able to identify the physical changes in his body when he is beginning to get wound up. He clenches his fists, and gets a shortness of breath. He said that in the future he would try to remove himself from the situation.

He said that he had learnt more about anger. He understood that people perceive things differently and people may not always feel the same way that he does.

Mindfulness Groups

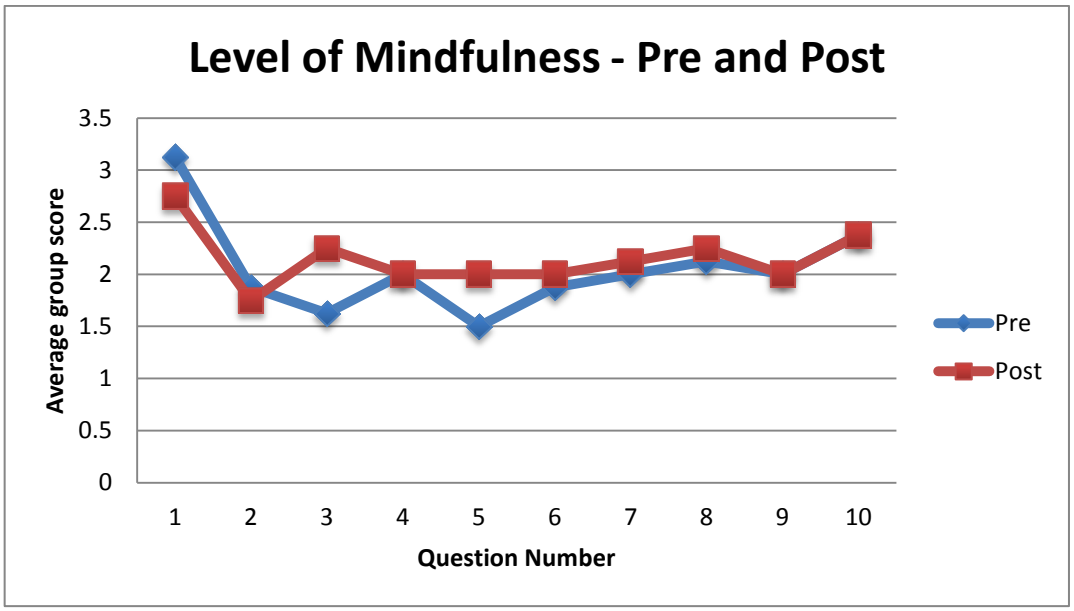
4.12 **.b** is a fun and engaging mindfulness course to give students a taste of mindfulness, adapted from the adult courses Mindfulness-based Stress Reduction (MBSR) and Mindfulness-based Cognitive Therapy (MBCT). Students learn different techniques of how to calm their mind, deal with difficulties, and respond more skilfully to whatever is happening right now, be that good or bad. The course uses visuals, video clips and practical exercises to make it fun and engaging for the young people.

4.13 The link Wellbeing Practitioner for Charters Secondary School attended an extended services meeting to discuss mindfulness as an intervention. The school expressed an interest to trial this with a selected groups of year 9 students in preparation for year 10 and the increase in academic demands. The head of year initially approached 14 students who had been selected to improve their social and emotional mental health. In the end 9 students (3 girls and 6 boys) chose to participate in the programme. Social integration, low confidence and self-belief, poor self-regulation and difficult home life were identified as areas of need for those students participating in the programme. The group format was for 8 sessions for 60 minute duration running from May – July 2016.

4.14 The **.b** mindfulness in schools 10 week programme was condensed into 8 sessions for the purposes of the group, due to time constraints session two (taming the animal mind – cultivating curiosity and kindness) and the final wrap up session were omitted at the practitioner’s discretion.

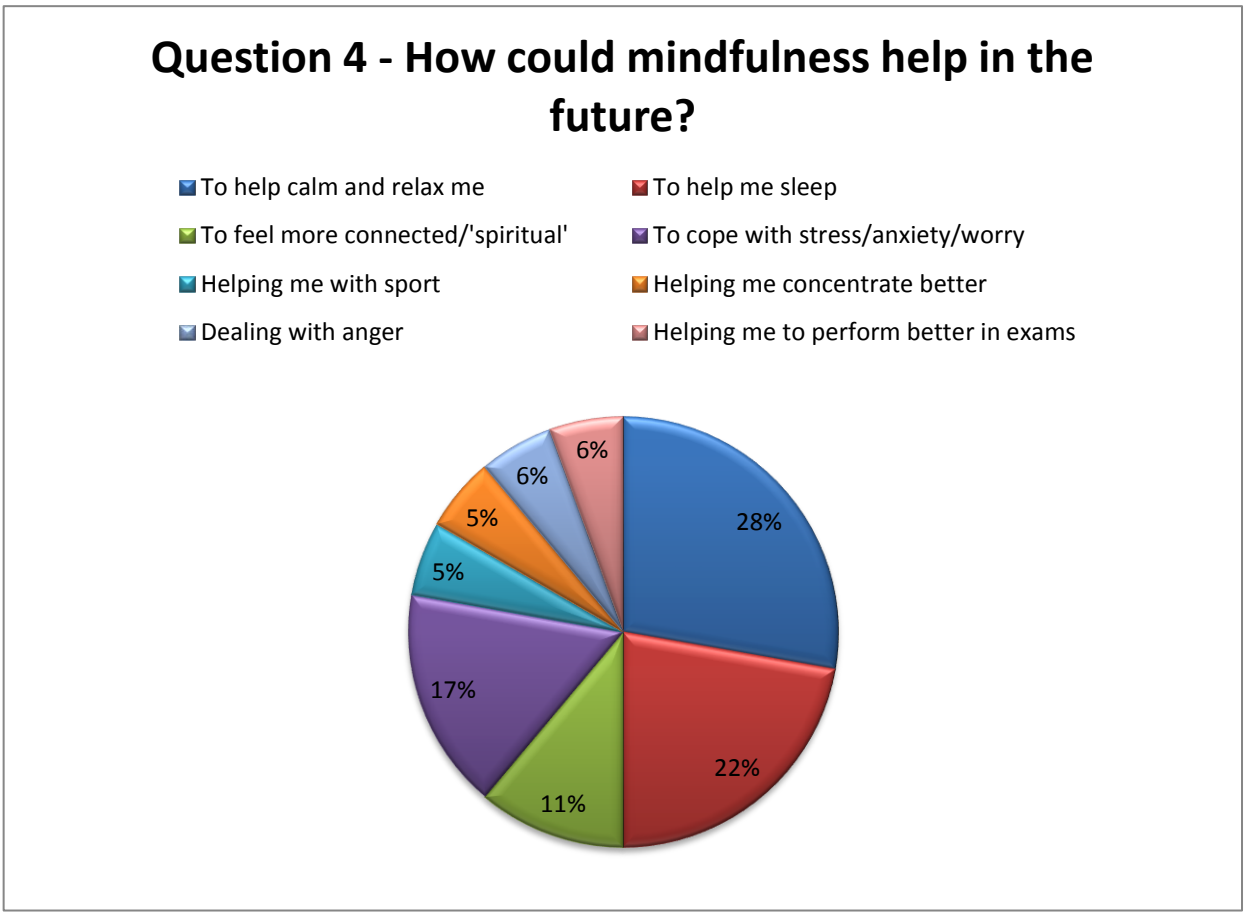
4.15 The evaluation involved the completion of the Child and Adolescent Mindfulness Measure (CAMM 10 item questionnaire) by young people pre and post intervention, with the aim to improve their self-acceptance and mindfulness skills. As can be seen from graph 2, level of mindfulness generally improved from pre to post intervention. In particular ratings for questions 3 and 5 showed a noteworthy improvement with students recording that they were noticing their thoughts and feelings more often and were more likely to accept them rather than push them away. Please refer to the CAMM questionnaire to see the content of all questions.

Graph 3: Student Ratings on the CAMM Questionnaire Pre and Post Intervention

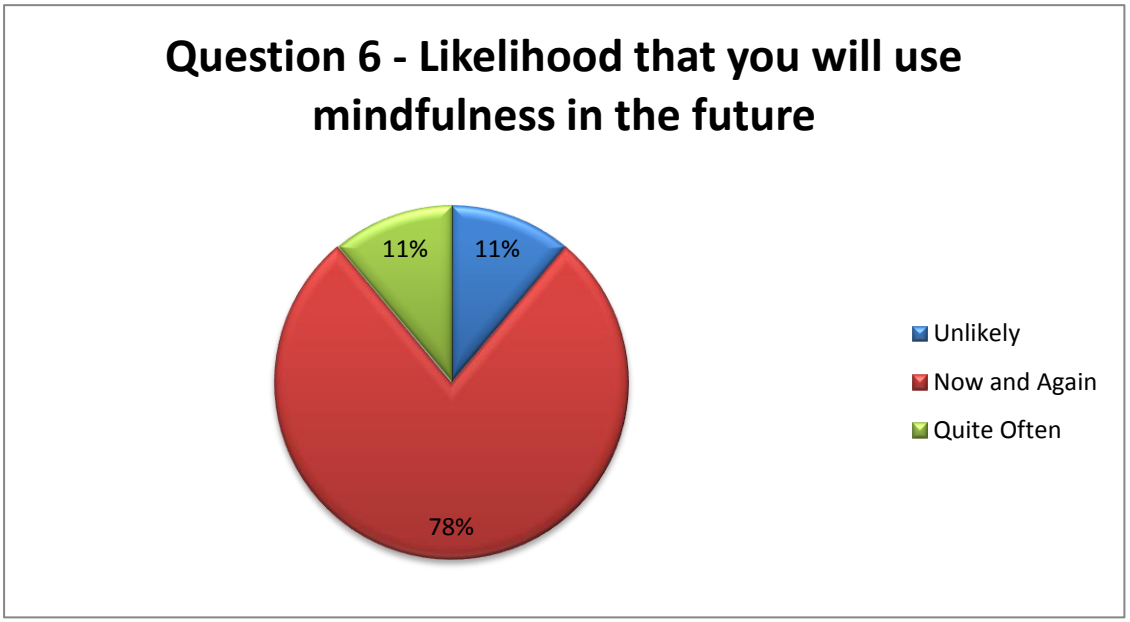


4.16 A 7-item summary questionnaire was developed by the practitioner to gain feedback on the sessions, skills that were acquired and opinions on future use. Pie Chart 1 below outlines the ways in which students reported that they would find mindfulness helpful in the future, showing the generalisation of skills learned from the sessions. More than half of the participating students indicated that the would be likely to use mindfulness techniques in the future as and when it felt necessary (see pie chart 2).

Pie Chart 1:

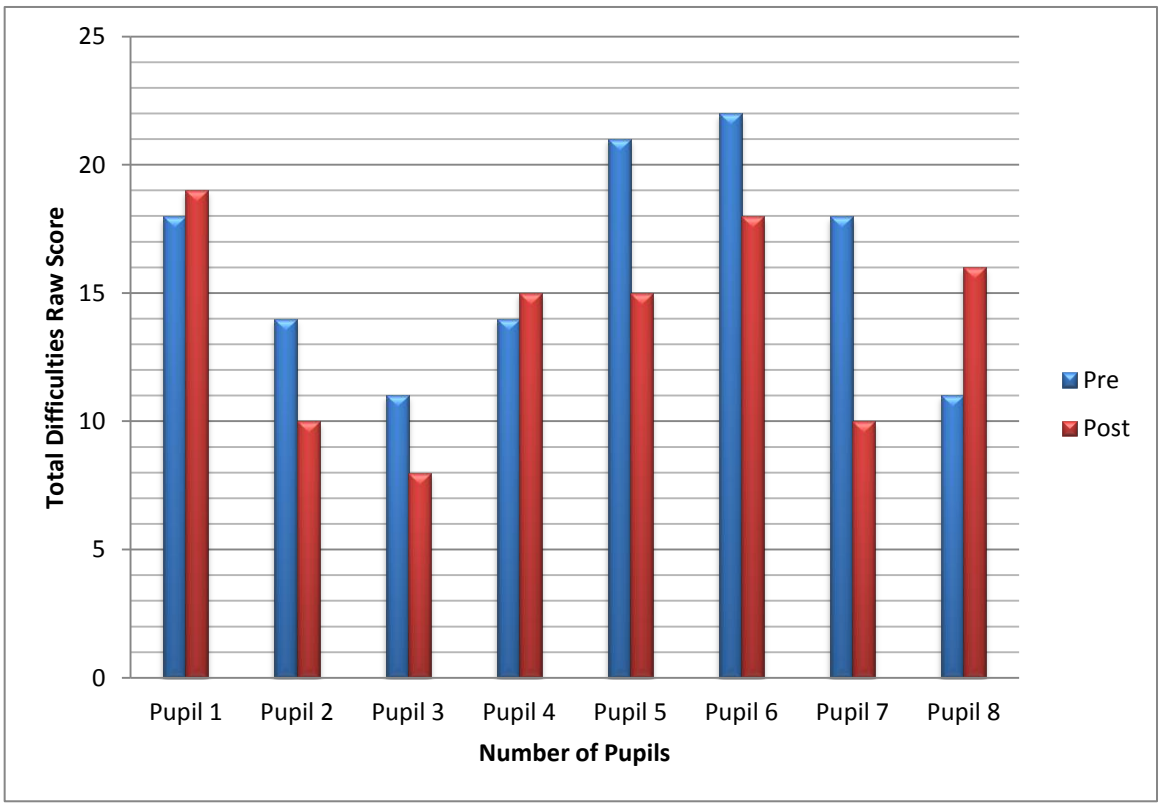


Pie Chart 2:



4:17 The SDQ (4-17) was completed by students alongside the previously mentioned measures to ascertain whether the intervention had an impact on the breadth of difficulties experienced. Eight young people completed an SDQ pre and post intervention with five recording an improvement in total difficulties experienced and all students showing improved ratings in pro-social behaviour. This is evidence for the preventative nature of mindfulness approaches and the importance of transferring skills to young people so that they can manage life circumstances in a healthy and adaptive way.

Graph 4: Self Report SDQ (4-17) – Raw Scores for total difficulties pre and post intervention



Whole Class Mindfulness Groups in Primary Schools

Paws b is a classroom introduction to mindfulness that aims to give Key Stage 2 students a taste of mindfulness, so that they know about it and can return to it later in life. Five primary schools were identified who were interested in trialling the programme with their year 5/year 6 students. In order to achieve the best outcomes, it was decided to deliver the programme across 2 years, starting at the end of year 5 and continuing the programme when students are in year 6 and are getting closer to their SATs.

The first half of the programme was delivered as six 30 minutes sessions, covering the topics Let's Explore Our Amazing Brain, Learning to Be Present In The Present Moment, and Finding A Steady Place - Grounding Ourselves When We Wobble. The students learned about different parts of the brain and their function, were introduced to the key concepts of mindfulness and had the opportunity to try a number of mindfulness practices.

For evaluation purposes students completed the Child and Adolescent Mindfulness Measure (CAMM, 10 item questionnaire) at the beginning of the programme and after the first half of the programme. Students were also asked to complete an 8-item summary questionnaire after the first six sessions to inform the delivery of the second half of the programme and make appropriate changes if necessary. Members of staff (where present) also completed a summary questionnaire. The same measuring tools will be used at the end of the programme (October 2016) to gather post intervention data.

Students' feedback included the following statements:

"I enjoyed the course because we learnt new things every time."

"I enjoyed it because I learnt things I have never learnt before, like how to steady yourself."

Feedback from staff included the following statements:

Question: Have you found the course beneficial for individuals and/or the class as a whole?
"Yes – some children are very anxious. It gives them some coping strategies."

"I think the course was delivered very well, and think that a lot more children within the school could benefit from the sessions."

Table 5 : Overall student feedback

	Poor					**Excellent**
What score would you give the course?	**1**	**2**	**3**	**4**	**5**	**6**
Cheapside	0%	0%	0%	20%	40%	40%
Holy Trinity	13%	7%	13%	20%	20%	27%
South Ascot Village School	15%	22%	19%	22%	19%	4%
St Francis	8%	10%	37%	10%	17%	13%
St Michael's	0%	0%	7%	14%	45%	34%
Overall	**9%**	**9%**	**17%**	**16%**	**28%**	**22%**

Based on the high number of students (130 in total) and the fact that the programme wasn't delivered on a voluntary basis, it is to be expected that students respond to it differently. Areas for improvement were identified based on the mid evaluation and the practitioner's own reflection and will be implemented in the second part of the programme. Students' feedback indicated that they prefer longer lessons which cover more material and lead to bigger learning outcomes. Based on this feeback, the second half of the programme will be delivered as three 60 minute sessions rather than six 30 minute sessions.

Best outcomes were achieved in those schools where a member of staff was present and actively participating in the mindfulness exercises. It's ideal for this member of staff to be the classroom teacher in order to be able to refer back to material covered and practice some of the techniques in normal classroom lessons. This will be encouraged in all schools for the second half of the programme.

Individual Interventions

4.19 Existential/Person Centred Counselling

Is a non-prescriptive way of counselling which aims to suspend all previous knowledge of the client, so that the counsellor can hear the client's story with no preconceptions or judgments. Existential counsellors do not treat any part of the client's story as more significant but look for themes that may be relevant. They treat clients with congruence, empathy and unconditional positive regard. For the purposes of evaluation a case study format was used to provide a more holistic and in-depth explanation of behaviour and positive outcomes resulting from intervention. These are written in the first person from the counsellor's perspective and outline reason for referral, weekly progression and outcomes.

4:18 Brief overview of case demographic/ figures

- 2 cases working with social care (1x Child Protection plan, 1 x Child In Need)
- 1 case with previous social care involvement
- 2 cases working with Intensive Family Support Service (IFSS)
- 3 cases have a parent with mental health issues
- 3 cases at risk of school exclusion
- 1 case has a diagnosis of Autism

4.20 Case Study A: RL. (12 weeks counselling)

RL was referred to me while in her GCSE year because she was suffering with Chronic Fatigue Syndrome and as a result had been unable to attend school. Before she became unwell she had been an 'A' student in all subjects and a keen sports woman. School was her sanctuary and she enjoyed learning. Various life events had led to her developing this condition. She was in constant chronic pain everyday. Her memory had become fragmented and she was unable to retain anything that she had learned previously. She was exceptionally anxious and fearful about her future. I counselled her using existential /phenomenology theory. I used the core conditions and listened closely to her story. I tried to enter her world as much as possible without making assumptions about what it must be like for her. I did not judge her or try to teach her techniques to help her relax. I just listened. Eventually she realised that I believed her. (Up to this point she had been seen by other professionals, doctors, teachers who were telling her that there was nothing wrong with her, that the test showed that nothing was wrong.) During the early

weeks of counselling RL was unable to open up and she repeated her story about how she became unwell over and over. By week 5 I believe that RL realised that I was not like her parents or the other professionals who made judgments and assumptions and did not believe her. She started to open up about her life at home and I understood the pressure that she was under and this may have explained why she had become so unwell.

4:21 As the weeks went by RL was able to walk more easily and she appeared more relaxed. One session she looked noticeably different she had applied make up and had dressed in bright clothes. Although R.L's parents were not totally happy with the counselling arrangements her mother brought her every week. As the weeks went by her mother began thanking me.

4:22 RL was able to return to school on a reduced timetable. I continued to see her for a further 6 weeks at Newlands School. After the six weeks we had a successful ending. I referred her to the school counsellor for further support. I believed that RL needed an outlet where she could vent her frustrations. This would enable her to talk about things that were upsetting her without bottling them up. The last I heard about RL was that she has sat her GCSE'S successfully.

4:27 <u>Dyadic Developmental Psychotherapy (DDP)</u>

DDP is a therapy and parenting approach that uses what we know about attachment and trauma to help children and families with their relationships. Central within DDP is PACE, a way of thinking which deepens the emotional connections in our relationship with others. PACE as a concept refers to - Playfulness, Acceptance, Curiosity and Empathy. Playfulness brings enjoyment to the relationship. Acceptance creates psychological safety. Curiosity refers to the exploration of themes within the relationship expressing a desire to know the other person more deeply. Empathy is used to communicate curiosity and acceptance, as the therapist recognises and responds to the family's emotional experience. Evaluation of support provided follows a case study format outlining presenting difficulties and impact of intervention.

4:28 Brief overview of case demographic/ figures

- 2 cases working with social care (1x Child Protection plan, 1 x Child In Need)
- 1 case with a history of social care involvement
- 2 cases working with Intensive Family Support Service (IFSS)
- 2 cases where there is suspected sexual abuse
- 100% cases have a parent with mental health issues
- 1 case with poor attendance (71.4%, which increased during the period of intervention)

4:29 Case Study A: John

John, aged 10, was permanently excluded form middle school in November 2015. He and his mother were referred for DDP to work on the attachment issues which contributed to his behavioural issues at school. During his early years John lived with domestic abuse (primarily from his father to his mother, as well as emotional abuse directed at him). He presents as hypervigilant, hyperactive and inappropriately protective of his mother. John's mother has her own mental health issues and suffers from depression.

4:30 The DDP work has enabled mum to be able to reflect on her own experience of being parented and how this has impacted on the parent she has become and her emotional difficulties. This in turn has made her more able and willing to reflect on the meaning behind her son's behaviour. During Dyadic Developmental Psychotherapy (DDP) sessions mum has been able to appropriately react to her son's emotional needs and to act as a secure base for him.

Feedback from the parent

"The work we have done together has been immensely helpful in helping me understand myself and why I am the way I am. Also, it has helped me in understanding and parenting my children… I can honestly say it has been one of the most beneficial things I've ever done"

Informed Strategies Cognitive Behaviour Therapy (CBT)

The Wellbeing Team offer brief, low-intensity, evidence based CBT informed strategies for young people and children, to help with anxiety and low-mood. CBT is a type of psychological therapy that has been found to be helpful for children and young people with anxiety disorders and depression. It is based on the concept that emotional problems are caused, and are kept going, by unhelpful patterns of thinking and behaviour. CBT aims to identify and reduce unhelpful ways of thinking and behaving and to build more helpful thoughts, behaviours and problem-solving skills in children and young people. CBT deals with current problems that are impacting on a young person's life rather than focusing on issues from their past. Approaches based on CBT principles are known to be an effective treatment option for a number of psychological problems. NICE guidelines (National Institute for Health and Care Excellence) recommend that CBT is a first line approach to help treat anxiety and depression.

30 RCADS were completed as part of initial assessments and requested pieces of work by schools, pre and post total anxiety and depression scores for 7 of the self-report RCADS are shown below. Six out of the seven young people recorded lower post scores for anxiety and depression following intervention.

Interventions have included psycho-education around understanding what is anxiety and low-mood, enabling young people to recognise and identify their own triggers and patterns of thoughts, feelings, behaviours and physical sensations; understanding what maintenance factors keep their symptoms going and agreeing which areas to focus on in order to change these negative belief systems; equipping young people with coping strategies such as breathing techniques, distraction strategies, relaxation, constructive self-talk and problem solving skills in order to help them manage and self-regulate their emotions.

Anxiety coping strategies run alongside a graded exposure plan, identifying and agreeing steps to help the young person overcome their fears and achieve their goals. It is important to state at this point, that working in close partnership with key support figures in school is crucial to the embedding and success of the exposure task. Pupils 2 and 7 (aged 8 and 9yrs), both suffered with separation anxiety, panic and school refusal. Building trust and confidence within the school was key to the achievement of their goals, reaffirming that school is a safe place. This was achieved by identifying a key person in school who was able to build a positive and trusting relationship with that young person to provide continuity and a safe and calm space where they were able to retreat to if required. Establishing a support system around the child helped them manage the up and downs of a school day more effectively, creating an alternative safe place

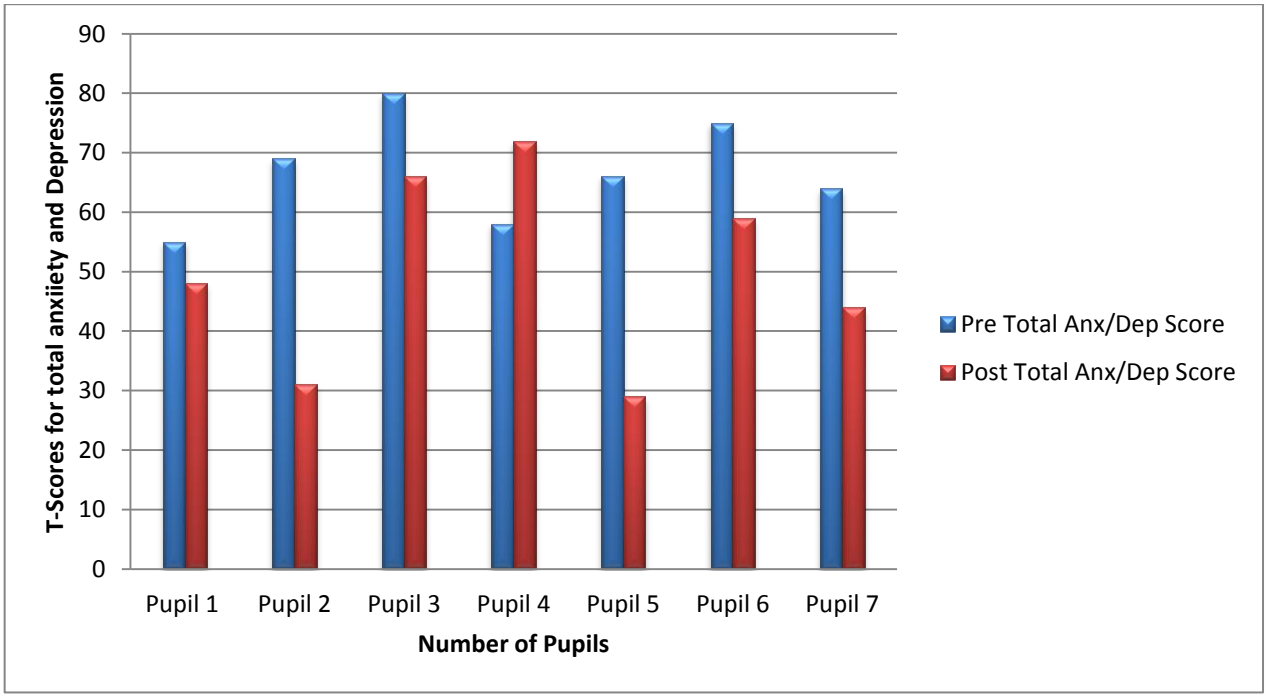
other than home. Due to the committed and positive partnerships formed with pastoral teams in school, both pupils have successfully re-integrated back into full-time education.

Young people who presented with low-mood and depression, worked through a behavioural activation plan, identifying their key life areas and values and focusing their energies around building activity plans within these areas. Both young people reported improvement in their mood and became more focused and motivated on their school work and exams. Pupil 1 achieved the A-Level grades she required to get into her first choice university, whilst Pupil 6 stopped self-harming, felt more connected with friends and family, gained clarity around their passions and aspirations and started a part-time job.

Pupil 5 worked through techniques of managing worry and a sleep hygiene plan, enabling her to function more effectively in school. Developed positive alternative approaches to coping with worry and emotions and subsquently built more positive relationships with peers and family.

Pupil 4's ratings did not improve, however, this particular young person suffered with selective mutism, panic and social anxiety. They had previously started another therapeutic intervention, unfortunately this broke down in the initial stages. This young person, did not want to communicate their feelings and chose to focus on managing physical sensations in order to change the cycle of anxiety. Pupil 4 found it a struggle at times to implement and practice some of the recommended techniques and strategies, however, engaged positively in every session and became more open and honest about what worked well, what didn't and how they were feeling. This is reflected in the results, demonstrating a more accurate picture of their anxiety compared to their initial pre RCAD results. On reflection of learning, Pupil 4 felt they had had a positive experience of therapeutic intervention which would enable them to engage with future provision more readily. Next steps for pupil 4 included one-to-one yoga sessions and youth support.

Graph 5: Self Report RCADS Scores Pre/post intervention



OUTCOME 2: To improve knowledge and understanding of mental health and emotional wellbeing amongst students and staff, creating an open and supportive culture around mental health in schools.

Emotional Wellbeing Champions Programme

The Programme was developed by the RBWM Psychology, Wellbeing and School Support Service to raise awareness and knowledge of positive mental health and to create an open, supportive culture around mental health in schools. This was done through a one day interactive workshop offered out to primary and secondary schools within the RBWM area (see table 3). The aims of the day were to equip students with knowledge on mental health and emotional wellbeing, to encourage them to tackle stigma in their school, and to empower students to develop anti-stigma campaigns for their school with the support of a lead member of staff. Funding for this project was allocated from the CAMHS Local Transformation Fund 2015/2016.

Six Primary school students from year 4-6 were selected to attend by a key adult within each participating school. Six Secondary school students from year 7-10 were chosen in a variety of ways – by written application, based on their existing role as a peer mentor or member of school council and those who had expressed a keen interest. A final workshop was held at Charters Secondary school with 15 attendants from year 10 and 12.

Table 6: List of Participating Primary, Middle and Secondary Schools

Primary Schools	Middle/Secondary Schools
All Saints CE Junior School	Trevelyan Middle School
Cookham Dean CE	St Peter's CE Middle School
Cookham Rise	Windsor Girl's School
Oldfield Primary	Furze Platt Senior School
St Luke's CE Primary	Newland's Girls School
	Charters Secondary School

Skills and knowledge were imparted through a range of interactive games, discussions and activities personalised to the age group of the students attending.

For the primary training day the emphasis was on the recognition of emotions and how facial expression, body language and demeanour can provide indicators as to how someone is feeling. The stress bucket demonstration was used to convey how negative feelings can affect us if bottled up. The students were able to identify daily stressors that they encounter and discuss strategies that may help reduce their stress level. Finally, students were encouraged to think about ways of looking after themselves, and were made aware of the importance to look after yourself before supporting others.

A highlight from the secondary day was the inclusion of a young person who was invited to share her own personal experience of self-harming and attempting suicide. The students showed a high level of interest in a lived experience of mental health. The young person's talk promoted speaking openly about problems and not hiding them inside, being aware of others and what they might be going through, and broke the fear of seeking help from professionals by giving a very positive account of a personal experience with CAMHS.

The evaluation of the one day mental health awareness training showed a high level of satisfaction with the quality of delivery, as well as very good learning outcomes in the students.

Primary

Table 7: Primary Student Reponses to what did you learn about mental health today?

Main Emerging Themes	Number of Pupils
Bottling up your feelings isn't good for you, express your emotions	10
It is important to talk to adults about your feelings	8
Be aware of others, check if they are ok	7
Anyone can have a mental health problem	2
Mental health problems can be overcome	2
Mental health is important	1
There are different types of mental health problems	1

Table 8 : Primary Student Responses to what changes will you make after today? (you can choose more than one option)

Main Emerging Themes	Number of Pupils
Support my team with our school campaign	30
Be more understanding of other people's feelings	28
Encourage my teachers to make time to talk about mental health in class	28
Look out for my friends more	27
Share what I have learnt with my friends	26
Talk more about my feelings	23
Do more things to look after myself	20
Try and find out more about mental health	19

Secondary

Table 9: Secondary student reponses to what did you learn about mental health today?

Main Emerging Themes	Number of Pupils
Mental health problems are more common than we thought (1 in 10)	20
Anyone can have a mental health problem	4
Not to judge others with what they are going through	4
People often mask their feelings, it's important to talk about them	6
The negative effects of stigma/ media influence	4
About different mental health problems	2
More understanding of what people are going through, signs to look out for and how to help.	5
What CAMHS is	1

Table 10: Secondary student reponses to what did you learn about mental health today?

Main Emerging Themes	Number of Pupils
Be more understanding of other people's feelings	26
Look out for my friends more	23
Encourage my teachers to make time to talk about mental health in class	23
Share what I have learnt with my friends	23
Support my team with our school campaign	22
Talk more about my feelings	21
Try and find out more about mental health	21
Do more things to look after myself	20

OUTCOME 3: To improve knowledge and confidence of school staff and parents when working with children and young people with emotional and mental health difficulties.

Mental Health First Aid (Youth) Training

The MHFA –Youth is a 2 day course which teaches people how to recognise the signs and symptoms of common mental health issues and provides help on a first aid basis and effectively guides those towards the right support services. The four main areas which are covered are as follows:

- What is mental health?
- Anxiety and depression
- Suicide and psychosis
- Self harm and eating disorders

At the end of the course, delegates will be able to:

- Spot the early signs of a mental health problem in young people
- Feel confident to help a young person experiencing a problem
- Provide help on a first aid basis
- Help protect a young person who might be at risk of harm
- Help prevent a mental health illness from getting worse
- Help a young person recover faster
- Guide a young person towards the right support
- Reduce the stigma of mental health problems

Two courses were delivered at a Windsor and Maidenhead venue in April and June 2016 respectively. The course was offered across RBWM schools for professionals supporting and working with 8-18 year olds.

The data provided below is from 22 delegates made up of primary and secondary school staff and staff from external agencies e.g. young carers.

Table 11: Delegate ratings of knowledge and understanding pre and post training

Course Location	Pre - Personal Confidence Score Scale 0-10	Post - Personal Confidence Score Scale 0-10	Shift	Pre - Knowledge & Understanding Scale 0-10	Post - Knowledge & Understanding Scale 0-10	Shift
Windsor	9	9	0	9	9	0
Windsor	8	10	2	9	10	1
Windsor	5	9	4	5	9	4
Windsor	6	9	3	6	9	3
Windsor	8	9	1	8	9	1
Windsor	8	9	1	7	8	1
Windsor	2	8	6	3	8	5
Windsor	2	7	5	2	7	5
Maidenhead	7	8	1	3	5	2
Maidenhead	6	8	2	6	9	3
Maidenhead	5	8	3	6	9	3
Maidenhead	7	8	1	7	9	2
Maidenhead	3	7	4	3	7	4
Maidenhead	6	10	4	7	10	3
Maidenhead	4	8	4	2	8	6
Maidenhead	8	10	2	8	10	2
Maidenhead	7	8	1	6	9	3
Maidenhead	4	8	4	4	8	4
Maidenhead	5	7	2	5	9	4
Maidenhead	3	7	4	3	9	6

Section 5: Service Delivery Plans for 2016 – 2017

A few developments have taken place during the summer term which will be actioned from September 2016 and continue throughout the academic year. These include the following:

- The Wellbeing Team objectives have been further developed focusing on social/emotional and wellbeing support for individuals and groups, enskilling school staff and children and young people and enhancing whole school practice.

- Further group interventions are being developed drawing on evidenced based practice and interventions. These groups will be tailored to both the primary and secondary age ranges.

- Links with schools will be further enhanced through the provision of a planning meeting at the start of the year and piloting of a whole school framework for emotional wellbeing and mental health.

- Two members of the Wellbeing Team will be delivering the ADHD Parent Factor Course. This course is designed to support the parents and carers of children and young people who have received a diagnosis of ADHD (the course is accessible to parents within two years of diagnosis).

Section 6: Appendices

Appendix 1: Interventions offered through the Wellbeing Service 2015-2016

Preventative

- School Workshops - Two Anti Stigma Mental Health workshops (primary and secondary) raising student awareness of mental health in schools and empowering students to challenge this in their schools through creative campaigns .
- Five whole class mindfulness groups for primary schools using Paws b resources from The Mindfulness in Schools Project (MISP).
- Two day training for schools and children services professionals in Mental Health First Aid.
- ADHD Parent Factor workshops - to provide parents with the knowledge and skills to support their child. Due to start September 2016

Early Intervention

- Assessments carried out on all young people whose Early Help referral has been accepted. Person centred plan is formulated for each young person.
- Therapeutic groups in school- developed using a needs analysis approach. The team have run three groups this year: 1) psycho -education group for year 9 boys with disruptive behaviours using choice theory 2) An emotional resilience group for year 9 girls with poor attendance and anxiety, 3) Targeted mindfulness group for secondary aged students with identified difficulties
- Signposting and one-off contact.

Targeted Support

- CBT Informed Strategies - for low mood and anxiety.
- Person Centred Counselling.
- Filial Therapy - teaching parents non-directive play skills so they can undertake therapeutic play sessions.
- Attachment Focused Therapy - a family therapy intervention to explore attachment trauma and start the repair purpose.
- Play and creative arts therapy - uses toys and creative arts materials to express emotions.

Appendix 2:

Case Study Examples

4:23 Case B: LA (12 sessions)

LA lived with extreme anxiety. She self harmed on a regular basis. She was referred to me when she disclosed that she was worried that she would bleed out if she accidently went too far. LA was unable to control her thought processes and would catastrophise every situation. She knew that she was doing it, but she could not help herself. The only time that she was not battling with constant anxiety was when she was asleep. She found it hard to sleep unless she self harmed.

4:24 LA found it difficult to eat and would lose weight when her anxiety spiralled out of control. O counselled LA in an existential/Phenomenological way. After a few weeks LA opened up to me. LA stopped self harming and gained weight during the period that I was seeing her. I referred her to Youth Talk for further support.

4:25 Case C: CH attended 6 sessions

CH had disengaged from CAMHS. She had suffered a rupture in the therapeutic relationship. CH was angry with her counsellor and had refused to attend appointments. CH was referred to the Wellbeing Service because she had stopped eating and had lost a significant amount of weight. Her school attendance was sporadic, and she was self harming on a regular basis. The CAMHS Psychiatrist said that he would not prescribe her medication unless she attended her appointments. I did not want to enter into a therapeutic relationship with CH. It was my intention to enable her to re-engage with her CAMHS therapist whom she had been seeing for over a year. I used the Existential/phenomenological principles to work with CH I had to be a little more prescriptive than I would normally be, since I had an objective. I loosely followed the Two Chair Gestalt exercise. I asked CH "What would you say to your therapist if she were sitting in that chair". With CH's permission I wrote down what she told me and emailed her therapist.

4:26 CH agreed to go back to see her therapist. She gained weight and her self harming reduced significantly. CH has recently finished her CAMHS counselling. She said that it was fine, and that she felt much better than she thought she would. She said that at the moment she does not feel that she needs further therapeutic support.

Appendix 3:

4:31 Case B: Harrison

Harrison, aged 10 years, was on the verge of being permanently excluded from school when they referred the case for DDP. The mother was very hard to engage and had a long history of lack of communication with school. The attachment focused therapy with mum enabled her to reengage in communications and negotiations with school during a very difficult period in their relationship. Mum was able to come into school and discuss her concerns and anxieties and form a plan for moving forward.

4:32 Case C: Karl

Karl, aged 10 years, was referred due to attachment issues. Karl lives in kinship care with his grandparents and struggling to make sense of his early life experiences. The school referred Karl due to low self esteem and having angry and tearful outbursts at home. In school, Karl was struggling to access the curriculum due to his low confidence around asking for help. Through DDP I was able to work with the grandparents to help them develop their understanding of attachment and how this impacts emotional development. We used this as a foundation to enable his grandparents to act as the secure base for Karl as he began to give meaning to his angry and sad outbursts. The massive impact to this case was in securing and deepening the bond between Karl and his grandparents. Alongside this the school reported Karl was 'a little more likely to join in class discussions. Lastly we were able to ensure a robust package of support was in place for Karl as he transitioned from primary to secondary school. Due to his initial presentation he could easily have fallen through the gaps of provision; work with the grandparents and school highlighted his emotional vulnerability whilst working to reduce this and plan support over a vulnerable life transition.

Document Name	Wellbeing Team Evaluation Report		
Document Author	Rebecca Askew		
Document owner	Rebecca Askew		
Accessibility	This document can be made available in other formats upon request.		
Destruction date			
Document approval dates	Version 1	Author	
	Version 2	Directorate Leadership Team	
	Version 3	Lead Member	
	Version 3	Public	
Circulation restrictions			
Review date			