Children and Young People’s Wellbeing and Mental Health Needs Assessment in the School Setting

August 2018
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Southampton City Council/ Southampton Clinical Commissioning Group
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1. Executive Summary

Key findings

- It is estimated that in an average class of 30 pupils, six pupils may be self-harming and three will have a diagnosable Mental Health (MH) condition. The response needs to be system-wide, and schools have a key role to play.
- A quarter of Southampton’s population (63,150) are 0-19 years of which an estimated 6,189 (9.8%) have a MH condition. This is a higher proportion than the national average as Southampton has numerous risk factors but few protective factors for MH.
- Nationally rates of MH problems in children and young people (CYP) have risen and this is reflected in the increasing demand and waiting time for services locally.
- Evidence shows school-based interventions to promote the MH and wellbeing of CYP are cost effective with every £1 invested in programs in schools having a £5.08 to £7.10 benefit, and that universal whole school approaches are the most effective.
- There are already numerous services to support MH and wellbeing available within or to schools in Southampton but the current provision is very variable across schools and difficult for users and MH and wellbeing service providers to navigate. There is a need for prevention and low level support, especially in primary school aged CYP.

Recommendations

Full recommendations can be found here: Recommendations

- Embed a city-wide whole school approach to MH and wellbeing. This requires both universal and targeted approaches including; the curriculum, whole school ethos, school’s social and physical environment, and links with all relevant stakeholders including CYP, teachers, school administration, parents and wider community members.
- Deliver the Green Paper expectations, including a MH lead in every school
- Develop a MH and wellbeing Single Point of Access which includes all services in Southampton to provide clear pathways to service providers, schools, parents and CYP
- Embed a city wide quality assured PSHE curriculum
- Consider options for supporting PSHE and a whole school approach to MH and wellbeing
- Maximise protective factors for example by increasing physical activity with the Daily Mile/Golden mile and My Journey active transport plans
- Promote a positive ethos in schools and student participation, for example through a city wide roadshow for World MH Day and ongoing liaison with the Youth Forum
- Create a school built environment supportive of wellbeing, for example through planning application and refurbishment policies regarding schools
- Develop a system for measuring wellbeing within schools by improving consistency of the Year 7 school nurse survey, so schools can monitor the impact of interventions and identify CYP who would benefit from targeted support
- Ensure the CAMHS offer to schools is consistent across the city and explore options for increasing MH and wellbeing support within primary schools
- Upskill teachers and external providers in the recognition of poor MH, using evidence based training
- Explore how MH peer support capacity could be increased
- Improve support for teachers own MH and wellbeing with interventions from Anna Freud and encouraging all schools to join the existing MH forums/networks
- Use behavioural difficulties as an early warning by adding MH to re-inclusion plans
- To aid coordination of CYPS MH and wellbeing projects set up a CYPs Emotional and MH Partnership Forum
- Conduct further deep-dive analysis to determine the needs of specific vulnerable groups of CYP such as those not in education, employment or training and those home schooled
## 2. Glossary/ Definitions

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>A&amp;E</td>
<td>Accident and Emergency</td>
</tr>
<tr>
<td>BME</td>
<td>Black and minority ethnic</td>
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<tr>
<td>CAMHS</td>
<td>Child and Adolescent MH Services – specialist NHS services including assessment and treatment when children and young people have emotional, behavioural or MH difficulties.</td>
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<tr>
<td>CCG</td>
<td>Clinical Commissioning Group, of which the ICU is part</td>
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<tr>
<td>Co-production</td>
<td>Young people and adults working together to come up with ideas and put them into practice.</td>
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<tr>
<td>CYP</td>
<td>Children and young people</td>
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<tr>
<td>DfE</td>
<td>Department for Education</td>
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<tr>
<td>EHWB</td>
<td>Emotional health and wellbeing worker</td>
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<tr>
<td>GP</td>
<td>General Practice</td>
</tr>
<tr>
<td>HCC</td>
<td>Hampshire City Council</td>
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<tr>
<td>HES</td>
<td>Hospital Episode Statistics</td>
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<td>HNA</td>
<td>Health Needs Assessment</td>
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<tr>
<td>ICU</td>
<td>Integrated Commissioning Unit which is part of the CCG</td>
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<tr>
<td>IMD</td>
<td>Index of Multiple Deprivation</td>
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<tr>
<td>JSNA</td>
<td>Joint Strategic Needs Assessment</td>
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<tr>
<td>LAC</td>
<td>Looked After Children</td>
</tr>
<tr>
<td>LGBT+</td>
<td>Lesbian Gay, Bisexual, Transgender and Questioning</td>
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<tr>
<td>LSOA</td>
<td>Lower Super Output Area</td>
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<tr>
<td>MASH</td>
<td>Multi agency safeguarding hub - the single point of contact for all safeguarding concerns regarding CYP in Southampton</td>
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<tr>
<td>MH</td>
<td>Mental health. MH is defined as a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community (World Health Organisation)</td>
</tr>
<tr>
<td>ONS</td>
<td>Office for National Statistics</td>
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<tr>
<td>NEET</td>
<td>Not in employment, education or training</td>
</tr>
<tr>
<td>NICE</td>
<td>National Institute for Health and Care Excellence</td>
</tr>
<tr>
<td>PSHE</td>
<td>Personal, Social, Health and Economic education</td>
</tr>
<tr>
<td>PH</td>
<td>Public Health</td>
</tr>
<tr>
<td>PHE</td>
<td>Public Health England</td>
</tr>
<tr>
<td>SCC</td>
<td>Southampton City Council</td>
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<tr>
<td>SEN</td>
<td>Special Education Needs</td>
</tr>
<tr>
<td>SPA</td>
<td>Single Point of Access</td>
</tr>
<tr>
<td>Statistical neighbours</td>
<td>Similarly deprived areas based on Chartered Institute of Public Finance and Accountancy Nearest Neighbours</td>
</tr>
<tr>
<td>UASC</td>
<td>Unaccompanied Asylum Seeking Children (aged less than 18 years)</td>
</tr>
<tr>
<td>Wellbeing</td>
<td>There are many different definitions of wellbeing but they generally include areas such as: life satisfaction, optimism, self-esteem, mastery and feeling in control, having a purpose in life, and a sense of belonging and support (NHS). It is increasingly used alongside MH, and is often favoured by schools and others whose main contribution is around prevention and health promotion.</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organisation</td>
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<tr>
<td>YOS</td>
<td>Youth Offending Service</td>
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3. Acknowledgements

This needs assessment would not have been possible without support from Amy McCullough, SCC along with the wider Public Health Team at the council and the CCG.

There were also a considerable number of stakeholders that provided data and/or agreed to be interviewed for this project. To the EHWB (Southampton Healthy Association), PH nursing team, educational psychologists, Education team, SCC Intelligence team, Solent NHS Trust, SCC Youth Engagement, No Limits, and CYP, I offer my thanks; this project would not have been possible without your time and insight.
4. Introduction

**Summary: Introduction**
- Many CYP have wellbeing and MH difficulties and this is increasing
- Schools have a role to play in supporting CYP to be mentally healthy
- There is a national and local agenda which recognises this need

4.1 Purpose
The purpose of this document is to describe the MH and wellbeing needs of CYP in Southampton. It will be used to inform the following:
- The Early Intervention Prevention Team offer to secondary schools by Southampton City Council and Southampton Clinical Commissioning Group.
- The PHSE offer and content of these lessons for secondary schools in Southampton.
- The development of the NIHR research bid by The University of Southampton regarding the evaluation of the Early Intervention Team service (which PH is supporting).
- Meet the action in Southampton’s Suicide Prevention Plan to “Investigate the provision of prevention and early help for secondary school pupils in light of the big lottery funding decision”.
- SCC and Southampton City CCG response to the ‘Transforming children and young people’s MH provision’ Paper.
- SCC plans to deliver Future in Mind, particularly the priority areas on “promoting resilience, prevention and early intervention”, a “system without tiers” and “workforce development”.

4.2 Background
It is estimated that one in ten young people (aged 5-16 years) experience a MH issue at any one time. For those aged 5-19 years suicide is the second most common cause of death, and a record number of children contacted ChildLine with suicidal thoughts and feelings of loneliness in 2016/17. In an average class of 30 pupils, six pupils may be self-harming and three pupils will have a diagnosable MH condition. These range from short spells of depression or anxiety through to severe and persistent conditions that can isolate and frighten those who experience them.¹

Rates of anxiety and depression in young people have risen 70% in the past 25 years.² Academic pressure, social media, bullying, poverty, lack of availability of professional MH support – all have been named as contributing to this epidemic of poor MH in our young people.³

Half of all MH conditions first occur by the age of 14, and three quarters by the time, someone is 24.⁴ Poor MH in childhood is associated with a number of negative outcomes in later life, including poorer educational attainment and employment prospects and a strong associated with behaviours that pose a risk to health, such as smoking, drug and alcohol abuse and risky sexual behaviour. Also,

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children from deprived backgrounds are significantly more likely to experience MH difficulties than those from more affluent backgrounds. Recent research shows that this inequality gap is widening.5

At the moment it can take a decade for many CYP to receive help after showing their first symptoms of mental illness, and Future in Mind estimates that less than 25% to 35% of those with a diagnosable MH condition are accessing support.6 7 Opportunities for help are often missed – due to a lack of resources, or an unwillingness to seek help – and action is usually reactive, rather than proactive.

The DfE recognises that “in order to help their pupils succeed; schools have a role to play in supporting them to be resilient and mentally healthy”.8 There is good evidence to support this and Ofsted has highlighted that CYP themselves say they want to learn more about keeping themselves emotionally healthy9. Moreover schools have a duty to promote the wellbeing of students.10

The last time a needs assessment was conducted on this topic in Southampton was in 2013,11 therefore a review of the situation and what more can be done to promote prevention and early intervention locally is needed.

4.3 Context
The importance of good emotional wellbeing and MH in CYP has been recognised nationally and locally.

National context:
Government Response to the Consultation on Transforming Children and Young People’s MH Provision: a Green Paper and Next Step (July 2018)12
The general focus is on earlier intervention and prevention, especially in and linked to schools and colleges. The report include:

- Creating a new MH workforce of community-based MH support teams
- Every school and college will be encouraged to appoint a designated lead for MH – the government will provide funding for this
- A new 4-week waiting time for NHS children and young people’s MH services to be piloted in some areas.

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Education and Health and Social Care Committees response to the Governments green paper (below). The report emphasises the front line role of schools and colleges in promoting and protecting CYPs MH and wellbeing. Issues raised included:

- Potential adverse effects of the current exam and testing system, with high stake exams and the curriculum narrowing on CYPs MH
- Lack of action on addressing the transition to adult MH services
- Lack of commitment to specific action to address the higher level of need in particular demographic groups, including LAC, those in the YOS, and those NEET
- Impact of social media on young people’s MH
- The need for education and MH services to work closely together.

Children and young people’s MH - the role of education (April 2017), recommendations included:

- Welcome the Government’s commitment to make PSHE mandatory
- Support a whole school approach that embeds the promotion of well-being throughout the culture of the school and curriculum
- Strengthen MH training for teachers to ensure they are properly equipped to recognise the early signs of mental illness and have the confidence to be able to signpost or refer to the right support.
- Strong partnerships between the education sector and MH services such as CAMHS
- Develop CYPs skills to make wiser and more informed choices about their use of social media.

Key ambitions in the NHS ‘Five year forward view’ (2016), include:

- 7-day NHS (right time, right care, right quality) – fewer out of area placements for acute care, more community-based care
- An integrated mental and physical health approach
- Promoting good MH and preventing poor MH at key moments in life, timely access to high-quality MH care, and creating mentally healthy communities through support housing, criminal justice system and ending stigma
- Building a better future – better data to provide transparency.

Future in Mind (2015), states that “We want [CYP] to grow up to be confident and resilient so [they] can develop and fulfil these goals and make a contribution to society.” In order to achieve this vision, the report outlines the following priorities:

- Promoting resilience, prevention and early intervention
- Improving access to effective support – a system without tiers
- Care for the most vulnerable
- Accountability and transparency
- Developing the workforce.

No Health Without MH: a cross-governMH outcomes strategy for people of all ages (2011), specifically makes MH a priority for PHE (the new national PH service) and states that MH is

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‘everybody’s business’. It prioritises early intervention across all ages, takes a life course approach and challenges stigma. However, while nationally, it has become clear that CAMHS needs to be transformed, the level of government investment is not proportionate to the level of demand that is being experienced.

Local context:

<table>
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<tr>
<th>Strategy</th>
<th>Priority/outcome</th>
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| Southampton JSNA16                            | Theme 3: Parenting, Childhood and Adolescence.  
1. Provide children and young people with a good start in life through integrating health and care services in Southampton.  
2. The Health and Wellbeing Board should promote the development of a child poverty strategy for Southampton (as recommended by the Children’s Commissioner).  
3. Reducing health and developmental inequalities must be a priority for those young children identified as vulnerable, ensuring the approach supports “proportionate universalism”. |
| Southampton Joint Health and Wellbeing Strategy 2017-202517 | Links to three of the key outcomes:  
**People in Southampton live active, safe and independent lives and manage their own health and wellbeing**  
- Encourage and promote healthy relationships and wellbeing of individuals of all ages, carers and families, particularly for those at risk of harm and the most vulnerable groups through increasing early help and support.  
- Prioritise and promote MH and wellbeing as being equally important as physical health.  
- Increase access to appropriate MH services as early as possible and when they are needed.  
**Inequalities in health outcomes are reduced**  
- Work with schools to improve healthy lifestyle choices and mental wellbeing and reduce the harm caused by adolescent risk taking.  
**People in Southampton have improved health experiences as a result of high quality, integrated services**  
- Prioritise investment in and embed a prevention and early intervention approach to health and wellbeing across the city. |
| Southampton Children and Young People’s Strategy 2017-202018 | Relevant priority areas:  
- Children in Southampton live happy healthy lives, with good levels of physical and mental wellbeing.  
- Children in Southampton’s communities are resilient, engaged, prepared for the future and able to help themselves and each other to succeed. |
| Southampton’s Suicide                          | An action to “Investigate the provision of prevention and early help for secondary school pupils in light of the big lottery funding decision”. |

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Prevention Plan, 2016\(^9\)

<table>
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<tr>
<th>Hampshire &amp; Isle of Wight STP priorities(^20)</th>
<th>An action to ‘improve the quality, capacity and access to MH services’.</th>
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<tr>
<td>Southampton City CCG vision &amp; objectives(^21)</td>
<td>Aims in the MH section to ‘Review and redesign current acute pathways and community service provision and develop a network of services across the whole age range’ and ‘Develop services and support to access early intervention and prevention services for all ages – to include the development of community solutions and navigation roles’.</td>
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<tr>
<td>Southampton City CCG Transformation Plan for Children &amp; Young People’s MH(^22)</td>
<td>In 2014 Southampton’s Health and Wellbeing Board decided to do a full review of MH services. A major theme identified was “more early help and targeted support for younger people including stronger links with schools and education to help them deal with MH issues” and ‘more focus on prevention, early intervention and recovery/resilience and on community-based solutions as a first option’. Relevant priority streams are: ‘CYP and families’ engagement in the future development of the transformation plan and MH review, including hard to reach groups, work on anti-stigma and suicide prevention awareness training in schools’ and ‘Improve links between CAMHS, schools and primary care services with identified CAMHS link in all schools.’</td>
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**Table 1: Local strategies and plans that link to MH and wellbeing in CYP**

**4.4 Scope**

**In scope:**
- CYP of secondary school age (11-16 years old)
- CYP of primary school age (4-11 years old) – using a “light touch” methodology
- CYP of sixth form/college age (16-18 years old) – using a “light touch” methodology
- SEN schools – using a “light touch” methodology
- Looked after children - using a “light touch” methodology as this was covered in detail in ‘Looked After Children Needs Assessment, SCC, 2016-2017\(^23\)’

**Out of scope (although some aspect may be touched on):**
- CYP with complex needs where MH and emotional wellbeing is not the primary need
- CYP not in education, employment or training (NEET)
- CYP not resident or at school in the city of Southampton
- CYP who are home educated (226 CYP in Southampton)
- Acute and inpatient MH admission
- MH medication use in CYP

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5. Methodology

**Summary: Methodology**

The HNA draws information from:

- A literature review of school-based interventions for MH and wellbeing
- An epidemiological assessment including existing national and local intelligence
- A stakeholder evaluation including focus groups with CYP, discussions with service providers and surveys of parents and school staff in Southampton
- Service mapping including gaps and over-provision

This report utilises the three main approaches to HNA in order to present as complete a picture as possible; a literature review, an epidemiological assessment and stakeholder evaluation (corporate assessment). The current range of current services available is briefly outlined including activity levels where available.

Content is derived from a range of qualitative and quantitative data from secondary and primary research. The methodology was designed to utilise the wealth of existing intelligence, nationally and locally, thus avoiding duplication, while also refreshing the voices of professionals, parents and CYP through primary research. The following existing local research was used:

- Data on providers and SCC teams’ performance and quality
- Other relevant Needs Assessments (i.e. CAMHS Needs Assessment 2015, health Needs of LAC 2016-17, Southampton Needs Assessment Early Targeted Support for Children and Young People With Emotional and MH Needs, May 2013)
- Healthwatch Southampton wellbeing work, 2017-18
- SCC Youth Forum report on Health and Wellbeing event, 2015
- Southampton Healthy Ambition Public Health Nursing Annual Report, 2016-17
- Headstart consultation work including ICU MH Matters engagement report 2015/16
- National What About YOuth?' (WAY) Study, 2014
- Southampton Pupils Attitude Survey, 2012
- ‘Your Health’ Year 7 pupil survey school nursing service, 2016/17
- Southampton Psychology Service - Promoting Psychological Wellbeing in Schools Audit, Autumn 2015
- Anna Freud National Centre for Children and Families Schools in Mind workshop, Southampton, July 2018

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5.1 Epidemiological
Contrasts with England average and other areas, such as statistical neighbours, where the information is available. Data were accessed from a variety of sources, primarily from the following:

- SCC PH Intelligence & Strategic analysis Team
- Public Health England Fingertips tools
- Department for Education

Where possible, data was separated to the lowest geographical level available and compared to our statistical neighbours and/or regional neighbours.

5.2 Corporate
A structured collection of knowledge and views of stakeholders; recognition of the importance of information and knowledge available from those involved in local services including service users and wider population. Two focus groups were conducted with a total of eleven CYP and surveys were sent to parents and school staff in Southampton. 24 schools and 294 parents responded to the surveys. The full methodology for stakeholder engagement can be found in Appendix A. This was an iterative process shaped by internal and external council staff insights. Questions composed were informed by:

2. Department for Education’s survey of MH support in schools and colleges31
3. Portsmouth City Council PSHE survey

5.3 Literature review
The literature review search was limited to papers published from 2008 onwards, from OECD countries. Any study type including quantitative and qualitative research was included. Papers from countries outside the UK were then excluded as there were concerns that education systems were too different and findings may not be applicable. On the topic of MH and wellbeing of CYP in schools, it has been noted that even with comprehensive electronic searches, a large proportion of papers were identified from lists of references and from personal communication. This points to the relative inadequacy of electronic databases and of the database coding of school MH promotion studies32. Therefore, snowballing for other relevant papers was done through reference lists and grey literature was included. Grey literature was searched for from relevant websites including the Department for Education, PHE, NICE, and Anna Freud National Centre for Children and Families. The full search strategy and PRISMA flow diagram can be found in Appendix B.

The quality of original research papers were appraised using tools from the Cochrane handbook for systematic reviews,13 of systematic review papers with the Critical Appraisal Skills Programme (CASP)

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tool\textsuperscript{34}. The quality of the studies were graded using NICE methodology,\textsuperscript{35} on 7-11 categories depending on the study type and a ‘global’ or overall rating was then allocated.

5.4 Risks and limitations
Risks associated with the HNA were:

- Consent/confidentiality issues around working with CYP (steps taken to minimise risk)
- Gaining the engagement of schools and their commitment to contributing to the Needs Assessment
- Working across professional boundaries (health and education) that prevent information-sharing
- Maintaining team impetus and commitment
- Translating findings into effective action

The Needs Assessment was mainly limited by:

- Time and resource constraints, particularly limited recruitment to CYPs focus groups, which impacted on number of participants
- Difficulty accessing data from CAMHS and school nursing service affected our understanding of take-up and waiting times
- Uncertainty about methodology and quality of some secondary data. This report used research conducted by third parties and cannot be certain on, for example, what timeframe respondents were asked about
- Gap in data (see section 8.4)
- Change in the commissioning lead for CYPs MH within SCC during the timeframe the Needs Assessment was conducted


6. Population

**Summary: Population**
- 25% of Southampton's population (63,150) are 0-19 years (higher proportion than the England average) and this is predicted to increase by 3.4% by 2021.
- There are 73 publicly funded schools/colleges in Southampton.

6.1 City profile
Southampton is a Unitary Authority and the largest City within the Hampshire region with a major port and an international airport. There are 73 (55 primary (infant, junior and primary), 12 secondary/college, and 6 special) publicly funded schools/colleges and one pupil referral unit (Compass school) in the city.

6.2 City population estimates
The last census was in 2011 so the estimates of the population resident in Southampton come from HCC small area population forecasts (SAPF). They take account of planned residential development as well as local birth, death and migration trends. In 2018, it estimated the population of Southampton to be 255,522 of which about 25% (63,150) are CYP aged 0-19 years and 19% (47,528) are in scope for this needs assessment (aged 5-19 years) (see Appendix C).  

Southampton has a higher percentage of its total population who are school aged compared to the England average. The higher proportion of people aged 15-24 (20% in Southampton compared to 12.4% nationally) is because of the large number of students.

6.3 Population Forecasts
Although Southampton’s birth rate is projected to remain steady until 2022, a previous increase in birth rate continues to place increasing demands upon a whole range of both universal services, such as schools, GPs and CAMHS. The HCCSAPF population forecast can be seen in Appendix C. [36] The under 18-year-old Southampton City resident population is estimated to increase by 3.4% from 2017 to 2021, with the greatest increase projected within the 10 to 14 year-old population with an 18% increase in numbers. [37]

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7. Level of need in the population

Summary: Level of need in the population
- It is estimated that in Southampton 6,189 (9.8%) CYP aged 19 or less have a MH condition, which is higher than the England average (9.2%)
- The type of disorder varies with conduct disorders being most prevalent in boys and emotional disorders most prevalent in girls
- More CYP are being admitted to hospital for MH inpatient admissions and self-harm in Southampton than the England average
- There is no consistent survey of the wellbeing of CYP but of those which have been conducted Southampton has a lower wellbeing score than the national average, and MH has been identified as a priority for the city by residents many times

7.1 MH prevalence estimates
There is no actual measurement of the prevalence of MH conditions in CYP but based on surveys, estimates can be calculated.

Prevalence rates are based on the International Classification of Diseases (ICD)-10 Classification of Mental and Behavioural Disorders with these strict impairment criteria. For children and young people aged 5 to 16 years, the decade-old British Child and Adolescent MH Survey (2004) by Green et al. for ONS remains the most referred-to source to inform estimates of local prevalence rates. [38] It found that one in ten children aged 5-16 has a clinically significant MH problem. The number can be stratified by age, sex and socio-economic classification (NS-SeC of household reference person) so that estimates in 2015 are that 9.8% of CYP aged 5-16 have a MH condition in Southampton compared to 9.2% for the England average and 8.5% for the South East region average.

Applying this proportion to current population estimates of 63,150 CYP (aged 0-19 years), would mean that there are currently 6,189 CYP aged 19 or less with a MH condition in Southampton. The break down by age and sex can be seen in Table 2. If the prevalence was the same as the England average there would be 379 less CYP suffering a MH condition.

Table 2: Estimates of number of CYP with a MH condition in Southampton in 2018

<table>
<thead>
<tr>
<th>Age group (years)</th>
<th>Male</th>
<th>Female</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 to 4</td>
<td>789</td>
<td>742</td>
<td>1531</td>
</tr>
<tr>
<td>5 to 9</td>
<td>762</td>
<td>715</td>
<td>1477</td>
</tr>
<tr>
<td>10 to 14</td>
<td>623</td>
<td>595</td>
<td>1218</td>
</tr>
<tr>
<td>15 to 19</td>
<td>995</td>
<td>968</td>
<td>1963</td>
</tr>
<tr>
<td>Total</td>
<td>3168</td>
<td>3021</td>
<td>6189</td>
</tr>
</tbody>
</table>

Numbers are estimates only, and based on extrapolating survey prevalence’s to HCC SAPF estimates

These prevalence rates of MH disorders have been further broken down by the prevalence of conduct, emotional, hyperkinetic and less common disorders. However, this prevalence data is based on the ONS survey ‘MH of children and young people’, which was undertaken in 2004, therefore the data should be treated with caution as it is 14 years old. A new national prevalence survey has been commissioned by the Department and will report in 2018 and the scope has expanded to include ages 2 to 19 years. 5.8% have conduct disorders, 3.7% have emotional disorders.

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and 1.5% have hyperkinetic disorders but this varies further by sex. Rates have been applied to current population estimates which can be seen in Table 3.

Table 3: Estimates of number of CYP aged 0-19 with specific MH conditions in Southampton in 2018

<table>
<thead>
<tr>
<th>Disorder</th>
<th>Male n (% of all males)</th>
<th>Female n (% of all females)</th>
<th>Total n (% of all CYP)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conduct</td>
<td>2,425 (7.5)</td>
<td>1,202 (3.9)</td>
<td>3,663 (5.8)</td>
</tr>
<tr>
<td>Emotional</td>
<td>1,002 (3.1)</td>
<td>1,325 (4.3)</td>
<td>2,337 (3.7)</td>
</tr>
<tr>
<td>Hyperkinetic</td>
<td>841 (2.6)</td>
<td>123 (0.4)</td>
<td>947 (1.5)</td>
</tr>
<tr>
<td>Eating disorders</td>
<td>162 (0.5)</td>
<td>31 (0.1)</td>
<td>189 (0.3)</td>
</tr>
<tr>
<td>Autistic spectrum disorder</td>
<td>453 (1.4)</td>
<td>92 (0.3)</td>
<td>568 (0.9)</td>
</tr>
<tr>
<td>Total</td>
<td>3,104 (9.6)</td>
<td>2,404 (7.8)</td>
<td>6,062 (9.6)</td>
</tr>
</tbody>
</table>

Numbers may not add due to rounding and some CYP will have multiple conditions. Numbers are estimates only, and based on extrapolating 2004 survey prevalence’s to HCC SAPF estimates.

7.2 Hospital episode statistics

Data is available from HES and ONS mid-year population estimate for the under 18 MH inpatient admissions rate per 100,000 population. This is the first finished episodes for all persons aged 0 to 17 years with primary diagnosis ICD-10 codes F00 to F99 – mental and behavioral disorders for 2011/12 to 2016/17. The average rate is 138.64 admissions per 100,000 population, however the rate ranges significantly across the city from the lowest admission rate of 60.58 in Peartree ward to the highest of 263.63 in Freemantle (see Figure 1)39. This overlaps with areas of deprivation in the city, based on the IMD 2015.

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7.3 Self-harm and suicide

Self-harm can be a presenting feature among some children and adolescents suffering from MH or wellbeing difficulties. CYP have disproportionately high rates of self-harm, both nationally and in Southampton. A cohort study suggests a figure of approximately 8% of CYP aged 15-16 years have self-harmed over a 12 month period⁴⁰. The APMS (2014) found that one in four 16-24 year old women (25.7%) reported having self-harmed at some point; about twice the rate for men in this age group (9.7%)⁴¹. The gap between young men and young women has grown over time. Applying these figures to the estimated combined population of Southampton, suggests that in 2016 there could be around 6,316 female and 2,512 male 16-24 year-olds in Southampton who have self-harmed.

HES data are available for hospital admissions where the main recorded cause was self-harm. In 2016/17 the hospital admission rates for self-harm amongst 10-24 year-olds were significantly higher in Southampton at 625.1 per 100,000 population (directly standardised rate), compared to the national average of 404.6. The rate has been increasing compared to the England average since 2013/14 and is higher than all statistical neighbours except for Plymouth (see Appendix D)⁴². The self-harm that presents to healthcare services is very much the ‘tip of the iceberg’, with the true burden of self-harm in the community being far higher.

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Suicide is a significant cause of death in young people. The APMS (2014) found that over 19% of males and 34% of females aged 16-24 year olds had had suicidal thoughts (equating to about 8,356 female and 4,920 males 16-24 year olds in Southampton) and that 6.7% of people had attempted suicide (about 3,381 16-24 year olds).

7.4 Wellbeing surveys
7.4.1 ‘What About YOUth?’ (WAY) Study
The ‘What About YOUth?’ (WAY) Study (previously known as the Local Health and Wellbeing Survey for Younger People) was a national survey conducted in 2014 on a sample of 15-year-olds randomly selected from the DfE’s National Pupil Database. It measured wellbeing using the Warwick-Edinburgh Mental Wellbeing Scale, which ranges from 14 to 70, with higher scores indicating better wellbeing. Southampton had a lower mean wellbeing score (46) than the England average (47.6) and the lowest out of all of its statistical neighbours.

7.4.2 Healthwatch events
In 2018, Healthwatch collected views of more than 1000 residents in Southampton on health and social care services. MH was identified as Southampton’s number one issue for 2018, which is the third year running. People raised this as an issue in 65% of areas, most notably the care and support available to children and young people. The lack of MH awareness, early intervention and difficulty accessing effective and appropriate support were key themes.

At the Healthwatch ‘get together for health and wellbeing’ drop-in event on 12th April 2018 resident of any age could share their views on a number of issues relating to health. MH and the school setting was identified as a priority.

7.4.3 Southampton Pupils Attitude Survey
Southampton Pupils Attitude Survey is a large-scale survey on MH and wellbeing. It was last conducted in Southampton in December 2012 on 2,064 pupils in Years 4, 6, 9 and 11 selected by schools. More than one in four pupils (26.8%) reported being bullied in the last year and even more (28.3%) reported being afraid of bullying. 2.3% reported feeling unsafe or very unsafe in their own homes. Generally, the proportion of pupils worrying about problems (ranging from friendships and homework to money problems and being healthy) increased with age. The exception was bullying, with significantly fewer Year 11 pupils worrying about this (24.5%) compared with pupils in Year 4 (41.1%). The largest increases (between Year 4 and Year 11) were found in those worrying about ‘school tests/exams’ (36.0% vs 71.3%), ‘the way I look’ (32.2% vs 58.8%) and ‘being healthy’ (40.7% vs 64.1%) (see Appendix E). Of note, the survey underrepresented the most deprived children in the city and the findings are now rather out of date.

7.4.4 ‘Your Health’ Year 7 pupil survey
The best and most comprehensive repeated view of the health and wellbeing of school age pupils available at the moment comes from the ‘Your Health’ Year 7 pupil survey that the 5-19 PH (School) Nursing service carries out (see Appendix E). In 2017 results from the 1,895 children that completed the year 7 questionnaire were that roughly 13% (240) felt scared or worried, 62% rated themselves as ‘happy’ or ‘very happy’ with the remainder feeling unhappy or in-between (see Appendix E). However, this does not represent other year groups and future commissioning of the survey is uncertain.

7.4.5 Head Start Survey
A survey which was carried out by Head Start amongst young people aged 11-16 in Southampton during 2015/16 focused on experiences of bullying. Although the sample size was relatively small, only 150 school pupils, the survey did offer insights into the type and nature of bullying. Amongst
respondents, 73% reported that they had been bullied and 92% had witnessed bullying. When asked where the bullying had taken place, the majority (91%) of respondents said at school and 33% reported bullying online. This shows that those being bullied are being so in multiple ways. The impact of the bullying is worrying with 30% reporting that they have self-harmed as a result of bullying and 18% having considered taking their own life.

7.4.6 Southampton Connect Imagine the Future boat trip
In June 2015, Imagine the Future boat trip was an event organised by Southampton Connect, Stuart Woods and Head Start. Four workshops were run, one of which was focussed Health & Wellbeing. Surveys were completed by 250 people aged 10-18 years old from 28 schools and 5 colleges in Southampton. The top three health and wellbeing issues that they identified were, bullying, physical worries (body image) and self-esteem. The top three improvements they wanted to see were counselling, confidence building and an expression room.

7.4.7 Southampton CCG Health roadshow
Southampton CCG ran a health roadshow in collaboration with a social enterprise ‘We make Southampton’ where an outreach group went to 21 locations across the city including outskirts and deprived areas to collect the views of residents. One of the main findings was ‘concerns about young people’s MH e.g. large numbers of peers on anti-depressants’. 43

7.4.8 Families Matter
Families Matter is Southampton’s response to the government’s Troubled Families agenda. The third most common reason that families have been referred into the program, with 356 families out of all currently active families, was MH.

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8. Who is at risk and why?

**Summary: Who is at risk and why?**

- Southampton has numerous risk factors but few protective factors for MH problems
- Risk factors include: more male CYP than female, a high proportion of pupils from BME backgrounds, families in poverty, households with dependent children that are homeless, Looked After Children, special education needs including learning and physical disabilities, in the Youth Offending Service, who have been abused, and who misuse substances
- Emerging areas with a recognised impact on MH include the use of technology and social media, gender identity, the built environment, and low birth weight

The reasons why CYP experience MH problems are likely to be complex. However, certain factors are known to influence the likelihood of someone experiencing problems.

The ONS MH of CYP survey identified two main dimensions termed resilience and risk factors that are factors whether a child is likely to develop MH problems.

- Resilience refers to protective factors enabling some children to cope
- Risk factors increase the probability of a child developing a MH problem

A list of factors can be seen in Figure 2. Both factors may be found within the child themselves, within the family or within the broader environment. More data on these can be found in Southampton’s JSNA: [Southampton JSNA](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/575632/Mental_health_of_children_in_England.pdf).

**Figure 2: Risk and protective factors for MH of CYP.**

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8.1 Risk factors
The association of socio-demographic risk factors with prevalence rates of MH problems or detrimental wellbeing among CYP are listed below with the context in Southampton applied.

Child
8.1.1 Sex
Boys are more likely to have a MH disorder than girls – 11.4% of boys and 7.8% of girls aged 5 to 16 years. Although more girls have emotional disorders than boys. [38] Overall the proportion of males and females is similar in Southampton but in younger age categories boys outnumber girls (see Appendix F). There are 30,182 males under age 20 in Southampton compared to 28,442 females. [36]

8.1.2 Migration, ethnicity and language
Research on the MH needs of young people from BME groups is complex and does not give a clear picture of either the prevalence of MH problems, or access to services. However, we know that in adult MH services, people from BME communities are over-represented at the secure end of the system and underrepresented at the primary and community level.45

Southampton has more pupils from BME backgrounds (33.8%) compared to the England average (30.6%) and this proportion has been increasing over time (see Appendix F). In the latest report from the Department for Education there are Irish (0.2%), White other (11%), Asian (12.2%), Afro Caribbean (3.9%) pupils. [46] Long-term international migration up to the end of June 2015 shows that Southampton has more international incomers than leavers (5,350 compared to 1,820). There is also a high level of internal migration, with 16,100 people arriving and 16,900 leaving over the same period. [46]

There is not clear evidence of the effect of speaking English as a second language has on MH in CYP. 172 different languages are spoken in schools in Southampton. Since 2004, there have been high levels of economic migration from Eastern Europe. As a result, Polish is the most common first language spoken within schools apart from English. A breakdown of all first languages spoken in schools is attached as Appendix C.46

8.1.3 Special education needs
CYP with SEN are more likely to have poor MH and lower levels of wellbeing. Research demonstrates that children with LD are over six times more likely to have a diagnosable psychiatric disorder than their peers who do not have LD, 36% and 8% respectively.47

The Department for Education has recorded the number of pupils with SEN. These can be in four broad areas including physical disabilities. The proportion of school aged children with any type of SEN in Southampton is 19.5%, significantly higher than the England average of 14.3% (in 2016), this is higher than all similarly deprived areas. The break down by type of SEN has been available since 2015. In 2017, the proportion of school children with social, emotional and MH SEN needs was significantly higher in Southampton (3.75%) than the England average (2.33%). This is worse in

secondary school aged children where the proportion in Southampton is again highest out of all of its statistical neighbours (see Appendix F).

There is no definitive record of the number of children with LD in England but it is possible to estimate. The School Census is the most comprehensive log, it shows in 2016 that 2,155 children in Southampton have a LD. This is 69.1 per 1000 children, which is the second highest area in England and significantly higher than England’s average at 33.7 and Portsmouth at 32.1. However, children with LD are often educated outside of their local area so residents in this category would be missed. Additionally, the Census does not include children being educated at home, in the three independent mainstream schools or the two independent special schools, so the true number is likely to be higher.  

8.1.4 Long-term illness, disability or medical condition

CYP with a physical disability have a two-fold increased risk of emotional/conduct disorders (characterised by serious antisocial behaviour, including aggressive, destructive and deceitful behaviour and violation of rules). The association between physical disability and MH problems could be explained in part by social isolation, unemployment and financial pressures.

In 2017, in Southampton 34.7 CYP aged 0-17 years (per 10,000) identified as ‘in need’ with child disability or illness identified as the primary reason for being in need at initial assessment, higher than the England average of 31.2.

8.1.5 Youth offending service

About 60% of Young Offenders who are in a secure setting have a MH of wellbeing problem.

Southampton has a higher rate (rate of 10-17 year olds receiving their first reprimand, warning or conviction per 100,000 population) of CYP in the Youth Justice System than the England average, 434.4 compared to 292.5. This is the highest out of all LAs in the South East. Due to the small numbers involved in the size of the sample collected by the YOS it is not possible to break down the data to ward level so data is presented at the postcode district which shows that the majority of young offenders live in the postcode area SO19 (which includes the wards of Peartree, Woolston, Sholing and Bitterne) and SO16 (Redbridge, Coxford and Bassett). These areas cover some of the most deprived areas of the city.

8.1.6 Substance misuse

If a young person engages with substance misuse this can affect their emotional, social and educational wellbeing. Similarly, CYP who misuse substances could be self-medicating to try and cope with traumatic events, relieve stress, or trying to come to terms with their own gender identity, sexuality, poor resilience, self-esteem, etc.

Nationally in 2016/17, 21% of CYP aged 18 or less who were in contact with services for substance misuse reported having a MH problem. Note that MH problems are reported only for new clients entering specialist services during the year and cannot be updated. Some individuals disclose or be diagnosed with problems later in treatment; therefore the total proportion may be lower than the true figure. In March 2017, 211 CYP in Southampton were in touch with substance misuse services.

and of those who had a vulnerability recorded 38% were a MH problem. Southampton has double the national average of under 18 hospital admissions for alcohol specific conditions.

Substance misuse can affect the quality of parenting a child receives. A CYP might not be receiving a good level of care, have attachment issues with the parent or could be neglected which would impact on the CYP MH. In Southampton in 2011/12 the number of parents of children aged 0 to 15 years old per 100,000 population in alcohol or drug treatment is 55.6 and 132.9 respectively. This is lower than the England average (147.2 and 110.4) and all statistical neighbours for alcohol treatment. This is the most recent data available but not it is six years out of date and the data is not able to give insight into the number of parents misusing substances who are not in treatment.

8.1.7 Lesbian, gay, bisexual, transgender and questioning
Evidence suggests people identifying as LGBT+ are at higher risk of experiencing poor MH. LGBT+ people are more likely to experience a range of MH problems such as depression, suicidal thoughts, self-harm and alcohol and substance misuse. The higher prevalence of mental ill health in LGBT+ people can be attributed to a range of factors such as discrimination, isolation and homophobia.

Local data were not available on the prevalence of MH problems or poor wellbeing among LGBT+.

8.1.8 Young carers and young adult carers
The evidence on the MH of young carers (aged 17 or under) is weak but surveys show that they have worse MH than their peers. The GP Patient Survey finds that a third more young adult carers report anxiety or depression than other young people; 39% for young adult carers, in contrast with 28% of young people without caring responsibilities.

Local data were not available on the prevalence of MH problems or poor wellbeing among young carers.

8.1.9 Exclusions
Evidence suggests that young people excluded from school or in alternative provision are much more likely to have a social, emotional and MH need than children not in alternative provision. Disruptive behaviour may be a sign of an underlying MH problem.

In 2015/16 in Southampton 8.9% of state-funded secondary school students have had a fixed period exclusion. This has improved significantly since 2012/13 when 15.2% of students had been excluded. The proportion is similar to the England average of 8.5% and less than most similarly deprived areas.

8.1.10 Weight
There is a clear bi-directional link between poor MH and obesity. Suffering from poor MH can lead to over eating and low physical activity levels potentially leading to overweight and obesity but being

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overweight or obese can also lead to poorer MH outcomes. Key points from the Obesity and MH report from the National Obesity Observatory in 2011 include:\footnote{N. O. Observatory, “Obesity and mental health,” 2011. [Online]. Available: \url{https://khub.net/c/document_library/get_file?uuid=18cd2173-408a-4322-b577-6aba3354b7ca&groupId=31798783} [Accessed 12 June 2018].}

- The MH of women is more closely affected by overweight and obesity than that of men.
- Evidence for association between obesity and poor MH is stronger in teenagers and adults than for younger children.
- The relationships between actual body weight, self-perception of weight and weight stigmatisation are complex and this varies across cultures, age and ethnic groups.
- The perception of being obese appears to be more predictive of mental disorders than actual obesity in both adults and children.

Equally CYP who are underweight may be at risk of MH difficulties. This could be a result of malnutrition and poverty (see 8.1.3 above) or a sign of an eating disorder (see 7.1 above).

Areas of deprivation tend to have lower levels of healthy weight. Data from the National Childhood Measurement Program show that in 2016/17 in Southampton 76.2\% of reception year children and 63.2\% of year 6 children are a healthy weight, similar to the England average. 1.94\% of year 6 children in Southampton were underweight which is higher than the England average (1.34\%).

**Family**

8.1.11 Looked after children

LAC are four times more likely to have poorer MH compared to children that have not entered social care. There are a number of factors that can contribute, for example, they could have experienced poverty, abuse, neglect and bereavement. Care Leavers can face numerous changes as they transition into adulthood for example, responsibility for their own finances, living arrangements and education, which can be daunting.\footnote{H. G. A.-B. N. Beagley E, “Mental Health Needs of Looked After Children in One of the Most Deprived Boroughs in England,” Arch Dis Child, vol. 1, no. 69, p. 99, 2014.}

In a 2014 audit of a local authority LAC population, 48\% had a MH problem, though less than half of those 48\% had been referred to CAMHS. Variation was shown depending on the type of placement with just over six out of ten children living in residential care found to have a MH disorder compared with four in ten of those placed with foster-carers or their birth parents. Southampton has the 19\textsuperscript{th} highest rate of LAC in England. The rate of LAC in Southampton has increased sharply over the last five years, from 85 per 10,000 children under 18 in 2011 to 120 per 10,000 children in 2015 (up 41.2\%), which is the highest of all its statistical neighbours.\footnote{Data on the prevalence of MH problems within LAC in Southampton was not available but the ‘LAC Needs Assessment, SCC, 2016-2017’ found that MH dominated the discussions from all professionals, with particular concerns around attachment and the behavioural impacts of poor MH and the potential for placement breakdown.}

8.1.12 Who are being abused or witness domestic abuse

Abuse may be of a sexual, psychological or emotional in nature, while neglect is the persistent failure to meet a child’s basic physical and/or psychological needs, such as failure to provide adequate food, shelter or clothing, protect a child from physical or emotional harm or ensure appropriate medical treatment. There is strong evidence to suggest that abuse and or neglect has a detrimental effect on MH and wellbeing.

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In 2017 the rate per 10,000 children aged under 18 years ‘in need’ due to abuse or neglect in Southampton was 335.5 compared to the England average of 172.9. Southampton has high levels of domestic violence and abuse, with 77% of Child Protection Plan cases involving domestic violence and abuse. The proportion of children living in households at risk of domestic violence has increased by 17% between 2013/14 and 2014/15.

8.1.13 Parent with a MH problem
Poor parental MH has been associated with poor outcomes in children. A number of biological dispositions, sociocultural contexts and psychological processes are likely to interact and can serve as protective factors or risk factors for both parents’ and children’s MH.

In the GP patient survey 2015/16, 14.8% of registered patients aged 18 years or older in Southampton answered “moderately anxious or depressed”, “severely anxious or depressed” or “extremely anxious or depressed” to the question “What is the state of your health today?” This indicator has the advantage over Quality Outcomes Framework rates as a significant proportion of people that have depression are not diagnosed. This is higher than the England average of 12.7% but slightly better than Portsmouth or Brighton.  

School
8.1.14 Peers
During adolescence, social determinants from outside the family become greater, with major influences of peers, wider social groups and the media becoming particularly important. Some influences may arise outside the school environment, such as engagement in political, religious and social groups, as CYP spend more time outside the parental home, and beyond parental influence but the school environment is the critical setting. Although there is a large literature on peer influence in the development of antisocial behaviour and substance misuse, for example, and sexual risk, violence and participating in criminal activity, there is also a literature on how peers help and support each other and buffer the effects of life stressors and protect against health risk behaviours. Longitudinal research has demonstrated that the quality of social interactions at age 20 can have a direct, unmediated effect on age-50 social and psychological outcomes. It is difficult to collect data on peer groups and no local data was available.

8.1.15 Bullying
Negative long-term health outcomes have been reported both for young people who bully others and for victims of bullying. Bullying perpetration is linked to increased delinquent behaviour, depression amongst girls, increased risk of suicidal ideation, poor school adjustment and increased risk of violence. Bullying perpetrators are at increased risk of substance misuse in early adulthood. Victims of bullying were also more likely to exhibit delinquent behaviour, experience higher rates of depression and internalising MH problems, increased risk of suicidal ideation and self-harm; more likely to have had psychotic episodes by age 18, showed poor school adjustment and were more likely to be a young parent under the age of 20.

Of the 1,895 year 7 children surveyed in ‘Your Health’ in 2017 roughly 6% (112) felt they were being bullied and required support (see Appendix E).  

Community
8.1.16 Poverty/ low-income

Income can have an adverse impact on the psychological functioning of mothers. There is a strong association between the lack of control perceived by mothers from low income backgrounds and the social and emotional wellbeing of CYP. It has also been found that children and families from the lowest 20% of household income are three times more likely to have common MH problems than those in the richest 20%.

Between 2008/9 and 2012/13, Southampton became relatively more deprived – of the 326 Local Authorities in England, Southampton is now ranked 54th (previously 72nd) most deprived (where one equals the most deprived), and nearly a quarter of the children in the city live in relative poverty. A map showing the IMD and ward boundaries is in Appendix F. [46] In 2015 data from HM Revenue and Customs showed 19.7% of children under 16 in Southampton lived in low income families (children living in families in receipt of out of work benefits or tax credits where their reported income is <=60% median income) compared to the England average of 16.8%. This difference has remained relatively constant since 2006. The school census counts the number of pupils known to be eligible for and claiming free school meals who attend a state funded nursery, primary, secondary or a special school. In Southampton in 2017 there were 17.5% of pupils up taking free school meals compared to 13.9% nationally. [46]

8.1.17 Homelessness/ temporary accommodation
There is evidence to suggest that children experiencing homelessness may experience ill MH. Homelessness places stress on parents and as well as children. It has been found that MH problems can be significantly higher among rehoused mothers and their children. Young people frequently sleeping on sofas of friends and family or on public transport are considered to be the ‘hidden homeless’. The number of ‘sofa surfers’ amongst young people is rising and because they are not officially classed as homeless they do not receive the support that they require. A recent survey carried out on 2,000 16-24 year olds by Centrepoint stated that 20% of young people had to sofa surf in the past year because they had nowhere else to go. Out of these young people 49% had sofa surfed for over a month.

Southampton has a higher rate of statutory homeless households with dependent children. The number of applicant households with dependent children or pregnant woman accepted as unintentionally homeless and eligible for assistance in 2016/17 was 2.2 per 1,000 households in Southampton compared to the England average of 1.9 (estimates were supplied by Department for Communities and Local Government). Local data are not available on their MH or on the number of sofa-surfers.

8.1.18 Unaccompanied Asylum Seeking Children
UASC aged less than 18 years are at a high risk of having poor emotional wellbeing due to the probability of them fleeing war/ conflict, being trafficked, tortured, sexually exploited and subjected to female genital mutilation. UASC tend to be males in their mid-teens. UASC do not tend to disclose MH problems until crisis point, this could be due to fear of affecting their asylum claim, issues around stigma, language and cultural barriers. A literature review published by the University of Bristol and Coram Voice found that approximately a third of the refugee and asylum seeking young people in one study had concerns about their MH, especially with regards to having anxieties about the past rights and entitlements to education, housing and leaving care services, as well as the status of their asylum claims and its impact on their future.

58 V. Hadley Centre for Adoption and Foster Care Studies, “Children and Young People’s Voice on Being in Care A Literature Review,” Coram Voice, Bristol, 2015.
In 2017 in England there were 4,560 UASC, of which 10 were in Southampton. Similarly deprived areas had between ten and 45 UASC.

8.1.19 Gypsy, Roma and traveller communities
CYP from the gypsy, roma and traveller communities are less likely to access universal services and therefore achieve poorer health, social and educational outcomes. Therefore, there is a higher probability that if a CYP is displaying poor MH this would not be picked up by professionals such as teachers.

Nationally, travellers are six times more likely to die by suicide than non-Travellers. In the 2011 census, 341 people from the Gypsy, Roma and traveller communities were living in Southampton. Local and national data were not available on the prevalence of MH problems or poor wellbeing among CYP from Gypsy, Roma and traveller communities.

8.1.10 Built and natural environment
Housing, the built and the natural environment can have direct and indirect effects on MH. Crowding (number of people per room) and loud exterior noise sources (e.g. airports) elevate psychological distress. Malodorous air pollutants heighten negative affect, and some toxins (e.g. lead, solvents) cause behavioral disturbances. Insufficient daylight is reliably associated with increased depressive symptoms.

No local data was available on the school environment but in England the worst shortage of school places in decades is putting increasing pressure on school buildings. With the problem forecast to get significantly worse it adds to the ongoing challenge of dealing with a school estate. Good school buildings have a significant and positive impact on pupil behaviour, engagement, wellbeing and attainment. The RIBA set out good design principles in their report Better Spaces for Learning.

8.2 Protective factors
There are some children who are more resilient than others in the face of certain life events. An important key to promoting children’s MH is to build on the protective factors which enable children to become more resilient. These are listed below with the context in Southampton applied.

8.2.1 Educational attainment
Learning ensures that children develop the knowledge, skills, and attributes that they need for mental, emotional, social and physical wellbeing now and in the future. The Department for Education records the number of pupils at the end of Key Stage 4 at the end of the academic year 2015/16 achieving 5 or more GCSEs, including English and Maths, at grades A*-C or equivalent resident in Southampton. Fewer pupils achieve five or more GCSEs A*-C (53%) compared to the England average of 57.8%.

8.2.2 School readiness
Children are defined as having reached a good level of development if they achieve at least the expected level in the early learning goals in the prime areas of learning (personal, social and emotional development; physical development; and communication and language) and the early learning goals in the specific areas of mathematics and literacy. Data from DfE shows that in 2016/17 Southampton has a similar number of children defined as having reached a good level of

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development at the end of the Early Years Foundation Stage as the England average, 70.2% and 70.7% of pupils at the end of reception respectively.\textsuperscript{42}

8.2.3 Breast feeding
Breastfeeding has been linked to positive emotional, health and cognitive outcomes for children.\textsuperscript{62} In 2015/16 48.7% of infants were breastfed at 6-8 weeks after birth, in line with the Wessex average and better than the national average of 45.2%.\textsuperscript{42}

8.2.4 Attachment and parenting
Attachment is a type of behaviour displayed by children to draw their primary caregiver towards them at moments of need or distress. Children whose caregivers respond sensitively to their needs at times of distress and fear in infancy and early childhood develop secure attachments to them. They have better outcomes than non-securely attached children in social and emotional development, educational achievement and MH.\textsuperscript{63} Locally data is not available.

8.2.5 Physical activity
Participation in physical activity in childhood has benefits for physical, mental and social health. It improves concentration and self-esteem, and can also improve school attendance, behaviour and attainment.\textsuperscript{64}

Southampton had the lowest proportion of 15 year olds who were physically active (engaged in moderate/vigorous physical activity for at least 60 minutes every day within the past 7 days) in the Way survey (2014/15) at 12.5% out of all LAs in the South East region and nearly all similarly deprived areas. The England average is also low at just 13.9% of CYP meeting the minimum recommended activity.\textsuperscript{42} More up-to-date data will be available in 2019 from Sport England Active Lives: Children and Young people.

8.2.6 Community activities
Participation in social and voluntary activities is associated with higher levels of life satisfaction.\textsuperscript{65} This is a very difficult factor to measure and there is no data available by age group. The Happy City Index creates a ‘People and community’ score based on four indicators (Total vote turnout in General Election 2017, number of volunteering organisations per 1000 people, RSA Heritage activities index and the ONS social fragmentation index).\textsuperscript{66} Southampton scored low (4.21 out of 10) for People and community, and lowest out of the South East region for community cohesion.

However, DIY streets are being trialled in Southampton outside various schools from 2018-2020. DIY Streets is a concept developed by Sustrans, which encourages communities to generate ideas for the improvement of their street. The concept aims to make the street less car dominated, and more community focussed. Typically, this involves creating a ‘community feel’ in the street, with artworks in the road and plants or trees. Wooden flower beds or tree plant pots (planters) are placed in the road to calm vehicle traffic.

\textsuperscript{64} H. A, “The connections between young people’s mental health and sport,” 2016.
\textsuperscript{65} U. J. e. al., “Children and young people’s emotional health and wellbeing needs assessment,” Liverpool Public Health Observatory, Liverpool, 2012.
8.3 Emerging areas

8.3.1 Multiple conditions
Some children experience more than one MH problem. This can make assessment, diagnosis and treatment more complex. The ONS MH of CYP survey (2004) found that one in five of the children with a mental disorder were diagnosed with more than one of the main categories of mental disorder. This figure represented 1.9% of all children. The most common combinations were conduct and emotional disorder and conduct and hyperkinetic disorder.\(^\text{67}\)

This was echoed in the focus groups with CYP who often felt that their situations were complex and multi-faceted and that schools were not equipped to deal with this (see Appendix H).

8.3.2 Impact of technology and social media
Perhaps the biggest shifts in CYPs behaviour over recent decades relate to the use of information and communication technologies. A recent study found 91% of young people aged 16-24 years old use the internet for social networking and these figures have only increased over the last ten years\(^\text{2}\)\(^\text{67}\). Online platforms such as social media have been found to be both beneficial (access to information, guidance and services, emotional support through online contacts) and detrimental (cyber-bullying, nature of content viewed, addictive, interrupts sleep, fear of missing out, issues around body image) to wellbeing and MH. Concerns have been raised about the length of time CYP are spending online. The UK Household Longitudinal Study found a clear association between longer time on social websites and higher total difficulties scores (see Figure 3).\(^\text{68}\)

Figure 3: Total difficulties score category by time spend on social networking website for children aged 10-15 years, in the UK, 2011/12. Taken from the UK Household Longitudinal study \(^\text{68}\).

The risks are widely discussed, the opportunities less so. In the focus groups most CYP felt positively towards social media rather than negatively. Some mentioned that they did not have friends in school but could connect to people online. There was reluctance around any regulating of social media.

As the digital world develops so does the need for a robust evidence base in order to understand the potential impacts on the end user, including impact on their MH. The Science and Technology Committee held an inquiry on the impact of social media and screen-use on young people’s health.

The formal report is pending but suggestions included social media should be mandatory in all PSHE, research on effect of interventions such a screen lock-outs, health warnings of break reminders on social media, guidance for parents and schools.

8.3.3 Low birth weight
There is emerging evidence that being born with a low birth weight (LBW) increases the likelihood of developing MH needs later in life. Children born at extremely LBW were reported by parents and teachers to be at significantly greater risk than normal birth weight controls for inattention and hyperactivity, internalising, and externalising symptoms. LBW children were also at greater risk for conduct and oppositional disorders, autistic symptoms, and social difficulties. Depression, anxiety, and social difficulties were elevated in LBW survivors in adulthood.69

8.3.4 Gender identity
Gender identity includes CYP who identify as transgender, gender fluid and non-binary. These CYP are also disproportionately affected by poorer MH. They are more likely to experience victimisation, violence and discrimination including non-recognition of gender that is different to one assigned at birth. Some transgender people undergo gender reassignment to match their physical characteristics to their gender identity, and MH can deteriorate whilst waiting for services, increasing the risk of self-harm and suicide. Gender dysphoria is described as experiencing discomfort or distress with the gender and sex assigned at birth.

It is difficult to estimate how many transgender people there are in the UK, as there are no official surveys or census questions that allow transgender people to identify themselves, but research by the Gender Identity Research and Education Society puts the figure between 300,000 and 500,00070. Another study estimates that the transgender population makes up between 0.3% and 0.5% of the population, meaning that there would be between 142 and 238 CYP aged 5-19 years living in Southampton.71 This estimate does not include young people who identify as non-binary or gender fluid.

8.5 Gaps in data
Key data missing locally:
- LGBT+
- LAC
- Young carers
- Homelessness/ temporary accommodation/ sofa surfers
- MH Services Data Set has no statistics on Southampton

Key data missing nationally:
- Black Minority Ethnic
- Gypsy, Roma and traveller CYP
- CYP who identify as transgender, gender fluid and non-binary
- CAMHS Transition into Adult MH Services

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9. Literature review

Summary: Literature review

- A literature review of studies from 2008 onwards, in the UK for effective school-based interventions to promote the MH and wellbeing of CYP found a total of 18 studies (eleven quantitative, two qualitative, five systematic reviews) and 12 grey literature items.
- The strongest evidence is for universal whole school approaches of which curriculum based programs are one part.
- Targeted support should include low-level support and ideally be provided by independent, external staff to the school.
- School-based interventions promoting MH and wellbeing are cost effective with every £1 invested in programs in schools having a £5.08 to £7.10 benefit.

The literature search of effective school-based interventions to promote the MH and wellbeing of CYP found 30 studies (eleven quantitative, two qualitative, 5 systematic reviews and 12 grey literature items). The full search strategy and PRISMA flow diagram can be found in Appendix B.

9.1 Quality of evidence base
Details of study quality are shown in Appendix G. Out of eleven quantitative studies, ten included a control group and three were randomised. The description of randomisation was reported only in one trial (Stallard, 2015), and intention to treat (ITT) analysis reported in only two. No trials reported double blinding or blinding of the assessor. The extent of loss to follow up was stated in 8/11 quantitative studies and was either not reported or not clear in the remainder. Only three studies followed up for more than a year with the maximum follow-up being two years. The remainder had a follow-up of 6 months of less so longevity of effects is uncertain. Some baseline characteristics about age, gender, and ethnic origin were reported in all RCTs but the details reported varied between trials. Common weaknesses were reliance on self-reported data and lack of long term follow-up.

Both of the qualitative studies had a clear theoretical approach and appropriate study design. However, only one (Kidger et al, 2009) clearly stated measures to maximise rigor, richness and reliability.

All of the systematic reviews has a clear research question, search strategy and quality appraisal system. The majority of systematic reviews did not comment on publication bias and were not able to perform meta-analysis due to varying outcome measures.

9.2 Types of school-based MH interventions
School-based MH programmes have been implemented using different approaches. These are broadly divided into three groupings:
- Indicated programs – restricted to those who have already developed a problem
- Targeted programs – delivered to children at high risk for developing health problems
- Universal programs – delivered to all pupils in the school regardless of need

Universal approaches can be further broken down into two different types of interventions:
- Curriculum-based – designed to teach skills through delivering a special curriculum in the classroom.
- Whole school approach – aim to develop health-promotion programs by extending the teaching beyond that of health knowledge and skills, by shaping the whole school ethos,
encompassing the school’s social and physical environment, and by developing links with all relevant stakeholders including pupils, teachers, school administration, parents and wider community members.

Three of the eleven quantitative studies were targeted, one was mixed and the remainder were universal approaches. Two of the eleven were whole schools approaches and the remainder were class-based interventions.

9.3 Evidence based interventions

**Universal approach**

There is stronger evidence to support the implementation of a whole school approach to promoting the MH wellbeing of CYP. This approach was developed during the 1990s, backed by the WHO in 2005, and also NICE, the National Children’s Bureau and UCL Institute of Health Equity.\(^{72}\) \(^{73}\) PHE advise that eight principles make up a whole school approach (see Figure 4).\(^{74}\)

**Figure 4: PHE principles to promote MH and wellbeing as a whole school approach**

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The whole school approach includes curriculum-based learning and targeted support where appropriate. Examples include the WHO health promoting Schools program for which the evaluation is pending,\(^75\) and Promoting Alternative Thinking Strategies (PATHS).\(^76\)

Opportunities exist to promote MH through both a dedicated PSHE curriculum and the wider curriculum. Pupils and students are more likely to engage in lessons that focus on wellbeing if they are of practical application and relevant to them. A range of curriculum-based programs showed promise, including those enabling children to learn to relax and cope with stress, those teaching conflict resolution and involving peer mediation and those teaching social skills and emotional literacy; but they need investigating in good quality randomised trials. They have been associated with improved coping strategies, better wellbeing, reductions in symptoms of anxiety and better awareness of MH. Sessions delivered in small rather than large groups, and those which were based on Cognitive Behaviour Therapy (CBT)-based resilience programs were most effective, such as FRIENDS,\(^77\) and Lessons for Living: Think Well, Do Well.\(^78\) Other examples include Zippy’s Friends,\(^79\) b (Stop-Breathe-Be) program,\(^80\) and Strengths Gym.\(^81\)

**Partnership working**

The CASCADE Framework for Collaborative Working has been developed by the Anna Freud Centre to support partners involved in supporting CYPs MH (CCG, NHS and LAs) to work with schools.\(^82\) It focusses on the following key elements: Clarity on roles, remit and responsibilities of partner organisations; Agreed best use of key points of contact in schools and CAMHS; Structures to support shared planning and collaborative working; Common approach to outcome measures for children and young people; Ability to continue to learn and draw on best practice; Development of integrated working to promote rapid and better access to support; and an Evidence based approach to intervention.

The Kings Fund (2017) report ‘MH and new models of care Lessons from the vanguards’ highlights learning from systems across England that are working in more integrated ways to improve MH and wellbeing outcomes.\(^83\) Areas which have developed a system-wide outcomes framework which encourages local partners from a range of disciplines, such as employment, housing, criminal justice, health and social care, community, as well as education to work together to promote MH are highlighted as most successful. Examples include THRIVE West Midlands and Tower Hamlets.

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9.4 Practical implementation
Some of the PHE principles to a whole school approach are described in more detail below, based on practical examples from the evidence.74

Ethos and environment
The literature states that a focus on positive MH rather than MH problems and illness is more effective. Studies found that improving the physical and psychosocial environment benefited interventions. Examples included improving student-staff relationships student relationships by teachers being less strict about what students regarded as trivial matters such as uniform, and reducing frequency of examinations so students do not feel overburdened. Developing the range and number of extra-curricular activities available and peer support programs also had a positive impact on wellbeing.

A review commissioned by the Department for Education on peer support interventions for CYP of school age (aged 4-18) was conducted in 2016. Only a small number of studies included robust evaluations but many studies collected feedback and self-reported outcomes. It found little evidence for group-based projects, on-line projects or community-based programs, but good evidence for school based one-to-one peer support. One-to-one school projects tend to be universal rather than targeted. Programs were more popular among girls than boys. Several studies note the importance of a clear focus, strong leadership by a co-ordinator and support throughout the school, including from senior school management and being a formalised project. Specific elements of formalised projects include: a structured process of monitoring and evaluation; having a dedicated space for peer support, with dedicated time slots; and formal training of peer supporters and co-ordinators. Examples in the UK include NSPCC peer support, Mayflower High School and the West Sussex Schools Peer Support program. 84

Student voice
Involving CYP in decisions that impact on them can benefit their emotional health and wellbeing by helping them to feel part of the school and wider community and to have some control over their lives. At an individual level, benefits include helping students to gain belief in their own capabilities, including building their knowledge and skills to make healthy choices and developing their independence.74

Targeted support
Numerous organisations including the Early Intervention Foundation, 5 PHE, 74 and NICE have all highlighted the importance of CYP having access to low level support, as well as specialist services (such as CAMHS), so that emotional, social and behavioural problems can be dealt with as soon as they occur. This can include pastoral support, training school staff or other providers.

Independent health led lessons or programs (external staff or schools nurses) were more effective at reducing MH conditions than teacher led programs, however more evidence is needed on sustainability. School engagement and commitment is essential, and therefore programmes usually last longer if offered by teachers however the current pressure on schools and poor recruitment of teachers has resulted in many schools not having the dedicated time, training and ongoing support to carry out this work. If delivered by teachers, a larger effect was seen for programs which included

significant teacher training, and ongoing supervision. Examples include FRIENDS, a health professional led CBT program.77

9.5 Cost effectiveness and feasibility
The case for promoting good MH and wellbeing has financial drivers as well as moral and policy drivers. For example, a child with conduct disorder (the most common mental disorder in childhood) over a 17-year period will have cost society ten times as much as a child without a MH problem. Intervening as early as possible can help to prevent those early indicators of problems occurring or escalating.7

The cost of providing MH support is estimated as:
- £5.08 per student to deliver emotional resilience programs in schools
- £229 per child for six counselling or group CBT sessions in a school
- £2,338 for a referral to a community CAMHS service
- £61,000 for an admission to an in-patient CAMHS unit85

Not only is provision much cheaper if delivered earlier, it is also more cost effective. PHE estimates that every £1 invested in emotional resilience programs in schools has a £5.08 benefit realised over 3 years.86

Programs were either delivered by teachers or trained health professionals, such as nurses with or without supervision provided by clinical psychologist. Most training was two days long and the cost of this varied from £95 to £332 per participant. Most of the curriculum-based programs were manualised with or without a workbook for the CYP. The cost for the curriculum ranged from free to £568. One study provided an economic analysis which found that the rate of return on investment was 12% and the Benefit Cost ratio was 1:7.10 so for every £1 spent on a program £7.10 was saved.

9.6 Research gap
Based on the literature review areas which need further research include:

- No consistent trend was seen for impact relative to length of intervention and while the majority of these programs were implemented over a year or more, further research is needed to establish the optimum content and length
- Which elements of leadership and management are most effective at promoting wellbeing using an organisation-wide approach and which competencies are required for effective leadership
- Which methods and techniques enable education establishments to work effectively with parents/ carers to promote the wellbeing of CYP
- Effects of social media on CYPs health

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10. Stakeholders

**Summary: Stakeholders**

- There is a lack of universal support for MH and wellbeing and low-level support is very variable across schools.
- There are gaps in support for primary schools and special schools.
- Most schools engage parents but few co-produce with CYP, or offer support to staff.
- Few schools have a formal monitoring system to measure CYPs wellbeing. This would enable targeting of CYP likely to benefit from wellbeing or MH support, as well as evaluate interventions.
- It is challenging for schools, parents and CYP to coordinate and navigate the numerous services and there are concerns that not enough early and low level support is available.
- School staff should be trained to identify pupils who show signs of MH difficulties early, but for targeted support (more intensive support for those pupils with medium to higher needs) external individuals and/or peer support are preferred.
- PSHE should include topics CYP feel are important to everyday life such as MH and wellbeing, life skills, staying safe online and crime and law.

A range of stakeholders were consulted (see Figure 5).

**Figure 5: Diagram of stakeholders relevant to CYP MH and wellbeing needs assessment.**

*group was consulted in the HNA process*
10.1 CYP
Two focus groups with a total of 15 CYP (aged 12-24 years) found:

- Accessibility was more important than having highly trained individuals. There is a demand for more low-level support which is open-ended and available at all times.
- External individuals and/or a peer support system are preferential to teachers as CYP feel they are less biased, confidential and have more time.
- Staff should be trained to spot pupils who show signs of MH problems early.
- Numerous concerns amongst the CYP about confidentiality and about not being seen to be visiting or using services suggests perception of stigma.
- PSHE should be extended so it is covered every year in school and includes topics CYP feel are important to everyday life such as MH and wellbeing, life skills, staying safe online and crime and law.

The full findings from the focus groups can be found in Appendix H.

10.2 Parents
A survey was circulated through some schools parent mail systems and SCCs Peoples Panel. 294 parents with a child(ren) at 77 schools responded. Because of the way the survey was distributed a small number (28, 5.7%) of respondents had children at schools outside Southampton (including Winchester, Eastleigh and Highlife) and these were not able to be excluded. The full findings can be found in Appendix I.

The main findings were:

- Most parents were confident in providing support for their child MH but were less confident in identifying when they need support.
- 13% of parents felt schools had a negative impact on MH and this was mainly in secondary rather than primary schools
- Only 28% felt there was sufficient support in schools
- 21% would not know where to get help from their child school
- Teachers cannot be relied on for MH support but should be trained in early recognition of when a child would benefit from help and how to signpost them appropriately
- More prevention and early help is needed within schools
- There is poor communication between GPs and schools with some CYP being bounced between them
- Frustrations around numerous reorganisations, high staff turnover in schools and funding cuts

10.3 School
The full findings from the survey sent to all schools in Southampton can be found in Appendix I. The survey was open 25th May – 29th June 2018. 24 out of the 73 schools completed the survey (14 out of 55 primary schools, seven out of twelve secondary schools/colleges, and three out of six special schools). The main findings were:

- Generally schools wanted more support regarding MH and wellbeing and felt under pressure in this area including comments such as “we now have GPs signposting parents to schools for counselling – with the expectation that it is provided”.
- Of the 24 schools only 15 had a MH lead but this did include all of the special schools. This is similar to national figures, the government green paper found that ‘nearly half of schools and colleges already have specific MH leads’. The most common formal training a lead had had was with Emotional First Aid however many leads had only minimal or no specific MH training. Most schools wanted further on-site training for staff.
The promotion and support for MH and wellbeing was very variable across schools including the support for staff, with comments including that it would be “useful to standardise the expectations from all schools across the City and share resources” and the need for “quality assurance PSHE offer that can be used to personalise the PSHE delivered in schools”.

Schools showed confusion around which services they were receiving. For example, Primary MH workers were reported as present in six schools, however only three of those schools actually had the service commissioned in them. Similarly, EHWB were reported in 12 schools, but only 8 of those actually received the service. Positively, nine schools said they had a peer support system in place.

Nearly all schools did feel they addressed MH and wellbeing to a degree in their curriculum but of note, 8 schools did not have dedicated PSHE lessons timetabled. Although a range of external providers are available, most schools used school staff to deliver the teaching.

Aspects of the curriculum which none of the schools reported including but were requested by CYP and are recommended in the grey literature were online safety including social media, addiction, bullying, relationships and sex education including consent, diet, exercise, mood and promoting good sleep. Many schools (11) stated that they do not feel prepared for compulsory RSE and gender identity was raised as an area of need.

The number of pupils self-reporting MH or wellbeing issues varied greatly from less than five per month in some schools to over 30 per month in others.

All schools had some wait time to see a counsellor, again this varied greatly from less than 7 days to over a month.

Four schools mentioned formal monitoring systems for the wellbeing of pupils (can be used to evaluate the impact of MH support and identify those pupils who may need targeted support. The methods were very inconsistent and not always evidence based. For example, two schools use the Anna Freud wellbeing measurement framework but some schools just used informal conversations with staff.

Most schools stated that they already engaged with parents, usually with information providing, face-to-face sessions of interventions with CYP that included them.

11 schools did not know about CAMHs schools MH forum or PSHE network. Those who were members found it quite to very useful.

Nearly all schools would be willing to buy additional services and pool resources.

A good case study of CYP involvement idea was a pupil from one school who lead assemblies and created support posters around the school on MH issues as a result of her father having CBT and the impact on her and her siblings.

The Anna Freud National Centre for Children and Families ran a workshop in Southampton in July 2018. It was attended by school head teachers and other staff from across Hampshire including Southampton. It was focussed on their Schools in Mind program and how staff wellbeing can be supported with the premise being one needs to look after their own MH to be able to help others including the CYP. Reponses included team time, briefings, supervision, cards, awards and B. mindfulness training. Full responses can be found in Appendix I.

10.4 Service providers
Details on the views of service providers regarding MH and wellbeing provision in Southampton can be found in Table 4. Generally it was felt that numerous services already existed but some were likely to overlap and/or duplicate, and it was challenging for schools, parents and CYP to coordinate and navigate these services. There were concerns around not enough early/low level support, support for special schools and support for teachers. The importance of being able to see the same professional throughout the time a CYP experiences difficulties was highlighted.
<table>
<thead>
<tr>
<th>Position</th>
<th>What is working well?</th>
<th>Where do you think the needs is/ room for improvement</th>
</tr>
</thead>
<tbody>
<tr>
<td>PSHE Network</td>
<td>Good communication through those schools that are in the network</td>
<td>Very few schools are members of the PSHE network</td>
</tr>
<tr>
<td>Educational Psychologist</td>
<td>Lots of services exist Able to prioritise</td>
<td>Distinction needs to be made between mood fluctuations and MH disorder Need early support (age and severity) Concerned special schools do not get extra support</td>
</tr>
<tr>
<td>EHWB worker</td>
<td>Independent contact within schools</td>
<td>Need more support in primary schools and for teachers</td>
</tr>
<tr>
<td>CAMHS</td>
<td>MH forums to share good practise and concerns Lots of support available in schools</td>
<td>Need more coherence about existing services to prevent overlaps/ duplication Develop Single Point of Access Early prevention to reduce pressure on higher level services Concerned about help available to special schools</td>
</tr>
<tr>
<td>Charity</td>
<td>A lot of services that feed into schools SFRG termly – annual meetings (No Limits, Sexpression, police) Liaise with other groups</td>
<td>Hard for schools to coordinate numerous services Avoid overlap and gaps e.g. many schools lack a counsellor Confusing picture for a young person Nationally, school nurses are depleted Pastoral lead but CYP want to speak to someone independent</td>
</tr>
<tr>
<td>Charity</td>
<td>A lot of services available</td>
<td>Referral pathways not clear – Refers to CAMHS even though he knows likely to be triaged down to primary MH worker</td>
</tr>
<tr>
<td>Charity</td>
<td>Long lengths of time with CYP without stress of meeting grades so a more relaxed environment</td>
<td>Hard for teachers to provide support – not right relationship or time</td>
</tr>
<tr>
<td>Charity</td>
<td>Increasing discussions about MH</td>
<td>Long waiting times to see services Lack of continuity, i.e. discharged after six sessions, all highlighted the importance of seeing the same professional throughout Clearer guidance for parents and CYP</td>
</tr>
</tbody>
</table>
11. Service provision

Summary: Service provision
- Nationally and locally there is an increasing demand for MH services which is not being met.
- Three universal, 25 targeted services and three forums to support MH and wellbeing are available within or to schools in Southampton.
- There is a large need for prevention and low level support, especially in primary school aged CYP.

Nationally data comes from the CAMHS 2015 Benchmarking Study included 79 organisations from across the NHS in England, Wales and Scotland. The results confirm national trends that referral rates, waiting times and cost of the service have been increasing (see Table 5).

Table 5: CAMHS 2015 Benchmarking Study findings

<table>
<thead>
<tr>
<th>Referrals</th>
<th>Tier 1-3 Services</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>An 11% increase in referral rates reported.</td>
</tr>
<tr>
<td></td>
<td>On average 3.051 referrals were received per 100,000 population.</td>
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<tr>
<td></td>
<td>Approximately 79% of referrals are accepted.</td>
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<table>
<thead>
<tr>
<th>Waiting Times</th>
<th>Tier 1-3 Services</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Mean maximum wait for a routine appointment 32 weeks, increased from 22 weeks in 2013/14.</td>
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<tr>
<td></td>
<td>Median maximum wait for a routine appointment 26 weeks, increased from 16 weeks in 2013/14.</td>
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<table>
<thead>
<tr>
<th>Contact Rates</th>
<th>Tier 1-3 Services</th>
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<tbody>
<tr>
<td></td>
<td>On average, 19,159 contacts are delivered per 100,000 population (4% increase from 2013/14).</td>
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<tr>
<td></td>
<td>79% of contacts are face to face.</td>
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<td></td>
<td>DNA rates of 11% have not changed for the last 3 years.</td>
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<table>
<thead>
<tr>
<th>Staffing Levels</th>
<th>Tier 1-3 Services</th>
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<tbody>
<tr>
<td></td>
<td>61 WTE per 100,000 registered population (0-18).</td>
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<tr>
<td></td>
<td>An increase from 60 WTE (2013/14) and 47 WTE (2012/13).</td>
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<tr>
<td>Tier 4 Services</td>
<td>36 WTE staff (all disciplines) per 10 beds.</td>
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<tr>
<td></td>
<td>An increase from 35 WTE (2013/14) and 34 WTE (2012/13).</td>
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<table>
<thead>
<tr>
<th>Cost of Service</th>
<th>Tier 1-3 Services</th>
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<tbody>
<tr>
<td></td>
<td>Mean costs to NHS of £5.7 million per 100,000 population up from 5.6 million last year.</td>
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<tr>
<td></td>
<td>Median costs have reduced since (2013/14) from £4.4 million to £4.3 million.</td>
</tr>
<tr>
<td>Tier 4 Services</td>
<td>Mean average cost per 10 beds has reached £2.3 million, an increase from £2 million (2013/14).</td>
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<table>
<thead>
<tr>
<th>Bed Occupancy</th>
<th>Tier 4 Services</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Bed Occupancy (excluding leave) has remained at 76%.</td>
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</table>

<table>
<thead>
<tr>
<th>Quality Measures</th>
<th>Tier 4 Services</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Reductions in violence and ligature incidents.</td>
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<tr>
<td></td>
<td>Use of restraint has increased slightly but prone restraint has reduced.</td>
</tr>
</tbody>
</table>

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11.1 Local service mapping
Locally, schools and colleges have various provision to support CYP with their MH and wellbeing including 3 universal services and 23 targeted services. Universal support includes the PSHE curriculum. Targeted support includes those available from the CAMHS Early Intervention team, and Southampton Healthy Ambition, employed counsellors, school nurses, emotional literacy support assistants, charities and inclusion/pastoral or welfare staff. A summary of these services with eligible age ranges and the referral process is below (see Table 6).

Schools also have access to a range of supporting services and schemes including, health awards and one-off non-recurring grant-funded projects. Further details of the grant-funded projects in 2016/17 can be found in Appendix J.

Table 6: A summary of services available within and to schools in Southampton in 2018 to support CYP MH and wellbeing.

<table>
<thead>
<tr>
<th>Organisation</th>
<th>Description</th>
<th>Age group</th>
<th>Special schools</th>
<th>Referral</th>
<th>Wait list</th>
</tr>
</thead>
<tbody>
<tr>
<td>Universal</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PSHE</td>
<td>A non-statutory school subject through which pupils develop knowledge, skills and attributes to help manage their lives. The curriculum is planned principally at the school level in Southampton currently.</td>
<td>5-16 but poor coverage from 12 up</td>
<td>Yes</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Healthy High 5 award</td>
<td>Children to have access to and be encouraged to take part in a ‘mindfulness minute’ as a group at least 3-4 times within a school week.</td>
<td>4-16, 17 schools signed up</td>
<td>Yes</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Sustainable transport initiatives</td>
<td>The sustainable transport team within SCC and My Journey deliver information and a range of behaviour change initiatives, including through schools and charities to increase active travel and physical activity (which evidence shows is associated with improved wellbeing).</td>
<td>4-18</td>
<td>Yes</td>
<td>N/A</td>
<td>No</td>
</tr>
<tr>
<td>Targeted</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Early Intervention Practitioners (CAMHS early intervention team)</td>
<td>Service for CYP who have not met CAMHS referral criteria. Provide 6-8 1:1 in-depth sessions (school or clinic based) for those with a higher level of need. Qualified as play therapist, social worker, MH or children’s nurse. A level of all services are free and extra can be purchased.</td>
<td>0-18</td>
<td>Yes</td>
<td>Taken from No Limits</td>
<td>Yes</td>
</tr>
<tr>
<td>Primary MH workers (CAMHS early intervention team)</td>
<td>Service for CYP who have not met CAMHS referral criteria. Run 1:1 sessions and group sessions including anxiety and cognitive analytic groups (school or clinic based). Can provide longer but lower level support than Early Intervention practitioners.</td>
<td>11-18</td>
<td>Taken from No Limits</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>No Limits emotional health and wellbeing (EHWB) workers (Southampton healthy ambition)</td>
<td>Social workers who can deliver targeted groups, up to five 1:1 sessions and a safe space for drop-in sessions. Sessions can focus on Anger Management, Anxiety, Self-esteem/Resilience, Emotion Management/low mood, Bereavement, supporting those vulnerable to CSE, Risk Awareness &amp; Harm Reduction, Young Carers, Appropriate boundaries, Friendship/Bullying, Skills for life and supporting Peer Mentoring.</td>
<td>11-18 (only in 1 college)</td>
<td>Yes</td>
<td>Open access</td>
<td>2-3 wks</td>
</tr>
<tr>
<td>No Limits family navigators (Southampton healthy ambition)</td>
<td>If a CYPs attainment or attendance at school is impacted by a health issue every GP practice in Southampton has a named Family Navigator who can assess, support and signpost families to services. Although these do not operate within schools they do lease with them.</td>
<td>5-19</td>
<td>Yes</td>
<td>GPs</td>
<td></td>
</tr>
<tr>
<td>Solent public health (early)</td>
<td>Every school in Southampton has a named school nurse (who carry out measurements for the National Child</td>
<td>5-19</td>
<td>Yes</td>
<td>Open access</td>
<td></td>
</tr>
<tr>
<td>Service Provider</td>
<td>Description</td>
<td>Age</td>
<td>Access</td>
<td>Cost</td>
<td></td>
</tr>
<tr>
<td>------------------</td>
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<tr>
<td>help nurses</td>
<td>Measurement Program. They can provide six sessions of brief interventions surrounding emotional health and well-being; this could be for any reason e.g. bullying, home life, school, friendships or relationships. They work with GPs, colleges, hospitals and other community services.</td>
<td>11-18, not in all secondary schools</td>
<td>No</td>
<td>Open access</td>
<td></td>
</tr>
<tr>
<td>No Limits Drop-ins</td>
<td>No Limits run weekly drop-ins at some secondary schools and colleges in Southampton (during term time only). These run in partnership with the local contraception and sexual advice service and give CYP the opportunity to talk to a No Limits Support Worker or Sexual Health nurse.</td>
<td>0-16</td>
<td>Yes</td>
<td>SENCo, parents, With-in 1 wk</td>
<td></td>
</tr>
<tr>
<td>Educational psychologists</td>
<td>Specialise in child development working with parents, carers, schools and other professionals to promote CYPs learning and development. They can work with an individual child, a class or a whole-school. The service is paid for by schools, the price varies depending on package (cheapest is £350 per day). The exception is one statutory assessment to each school per term and SEN assessment which are paid for by the council.</td>
<td>0-18/ No Limits 11-18</td>
<td>Yes</td>
<td>Varies</td>
<td></td>
</tr>
<tr>
<td>Specially commissioned counsellors</td>
<td>As well as the EHWB workers No Limits can provide an additional service of trained counsellors to schools but for a fee (£3000 per year). There is one qualified counsellor for &lt;11s and five for &gt;11s. However the &lt;11 counsellor post will end in June 2018 (non-recurring grant funded). There are also other private counselling companies.</td>
<td>11-25</td>
<td>Yes</td>
<td>Open access</td>
<td></td>
</tr>
<tr>
<td>No Limits groups (external to schools)</td>
<td>Schools can refer to numerous groups at the No Limits centre including: Advice Centre, Work Club, DASH (Drugs &amp; Alcohol Service), Counselling, Teen Safe House (13-19 years or 16-25 years Peer Support), Time4U (learning disabilities), Bright Beginnings (young parents), Homelessness support, Money &amp; Budgeting, Sexual Health Clinic, Breakout Youth (LGBT+), Next Steps (Care leavers, Young Offending) and Youth Ambassador.</td>
<td>STAR 11-18</td>
<td>Yes (only one)</td>
<td>Open access</td>
<td></td>
</tr>
<tr>
<td>Yellow Door STAR project</td>
<td>Sessions to raise awareness about sexual abuse, consent, healthy relationships, sexting, gender identity, and pornography. One outreach worker can provide the in-house counselling services for anyone who has had a form of sexual or domestic abuse experienced or witnessed (individual, group, family therapies) at schools.</td>
<td>STAR 11-18</td>
<td>Yes (only one)</td>
<td>Open access</td>
<td></td>
</tr>
<tr>
<td>Saints Foundation</td>
<td>Saints run 5 programs linked to schools for CYP with poor attainment, low confidence or who are struggling academically/socially. All of the providers are trained in restorative justice and working with red umbrella but have no formal MH training. Free to schools.</td>
<td>Premier league primary stars: aims to increase the knowledge, skills and confidence of teachers, as well as increase CYPs participation in physical activities. The project uses PSHE, to improve young people’s resilience and emotional wellbeing.</td>
<td>4-11</td>
<td>No</td>
<td>School staff</td>
</tr>
<tr>
<td>Community champions:</td>
<td>an allocated staff member in each secondary school to provide support. Premier league enterprise: For Yr7-8, group sessions, 12-8 per group. Complete a 12 week program with club branded curriculum, to achieve an accredited OCR Entry Level 3 in Business and Enterprise. Saints connect: For Yr9. Staff increase engagement with sport, music or art. Works in deprived parts of the city and with BME communities.</td>
<td>Community champions:</td>
<td>11-16</td>
<td>Saints connect in some special schools</td>
<td>School staff, or self-refer if school has drop-in</td>
</tr>
<tr>
<td>Saints connect:</td>
<td>Community champions:</td>
<td>11-16</td>
<td>Saints connect in some special schools</td>
<td>School staff, or self-refer if school has drop-in</td>
<td>No</td>
</tr>
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<td>aims to increase the knowledge, skills and confidence of teachers, as well as increase CYPs participation in physical activities. The project uses PSHE, to improve young people’s resilience and emotional wellbeing.</td>
<td>4-11</td>
<td>No</td>
<td>School staff</td>
<td></td>
</tr>
<tr>
<td>Premier league enterprise:</td>
<td>For Yr7-8, group sessions, 12-8 per group. Complete a 12 week program with club branded curriculum, to achieve an accredited OCR Entry Level 3 in Business and Enterprise. Saints connect: For Yr9. Staff increase engagement with sport, music or art. Works in deprived parts of the city and with BME communities.</td>
<td>11-16</td>
<td>Saints connect in some special schools</td>
<td>School staff, or self-refer if school has drop-in</td>
<td>No</td>
</tr>
<tr>
<td><strong>Mentoring session</strong></td>
<td>1:1 sessions can be offered in a range of locations but most often at CYPs home.</td>
<td>4-16</td>
<td>Yes</td>
<td>Open access</td>
<td>Yes</td>
</tr>
<tr>
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</tr>
<tr>
<td><strong>Behaviour Resource Service</strong></td>
<td>A dual-funded MH hub, acts as a single point of access for all CAHMS and behaviour related problems for LAC, children subject to Permanency Planning, who meet criteria for consideration of care, who require multi-agency therapeutic intervention, who are accessing the Adolescent Resource, who are at risk of requiring Out of City Placement, who present with forensic concerns or are at risk of in-patient admission. Paired Reading project is a program that was introduced in selected primary schools in Southampton in 2016 for LAC. It involved teachers sitting with a child for 10 min a day, individually, reading with them, focussed on both attachment and early literacy.</td>
<td>3-18</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Inclusion/pastoral staff</strong></td>
<td>Gives help and support to students as well as providing information, advice and guidance. The offer varies across schools but may include anger management and counselling, motivational groups, and behavioural support.</td>
<td>4-19</td>
<td>Yes</td>
<td>School staff</td>
<td>N/A</td>
</tr>
<tr>
<td><strong>Education Welfare Development</strong></td>
<td>A social work service in schools mainly focused around trying to raise attendance. Some infant, junior and primary schools offer evidence based parenting programs.</td>
<td>4-19</td>
<td>Yes</td>
<td>School staff</td>
<td>N/A</td>
</tr>
<tr>
<td><strong>SEN support</strong></td>
<td>Can include: a special learning program, extra help from a teacher or assistant, to work in a smaller group, observation in class or at break, help taking part in class activities, extra encouragement, help communicating with other children and support with physical or personal care difficulties.</td>
<td>0-16, in all schools</td>
<td>Yes</td>
<td>Via SEN Coordinator</td>
<td>No</td>
</tr>
<tr>
<td><strong>Safeguarding</strong></td>
<td>Southampton Local Safeguarding Children Board (LSCB) have a representative in every school in Southampton. Their remit is to safeguard and promote the welfare of children including MH.</td>
<td>0-16, in all schools</td>
<td>Yes</td>
<td>Via MASH</td>
<td>No</td>
</tr>
<tr>
<td><strong>Emotional Literacy Support Assistants (ELSA)</strong></td>
<td>Focus on teaching emotional literacy skills and thereby developing such resilience skills as the ability to reflect on difficult events. Cover topics including social skills, friendships, and anger management. Training can be provided to school staff at a cost of £750 per day.</td>
<td>5-11, in most schools</td>
<td>Yes</td>
<td>School staff</td>
<td>No</td>
</tr>
<tr>
<td><strong>Nurture groups</strong></td>
<td>Classes between 6-12 CYP which focus on emotional and social development as well as academic progress. Supported by staff and parents. Training courses for schools in Southampton are available from SCC from £150.</td>
<td>0-18, in some schools</td>
<td>Yes</td>
<td>Usually teacher</td>
<td></td>
</tr>
<tr>
<td><strong>Peer support</strong></td>
<td>Peer support can range from helping a friend to discussing problems, through buddying, befriending schemes, 1:1 and group sessions. They benefit the mentor and mentee.</td>
<td>0-18, in some schools</td>
<td>Yes</td>
<td>Usually teacher</td>
<td></td>
</tr>
<tr>
<td><strong>Solent Mind Heads Up</strong></td>
<td>Speak at events e.g. assemblies to help people learn more about CYPs MH and challenge stigma. Provide workshops on topics including exam stress, body image, anxiety and general MH awareness. Offer the Decider Life Skills workshop which teaches coping strategies to improve CYPs wellbeing and give them the tools to manage day to day emotions. Offer group work to support specific individuals with emotional difficulties.</td>
<td>4-18</td>
<td>Yes</td>
<td>School staff</td>
<td></td>
</tr>
<tr>
<td><strong>SoCo music</strong></td>
<td>SoCo Music Project is a community music organisation. Several programs are linked to schools where, specialist music leaders run one-to-one sessions with positive and aspirational music-making activities to support emotional wellbeing.</td>
<td>11-18, in some schools</td>
<td>Yes</td>
<td>School staff</td>
<td>Yes</td>
</tr>
</tbody>
</table>
Youth Options | Single day to full academic year programs including: team building days, residential, transition support, prefect leadership training, alternative and fixed term provision (on managing emotions in positive ways, improving peer relationships). They also run Forest school: curriculum linked forest activities/bushcraft aimed at developing confidence and independence. Cost £6.50-7 per CYP. | 0-18 | Yes | School staff | Yes

LifeLab | LifeLab provides a purpose built laboratory in Southampton General Hospital and delivers sessions in schools to introduce science that explains how lifestyle choices at an early age can drastically affect CYPs health and the health of their future children. Through hands-on learning young people are empowered to make healthier choices and reduce their risk of developing chronic diseases including MH problems. | 11-16 | School staff

Princes Trust Program | The Positive Activity program for young people provides targeted youth support, personal development and progression programs to help young people achieve their planned goals and move on into adult life. | 11-19 | Yes | School staff

YMCA Fairthorne Group | A charity which runs the Engage Program, adventure experiences for schools and a range of Breakfast & After school clubs. | 4-16, some schools | No | Open access | No

11.2 Services in relation to need
CAMHS specifications have historically been arranged around a tiered model that become increasingly specialised in function:

Tier 1 – universally encountered and can be addressed in everyday settings

Tier 2 – require consultation, targeted or individual support

Tier 3 – require the involvement of specialist support

Tier 4 – highly specialist/inpatient

Estimates of the number of CYP who may experience MH problems appropriate to a response from CAMHS at Tiers 1-4 have been provided by Kurtz (1996). These estimates have been widely used although there are some technical issues with its application, the paper’s age and its sources. Table 7 shows these estimates for the population aged 19 and under in Southampton.

Table 7: Estimated number of CYP aged 0-19 years who may experience MH problems appropriate to a response from CAMHS, Southampton, 2018

<table>
<thead>
<tr>
<th></th>
<th>Tier 1</th>
<th>Tier 2</th>
<th>Tier 3</th>
<th>Tier 4</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prevalence estimates Kurtz (1996)</td>
<td>15%</td>
<td>7%</td>
<td>1.85%</td>
<td>0.075%</td>
<td>100%</td>
</tr>
<tr>
<td>Southampton</td>
<td>9,473</td>
<td>4,421</td>
<td>1,168</td>
<td>47</td>
<td>63,150</td>
</tr>
</tbody>
</table>


The intention of the 1995 tiered model was to differentiate between the forms of support that may be required and to assign users care based on the complexity of their needs. However, this led to services arranged within an escalator model and has been critiqued nationally for leading to service divisions. Therefore, nationally and locally services have begun moving away from the tiered model to a new patient-centred, whole system model focussed on patient outcomes. The new model uses

pathways of care which span across the continuum of need from universal support through to inpatient care. Tiers 2 and 3 have been replaced by a single ‘targeted’ specification for CAMHS.

MH and wellbeing services for CYP within and available to schools in Southampton have been mapped against estimated need in Southampton using the Continuum of needs model in Figure 6. Non-recurring projects have not been included in this.

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Figure 6: Continuum of needs model showing MH and wellbeing services within and available to schools in Southampton mapped against estimated need, 2018.

**Universal**
- Level 1: Prevention
  - 63,150 0-19 year olds resident
  - PSHE, 5-16 years
  - Healthy High 5 award ‘mindfulness minute’, 4-16yrs
  - Active travel programs, 4-18yrs
  - Assemblies
  - Tutor time

**Targeted**
- Level 2: Additional needs
  - 9,473 CYP to need a response from CAMHS Tier 1
    - 4,785 CYP accessed No Limits (2017/18) and rates have been increasing since 2014/15
    - Primary MH workers, 11-18yrs, 4FTE
    - Southampton healthy Ambition, 21FTE:
      - Emotional health and wellbeing workers, 11-18yrs
      - Solent Public Health nurses, 0-16yrs
    - No Limits drop-ins, 11-18yrs
    - No Limits groups, 11-25yrs
    - Yellow Door, STAR 11-18yrs
    - Saints Foundation, 4-16yrs, 10FTE
    - Solent mind 4-18yrs, Youth options 0-18yrs, Princes Trust 11-19yrs, LifeLab 11-16yrs, SoCo music 11-18yrs, YMCA Fairthorne 4-16yrs
    - Inclusion/pastoral staff
    - Welfare development officers
    - SEN support, 0-16yrs
    - Safeguarding, 0-16yrs
    - ELSA, 5-11yrs
    - Nurture groups, 0-18yrs
    - Peer support, 0-18yrs

**Special**
- Level 3: Multiple, complex needs
  - 4,421 and 1,168 CYP to need a response from CAMHS Tier 2 and 3 respectively
    - 1,755 CAMHS referrals received (2017/18)
    - 244 CYP waited >18wks for initial assessment (2016/17)
    - Specific therapies have a 6-12 month wait (2016/17)
    - 20.6% of referrals were from education
      - 3,663 (5.8%) conduct disorder
      - 2,337 (3.7%) emotional disorder
      - 947 (1.5%) hyperkinetic disorder
      - 189 (0.3%) eating disorder
      - 568 (0.9%) ASD
- Level 4: Acute needs
  - 47 CYP to need a response from CAMHS Tier 4

In Southampton the average rate for hospital admissions due to mental and behavioural disorders is 138.64 which would equate to 87.6 in 0-19 year olds

- Behaviour Resource Service, 3-18yrs
- Bursledon house, 0-16yrs
- Leigh house inpatient treatment, 11-18yrs
- Out of Area residential care
- Early interventions psychosis service
- Hospital Liaison MH team

**Key:**
- Estimated need
- Services available
- Services out of scope of HNA
Nationally the demand for CYP’s MH services is rising and so are waiting times. On average CYP are waiting 26 weeks for their first appointment and up to 42 weeks to receive treatment.\(^9\)

**CAMHS**

Local CAMHS data is of questionable quality. In Southampton in 2016/17 CAHMS had 197 (20.6%) referrals from education services. This comprised 20.6% of all referrals with the majority (477, 49.9%) from Generals Practitioners. The number of referrals has fluctuated from 2014 to 2018. In 2017/18 there were 1,755 referrals of which 414 (31%) were declined (see Appendix D). The national Key Performance Indicator (KPI) target is that at least 35% of CYP with a diagnosable MH condition receive treatment from an NHS-funded community MH service by 2020. Following the screening assessment individuals are then channelled into specific therapies which can have a 6-12 month wait. In Southampton the waiting times have increased gradually since January 2017 with 224 CYP waiting over 18 weeks to be seen for an initial assessment in 2016/17 (see Figure 4). Three additional locum staff have been employed to focus on assertive outreach and as a result since June 2017 the waiting times have been improving which is not reflected in Figure 7.

**Figure 7: Percentage of CAMHS referrals seen within 18 weeks for a routine screening assessment in Southampton from 2014 – 2017**

![Figure 7](image)

Data provided by CAMHS Southampton, quality uncertain.

**No Limits**

No Limits is a charity which offers free and confidential information, advice, counselling, support, and advocacy for children and young people under 26 who live in Southampton. Numerous services are available including; Advice Centre, Work Club, DASH (Drugs & Alcohol Service), Counselling, Teen Safe House (13-19 years or 16-25 years Peer Support), Time4U (learning disabilities), Bright Beginnings (young parents), Homelessness support, Money & Budgeting, Sexual Health Clinic, Breakout Youth (LGBT+), Next Steps (Care leavers, Young Offending) and Youth Ambassador.

The number of CYP accessing No Limits has been increasing from 4,785 CYP in 2011/12 to 7,758 CYP in 2017/18 (see Figure 8). This includes access of any type and is not solely limited to contact with staff in schools.

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Figure 8: Number of CYP accessing No Limits in any form in Southampton 2011 – 2018

Data provided by No Limits Intelligence, Southampton

11.3. Workforce
The Royal College of Psychiatry makes the following recommendation ‘a 0-18th birthday service of 20 FTE per 100,000 should be able to manage 40 new referrals per FTE per year, in an average UK population of average deprivation, where under 20% of the population are under 18’. Southamptom CCG’s Transformation Plan shows the workforce of Solent CAMHS has risen with 40.29FTE in Oct 2015 up to 56.15FTE staffing establishment in Sept 2017. This is for 63,150 CYP (2018 estimate), however over 20% of Southampton’s population are 0-18 years old and the city is more deprived than average. Locally, many CAMHS posts remain unfilled.

The wider workforce is more difficult to account for but in 2017 Southampton Healthy Ambition had 21FTE and the educational psychology service had 11.5FTE. At No Limits the 11 years and under counsellor temporary post ended in June 2018 (non-recurring CCG grant) (see Appendix J) and there are 5FTE for CYP over 11 years of age.

The Green Paper Transforming CYPs MH provision (2017) proposes utilising the current education workforce in schools and colleges to deliver designated leads for MH. [12] Given the existing significant and complex pressures on school and college staff this may not be a realistic or appropriate expectation.

11.4 Single Point of Access
The SPA provides a single point of contact for referring agencies and service users into services. SPA in Southampton is run by Solent NHS Trust. It is an NHS call center based in the Royal South Hants Hospital and is part of a centralised referral, triage and assessment allocation for the city. It already runs for some of Solent’s Community Services including sexual health, diabetes, podiatry, and district nursing. For MH services SPA is already established for CAMHS and since July 2018 has been extended to include joint working with one charity, No Limits. Referrals can be made by phone, an online referral form or directly via a GP system (System One).

11.5 Forums available to schools and CYP
Southampton PSHE network
The Southampton PSHE Network is for professionals involved in the delivery of PSHE in the city. It shares resources and has been working with PH commissioners and other organisations who can support schools in the teaching and delivery of PSHE/ RSE.

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**Solent CAMHS School MH forum**
The Solent CAMHS School MH forum is facilitated by CAMHS Solent. It is available to Early Years and all schools in Southampton including more recently Special schools. The forum aims to:
- Identify issues and changes being seen within schools
- Share best practice, learning and models being used across the city
- Provide supervision and scope training needs for school staff working with CYP with MH problems
- Ensure schools understand the referral and triage process to CAMHS
- Develop a work programme of school-level preventative interventions

**Schools in Mind network**
Schools in Mind is a branch of the Anna Freud National Centre for Children and Families. It is a free national network for school staff and allied professionals that shares trusted, up-to-date, practical, academic and clinical expertise regarding wellbeing and MH issues that affect schools.

A branch of this is the national Youth Wellbeing Directory, which has been developed as a national database, searchable by postcode of all MH and wellbeing services available to CYP. To be listed services must be free to access for CYP aged 25 years or less. It is maintained by staff at Anna Freud but any organisation or local authority are able to add their details.

**Amplified network**
Amplified network is an NHS England funded program to increase participation of CYP and their families in MH systems – both in the commissioning and design of the MH services they use. Every year Amplified selects and supports twelve Trailblazers to develop participation in their organisation. They will likely be recruiting for Year three trailblazers in March 2019.

**11.6 Unmet needs, service gaps and over provision**

**General points**
- Lack of universal support and inconsistent low-level support. CYP, parents and professionals want earlier interventions and more preventative work
- Few schools are signed up to the PSHE network or Solent School MH forum
- Set sessions means CYP are discharged from services before they feel ready but longer session would result in even greater waiting lists
- There is no single point of information for CYP to access about sources of support available
- Schools do not have good links with GP Practices

**Services for primary school aged children**
- There are fewer support services available to primary school aged children
- No EHWB workers and few Saints foundation workers
- No counsellor for 11 and under at No Limits
- Only one primary school which responded to the survey had a counselling service but this had a wait time of over one month

**Services for secondary school aged children and colleges**
- Support of wellbeing and MH is very inconsistent across schools including PSHE
- There is a lack of response to the impact of social media on young people

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Services for special schools
Inconsistent support across special schools including few with a counselling service, primary MH workers, early intervention practitioners, EHWB workers or Solent PH nurses

Specific groups with unmet needs
CYP who have been excluded, gender identity, homeless, LGBT+, refugees, asylum seekers or vulnerable migrants
12. Funding

**Summary: Funding**
- Southampton spends more than the England average on CYPs services but in-line with similarly deprived areas
- For 2017/18 Southampton CCG have a direct CAMHs budget for CYPs MH and wellbeing of over £4 million, of which just under £1 million is set aside for the Transformation Plan

The DfE holds data on the rate of spend on CYPs services (excluding education) per person aged 0-17 years. In Southampton it is £966 per person for the financial year 2016/17, which is more than the England average (£779) but similar to local authorities in similarly deprived areas.94

Table 8 shows the high level breakdown for funding allocated by Southampton CCG out of the direct CAMHs budget for CYPs MH and wellbeing for 2017/18.

**Table 8: Southampton CCG direct CAMHs budget for CYPs MH and wellbeing for 2017/18**

<table>
<thead>
<tr>
<th>Specification</th>
<th>Amount (£)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community CAMHs</td>
<td>3,138,000</td>
</tr>
<tr>
<td>Building Resilience Service</td>
<td>1,071,000</td>
</tr>
<tr>
<td>Counselling</td>
<td>40,000</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>4,249,000</strong></td>
</tr>
</tbody>
</table>

NB. Does not include 0-19 Prevention & Early Help services, such as, school nursing, health visiting, and early help

In 2016/17, the CCG/ICU tendered a range of non-recurrent grants from Transformation Funding underspend. These were non-recurring so have not been included in Table 7 but future grants are likely. Details of these projects can be found in Appendix J.

Table 9 shows a further breakdown of the Local Transformation Plan Investment identified for 2017/18.

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Table 9: Southampton CCG Transformation Plan Investment for 2017/18

<table>
<thead>
<tr>
<th></th>
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<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>£50,000</td>
<td>£50,000</td>
<td>Navigators – to support children, young People and their families to access the services most appropriate to their needs. This navigation function will also support professionals and ‘hold’ clients through periodic check-ins.</td>
</tr>
<tr>
<td>2</td>
<td>£65,000</td>
<td>£65,000</td>
<td>Community solutions – including a worker, peers support and grants/training</td>
</tr>
<tr>
<td>3</td>
<td>£50,000</td>
<td>£50,000</td>
<td>EIP – Continuation of CAMHS clinicians within the EIP team to become evidence compliant and to ensure that CYP are being seen within EIP teams and not remaining in CAMHS. MDT sessional input and pathway development to include CAMHS consultant psychiatrist sessions, MH nurse and Systemic Family Therapy sessions. Existing members of staff being used and an increase in consultant psychiatrist time (3 sessions) has been recruited to.</td>
</tr>
<tr>
<td>4</td>
<td>£140,000</td>
<td>£147,156</td>
<td>CYP ED Service – Dedicated Eating Disorder funding has been used to recruit additional staff to form a multi-disciplinary CYP ED pathway. Additional staff have been recruited, this includes the dietician and NMP roles as well as the CBT therapist and occupational therapist roles. Clinicians have attended specialist ED training at the Maudesley Hospital in</td>
</tr>
<tr>
<td>5</td>
<td>£202,678</td>
<td>£202,678</td>
<td>Early Intervention – Three early intervention workers recruited (two Band S &amp; one Band 6). Extend primary care MH worker role to all schools in the city and develop a Schools Forum for primary schools, 3 primary support workers recruited for 17/18 and option to extend by a further 3 in 18/19 with further increase in CAMHS Transformation Funding.</td>
</tr>
<tr>
<td>6</td>
<td>£59,034</td>
<td>£59,034</td>
<td>Crisis Care Services – Crisis care lead recruited and overseeing changes within crisis services as part of the wider STP crisis care concordat.</td>
</tr>
<tr>
<td>7</td>
<td>£40,000</td>
<td>£40,000</td>
<td>Counselling Provision – Extension of counselling provision including development of digital streams and collaborative work with schools</td>
</tr>
<tr>
<td>8</td>
<td>£36,800</td>
<td>£36,800</td>
<td>Learning Disabilities – Increased psychology and nurse input into LD team</td>
</tr>
<tr>
<td>9</td>
<td>£60,000</td>
<td>£60,000</td>
<td>Commissioning – supplement to commissioning resources to enable smooth implementation of transformation plans and continued commissioning capacity – service development officer recruited 2017.</td>
</tr>
<tr>
<td>10</td>
<td>£17,500</td>
<td>£17,500</td>
<td>Southampton MH Alliance – Contribution to ageless alliance to bring together service users, carers and providers</td>
</tr>
<tr>
<td>11</td>
<td>£20,000</td>
<td>£20,000</td>
<td>Peer Support – Group work with embedded peer support development</td>
</tr>
<tr>
<td>12</td>
<td>£51,969</td>
<td>£51,969</td>
<td>Community Group Work – Continuation of pilots to test market needs and inform future needs.</td>
</tr>
</tbody>
</table>

Total £792,981  £748,168

The budget allocation for MH Peer Support groups is for young people and adults in Southampton and service procurement is planned for April 2019.
13. Recommendations

**Summary: Recommendations**
- There are 24 recommendations to enable schools to improve the MH and wellbeing of CYP in Southampton.
- Improvements can be made in universal support including the curriculum, targeted support, the training and support for teachers, involvement of parents, and the use of multiagency working.
- Priority recommendations are:
  - Delivery on the Government Green Paper expectations including a MH lead in every school
  - Embedding a city-wide whole school approach to MH and wellbeing, which includes shaping the whole school ethos, encompassing the school’s social and physical environment, and developing links with all relevant stakeholders including pupils, teachers, school administration, parents and wider community members.
  - Develop a MH and wellbeing Single Point of Access which includes all services in Southampton to provide clear pathways to service providers, schools, parents and CYP
  - Embed a city wide quality assured PSHE curriculum

Following the literature review an evidence-based, whole school approach is recommended. Given the rise in local MH and wellbeing problems and the range of existing services, there is a need to better coordinate access to services through a Single Point of Access. Details of the recommendations are described in Table 10 and coded with a RAG rating.

In addition to the locally actable recommendations, more research is needed on optimum length of MH programs, which elements of leadership are most effective at promoting wellbeing and which methods enable education establishments to work effectively with parents. This is a national agenda and has been flagged in evidence reviews.
<table>
<thead>
<tr>
<th>Recommendation</th>
<th>Actions to consider</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Universal support</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| Embed a city-wide whole school approach to MH and wellbeing which aligns with the work on restorative practice | - This includes shaping the whole school ethos, encompassing the school’s social and physical environment, and developing links with all relevant stakeholders including pupils, teachers, school administration, parents and wider community members  
- Maximise protective factors for wellbeing including physical activity, community activities, breast feeding and strong attachments (see details below) | |
| Consider options for supporting a whole school approach to MH and wellbeing | Learn from the pilot model in Portsmouth (£15K matched by PH and education) to fund a joint traded service PSHE Development Manager post. The evaluation of this post will be available in April 2019. An ex-teacher is employed to embed a whole approach to MH and aligns this with restorative practice. | |
| Support schools to join the Healthy High Five award (mindfulness minute and Daily Mile/ Golden Mile) | - Contact each school who requested support to identify need, develop action plan and implement plan  
- Currently 23 schools are signed up of which the majority are primary schools | |
| Support schools to sign up to My Journey to encourage physical activity | - As per Access Fund Plan  
- Contact each school who requested support to identify need and action plan  
- 15,300 students at 38 schools have been engaged to far. More information [here](#). | |
| Increase student participation in developing support for wellbeing and MH | Explore options including; sharing local case studies (see [Appendix I](#)), recruiting more Lifelab Youth health champions (training includes MH five-a-day, anti-bullying and beat exam stress lessons), promoting Amplified network and YoungMinds Activists and making a Future in Mind co-production pledge. | |
| Promote a positive ethos within schools | - Citywide event with Time to Change, Southampton Youth Forum and Solent CAMHS to do a roadshow to three primary schools and deliver anti-stigma and MH coping activities to Year 6 pupils  
- Continue anti-bullying initiatives  
- Contact school governor networks to raise awareness about their role in highlighting MH and school settings | |
| Create a school built environment supportive of wellbeing | - Planning applications for developments including those likely to impact on MH or education, to be sent to PH as a consultee e.g. playing field space  
- Add a school specific section to the current planning response checklist  
- Review schools refurbishment policy | |
| Develop a system for measuring wellbeing within schools to monitor the impact of school interventions and identify CYP who would benefit from targeted support | - Improve consistency around existing local measures such as the Year 7 school nurse survey, so that information is collected in a validated way which is comparable geographically and for time trends  
- Liaise with PH to ensure validated questions are included | |
<table>
<thead>
<tr>
<th><strong>Link to Transport team SCC evaluations which are considering outcome measures from Child Outcomes Research Consortium,</strong>[95] Anna Freud framework[96]</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Use compulsory RSE as an opportunity to deliver a PSHE program in all schools</strong></td>
</tr>
<tr>
<td>- RSE workshop via CAMHS forum or PSHE network (to prepare schools and increase awareness of networks)</td>
</tr>
<tr>
<td>- SCC to develop work plan to support schools to develop mandatory PSHE</td>
</tr>
<tr>
<td><strong>Embed a city wide quality assured PSHE curriculum offer for schools which includes topics important to CYP and emerging areas</strong></td>
</tr>
<tr>
<td>- Add personal wellbeing, and supporting others with MH, life skills, staying safe online, social media (impacts on MH, bullying, and potential distorting effect on information), drug/alcohol addiction, crime and law, and gender identity (see Appendix J)</td>
</tr>
<tr>
<td>- Promote Mentally Healthy Schools website, a collection of quality assured resources including lesson and assembly plans (evidence based and reviewed by clinical and educational experts, age and key stage appropriate and up-to-date)[97]</td>
</tr>
<tr>
<td><strong>Encourage all schools to join the existing forums and networks</strong></td>
</tr>
<tr>
<td>- Re-circulate information about the PSHE network, Solent CAMHS Schools MH forum, and national Schools in Mind and Amplified networks</td>
</tr>
</tbody>
</table>

**Targeted support**

| **Provide clear pathways of referral to service providers, schools, parents and CYP** |
| - Develop a multiagency SPA for MH and wellbeing in Southampton, wider than Solent services and extended to voluntary services and non-recurring grant funded projects. |
| - As a last resort upload information about services to the national Youth Wellbeing Directory[92] or expand Southampton Information Directory (however this is a short term solution as would need constant updating and is not well known or accessed) |
| **Ensure the CAMHS offer is consistent across all schools and increase support within primary schools** |
| - Explore options for supporting access to counselling in primary school aged children after CAMHS non-recurring grant ended |
| - Link existing services to the Government Green paper recommendations to inform future commissioning of the Early Intervention team offer, using the HNA service mapping |
| **Upskill teachers and external providers in the recognition and management of poor mental health, using evidence based training** |
| - Emotional first aid (in line with CAMHS training to parents and what majority of schools use already), MH first aid (national commitment) or a reduced Connect 5 |
| - Link leads for Emotional First Aid and Restorative practise training programs |
| **Train independent staff to deliver more low level support to CYP (one-to-one sessions and group sessions)** |
| - Focus on primary schools |
| - Up-skill organisations already within the school network such as, Saints Foundation, Youth Options, Princes Trust, SoCo music, with the chosen training package (see above) |

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| Improve peer support within schools | - ICU to use a proportion of the MH peer support budget to further develop a peer support system |
| Address the higher level of need in particular groups | - ICU and PH to identify priority groups with unmet needs (gender identity, homeless, LGBT+, migrants, CYP NEET CYP who are home-schooled) which would benefit from a “deep dive” analysis to further understand specific needs and how they could best be met  
- Follow up on LAC Needs assessments actions of LAC health team to formalise a health review process with PH nurses and promoting life-story work |
| Use reduced timetables, detentions, fixed-term and permanent exclusions as an early warning system | - Inclusion services, SCC will add MH/ wellbeing as a consideration in the new guidance that is being developed for schools and governors about exclusions including a re-integration plan  
- Inclusion services contact all schools if a CYP has 8+ days of fixed period exclusions per year  
- Train a staff member of every school in restorative practice as part of the Child Friendly Southampton campaign |
| **Teachers** | - In-line with CAMHS responsibility Solent CAMHS Schools MH forum  
- Train a teacher from each school in chosen training package (see above)  
- Raise awareness Southampton annual PSHE CPD training conference |
| Improve support for teachers own MH and wellbeing | - Schools to select from a range of free interventions from the Anna Freud website  
- Link to economic development and PH joint post for workplace health (rolling out PHE HNA tool) |
| **Parents** | - Encourage joining Amplified network  
- Schools to continue to involve parents in interventions and communications |
| **Multi agency working** | - Group should have wide representation across the system – Local Authority, CCG, local NHS providers, schools, primary care, service user representation, voluntary and community sector and parent carers  
- Link to safeguarding and SEND forums |
| Improve links between primary care and schools | - Develop SPA (see above recommendation) |

RAG rating key:
- **Green**: Deliverable and plans in place
- **Yellow**: Deliverable within existing resources
- **Red**: Additional resources or funding required

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14. Barriers and enablers

Barriers
There are a variety of reasons why some schools may have difficulties promoting wellbeing and MH. These include:

- Until 2011 there had been strategic support from a Healthy Schools Coordinator, who was a PSHE education subject specialist and had been employed for many years by the Education department of Southampton City Council. Her role had covered the overarching coordination of the Healthy Schools award, the Healthy Schools network and the PSHE teachers’ network. She worked closely with the Health Promotion team in Solent NHS Trust and had built strong relationships with staff leading on PSHE and Healthy Schools in many of the schools.
- The Ofsted Common Inspection Framework 2015 for all schools, mentions that Ofsted inspections include graded judgements on ‘Personal development, behaviour and welfare’. However, although these elements of the school inspection are embraced by PSHE education, the wording is very loose and open to wide interpretation.
- Health and wellbeing is not, in general, as high a priority area for schools, compared to academic achievement for example. The focus on academic achievement, raising standards, and pupil attendance is intense and staff workload is immense.
- Although RSE is becoming compulsory for secondary schools, PSHE is still not a statutory subject.
- Regular staff changes in schools and low morale of teachers has led to a lack of continuity in those leading on health and wellbeing programs. It can be difficult for teachers to attend twilight meetings for PSHE due to heavy workloads, problems with finding cover for lessons, part-time teachers who do not work on specific days or times when meetings are held, and difficulties with travelling across the City to meetings.
- Some primary and secondary schools in Southampton are no longer under local authority control and have become academies. Some schools that are not part of academy chains work in clusters or federations, other schools do not, so it can be challenging to have a coherent way of working in relation to PSHE and MH and wellbeing.
- Some schools may not be ready to engage for a variety of reasons, such as a poor Ofsted report, internal changes in staff numbers, changes in pupil intake, addressing changes to the national curriculum and SATs assessments.

Enablers
There are a number of levers that are currently available for schools and their partners to support improvements in CYPs MH and wellbeing:

- Ofsted inspection framework looks at ‘Personal development, behaviour and welfare
- The primary national curriculum Social, Moral, Spiritual and Cultural education
- Evidence of links between MH and attainment and improved attendance
- The link between PSHE education, the national curriculum and Ofsted inspections
- The new Health High Five award which many schools are already engaging well with
- A local desire to improve the MH and wellbeing of pupils and staff in schools and the wider school community.

17. Appendices

Appendix A | Stakeholder methodology

Methodology

Parents
(1) Parent mail systems
4 schools (3 primary and 1 secondary have agreed to send out the survey via their parent mail systems)

(2) Peoples Panel
Send out a question specifically for parents to answer (children aged 0-18)

(3) Health watch
Health watch Southampton was sent the survey and asked to distribute through their mail and social media channels.

Email:
Southampton City Council are reviewing the mental health and wellbeing of children and young people in the city, including the support available at schools. If you have time, please complete the following survey: [https://southamptoncitycouncil.researchfeedback.net/wh/s.asp?k=152723842270](https://southamptoncitycouncil.researchfeedback.net/wh/s.asp?k=152723842270)
It only takes about 5 minutes and will be closed at 9am on Monday 18th June. Your views are really important in understanding the mental health and wellbeing needs of our children and young people in Southampton. The results will be used to help inform future services and will be available via all schools in the city from September 2018.
An additional survey for all head teachers (or PSHE leads on their behalf) will also be circulated shortly which I would be really grateful if you could complete.

Thank you for your help.

Kind regards,
Rachael
Dr. Rachael Marsh, BMBS, MSc, DFPH
Public Health doctor, Southampton City Council

Survey:
This survey is to be completed by parents of a child aged 4-18 at a school or college in Southampton.

The survey will be used to inform a Needs Assessment on mental health and wellbeing of children and young people in the city and a University of Southampton evaluation of the impact of mental health and wellbeing interventions in schools. All responses will be treated confidentially by Southampton City Council.

What do we mean by mental health and wellbeing?
When people talk about mental health they are describing a spectrum of conditions and ideas relating to mental or emotional unwellness. A rounded view of mental health is not achieved by focusing solely upon mental illnesses such as, depression, anxiety, ADHD, and eating disorders, but includes factors that influence peoples’ behaviours and wellbeing positively, for good mental health and wellbeing. Achieving good mental health and wellbeing is about having resilience, the strength to overcome the difficulties and challenges everyone faces at times in their life. It is also about
having confidence and self-esteem, to be able to make decisions and believe in ourselves, our ability to make and keep friends and relationships, and generally feeling happy and satisfied with life.

Personal details:
My child(ren) attends a primary school/secondary school/special school/sixth form or college
If you are willing, please specify the name of your child(ren)’s school [comment box]

1. Would you feel confident in identifying when your child(ren) would benefit from mental health support?
   - Very confident
   - Confident
   - Somewhat confident
   - Neither
   - Somewhat unconfident
   - Unconfident
   - I am not at all confident with this

2. Would you feel confident in supporting your child(ren)’s when they have low level mental health needs (e.g. low mood, stress)?
   - Very confident
   - Confident
   - Somewhat confident
   - Neither
   - Somewhat unconfident
   - Unconfident
   - I am not at all confident with this

3. What impact do you feel your child(ren)’s school has on their wellbeing?
   - Very positive impact
   - Fairly positive impact
   - Slightly positive impact
   - Neither
   - Slightly negative impact
   - Fairly negative impact
   - Very negative impact

4. To what extent do you agree or disagree with the following statements: (Strongly agree; Agree; Disagree; Strongly disagree)
   - There is sufficient support for mental health and wellbeing in my child(ren)’s school
   - I would know how to get help for my child(ren) within their school if they experienced a mental health difficulty
   - I know the help I sought from their school will lead to a good outcome for my child(ren)

5. How would you prefer to engage with your child(ren)’s school about a mental health and wellbeing issue?
   - I would prefer not to engage with this via a school
   - I would prefer interventions for pupils/students that include parents/caregivers
I would prefer face-to-face sessions for parents/caregivers about young people’s mental health
I would prefer One-to-one support (e.g. counselling) for parents/caregivers
I would prefer receiving information/advice about supporting children and young people mental health
I would prefer receiving information about the schools mental health plan and provision
I would prefer something else (please specify)

6. Have you ever tried to access pastoral or other support for your child(ren) from their school in relation to a mental health condition before?
   Yes
   No

7. Do you have any other comments about the mental health and wellbeing support you would expect to see available for children and young people in schools?
   [Comment box]

Thank you. The results of the Needs Assessment should be available by August 2019 and will be communicated to all schools.

CYP
(1) Link with Health watch
Health watch health-themed event on 12th April drop-in day:
   1. Adults - What should places of education do? What do you think schools, colleges and universities should do more to help children and young people with their mental health and wellbeing?
   2. CYP - How would you help a friend who’s having problems/difficult feelings?

(2) Commission focus group facilitated by No Limits
No Limits run several relevant groups which would enable access with CYP at high risk of low levels of emotional or mental health and wellbeing. Bright Beginnings (teen pregnancies), Next Steps (care leaves, YOS, young carers), Time4U (learning disabilities), and DASH (drug and alcohol use). 1-2 sessions will be organised to run a workshop/discussion on the follow aspects.


Location: room in no limits, setting familiar and comfortable even to those not usually attending, checked set up was not too formal e.g. no tables, circle of chairs, leads sat apart

Lead: Agnes Papp (No Limits), known to and familiar to the CYP

Size: 3 groups of 6-12 CYP, already familiar with each other within groups, broken down by age
Length: 1-2 hours

Information governance: notes stored on password protected devices or in locked, deleted after use
Record: audio recording plus notes for non-verbal language and interactions
Support: No Limits to sign post if serious issue raised
Structure:
- Aim - what information will be used for to gain informed consent
- Ground rules – write on flip chart so visible throughout session, consent and confidentiality, not talking over each other, respectful
- Can audio record so I don’t have to have my head down and write notes all the time?
- Ice breaker
- Get written consent forms signed
- What do we mean by mental health and wellbeing?
- Run over same questions for all groups with break
- Prompts – what about those that haven’t had a chance to speak
- How would they like feedback – through No Limits?
- Thank for participation

What information will be used for
The focus group will be used to inform a Needs Assessment on mental health and wellbeing of children and young people in the city – to inform services in schools (used to be top down but now want their views). All responses will be treated confidentially by Southampton City Council and The University of Southampton and at no point will be passed onto any other parties. The responses may be used to inform a research bid to the National Institute for Health Research (NIHR) to fund the evaluation and may at a later date also be used to inform the content of published research papers. However, all responses would be grouped, anonymised, and at no point would it be possible to identify individuals.

What do we mean by mental health and wellbeing?
When people talk about mental health they are describing a spectrum of conditions and ideas relating to mental or emotional unwellness. A rounded view of mental health is not achieved by focusing solely upon mental illnesses such as, depression, anxiety, ADHD, and eating disorders, but includes factors that influence peoples’ behaviours and wellbeing positively, for good mental health and wellbeing. Achieving good mental health and wellbeing is about having resilience, the strength to overcome the difficulties and challenges everyone faces at times in their life. It is also about having confidence and self-esteem, to be able to make decisions and believe in ourselves, our ability to make and keep friends and relationships, and generally feeling happy and satisfied with life. Draw on flipchart whole spectrum: mental health (difficult feeling) --> wellbeing (happy)

Questions
Outside the curriculum:
- What are the key problems/difficult feelings you and other young people you know experience?
- If you have difficult feelings, who in your school who would you go to and why?
- Are there things your school does that help students who are having problems or difficult feelings?
- How do teachers respond to problems that young people face?
• What other things could your school do to help students feel happy?
• What other things could your school do to help people who were having problems/difficult feelings?
• What do you think of peer support?

In the curriculum:
• Tell us about PSHE and/or Relationships and Sex Education (RSE) in your school?
• Does the subject of mental health and wellbeing come up in other lessons?
• Prompts: how many lessons, topics, who teaches, what do they do, what they like/dislike about the lessons, useful or not, are there any topics in particular that would be useful to cover?

Potential topics: Mental and emotional wellbeing, Anxiety, Dealing with feelings, Relationships and sex education, Consent and respect in relationships, Bullying, Friendship, Strategies for saving face while saying no, Road safety, Drugs and substance misuse, Alcohol, Smoking, Online safety, social media, Body image, Domestic violence, Personal hygiene, Diet, exercise and mood, Financial literacy and debt, Gambling, Addiction, Preventing extremism, Oral (dental) health, Promoting good sleep, Immunisations, antibiotic resistance and infection control, Accessing healthcare including appropriate use of emergency care.

Schools
Forums
Notified Southampton Education Leadership Forums (SELF) of plans

Survey to all primary, secondary, and special schools, and colleges through head teachers
Questions adapted from DfE - Supporting Mental Health in Schools and Colleges Quantitative Survey, 2017.

An online survey was sent to head teachers and deputy head teachers of all schools in and colleges in Southampton. A follow-up, reminder email was sent two weeks later to increase the response rate. Results were collated by the Intelligence team in Southampton City Council.

Email:
Dear Head Teacher,

Earlier this year an announcement was made via SELF that Southampton City Council are reviewing the mental health and wellbeing of children and young people in Southampton, with a focus on the school setting. It will be used to inform the Early Intervention Prevention Team offer to schools, the PHSE offer and content of these lessons, the development of an NIHR research bid and meet the action in Southampton’s Suicide Prevention Plan to “Investigate the provision of prevention and early help for secondary school pupils in light of the big lottery funding decision”.

A key part of this process is collecting the views of head teachers so please complete the following survey (Deputy Head Teachers or PSHE leads can complete it on behalf of the Head Teacher):
https://southamptoncitycouncil.researchfeedback.net/wh/s.asp?k=152715576391

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The survey is likely to take 15-20 minutes but please prioritise this as your views are really important in understanding the mental health and wellbeing needs of children and young people in our city and ensuring our recommendations are as well informed as possible. The **deadline is the 22\textsuperscript{nd} June** and results will be available via SELF from September 2018.

Many thanks for your time.

Kind regards,

Dr. Rachael Marsh, BMBS, MSc, DFPH
Public Health doctor, Southampton City Council

**Survey:**
This survey is to be completed by head teachers or personal, social, health and economic education (PSHE) leads.

The survey will be used to inform a Needs Assessment on mental health and wellbeing of children and young people in the city and a University of Southampton research bid to the National Institute for Health Research for the evaluation of the impact of mental health and wellbeing interventions in schools.

**What do we mean by mental health and wellbeing?**
When people talk about mental health they are describing a spectrum of conditions and ideas relating to mental or emotional unwellness. A rounded view of mental health is not achieved by focusing solely upon mental illnesses such as, depression, anxiety, ADHD, and eating disorders, but includes factors that influence peoples’ behaviours and wellbeing positively, for good mental health and wellbeing. Achieving good mental health and wellbeing is about having resilience, the strength to overcome the difficulties and challenges everyone faces at times in their life. It is also about having confidence and self-esteem, to be able to make decisions and believe in ourselves, our ability to make and keep friends and relationships, and generally feeling happy and satisfied with life.

**Personal details**
Name of school:
Type of school - primary/ secondary/ special/ college

**WHOLE SCHOOL**
Do you have a designated lead for mental health?
No/ Yes
If you have answered (yes) what training has this individual had?
[Comment box]

What is the remit of the mental health lead in your school? (please tick all which apply)
Supporting individual pupils
Teaching pupils about mental health and wellbeing
Training staff
Liasing with specialist mental health services
Coordinating and developing mental health provision in the institution
Other (please specify)
What sessions and activities to promote positive mental health and wellbeing among all pupils do you have? (please tick all which apply)

- None
- Dedicated timetabled PSHE lesson
- Cover the subject of mental health and wellbeing in lessons other than PSHE
- Tutor time
- Assemblies
- Skills sessions
- Support programmes and services coming into school for specific groups of pupils
- A worry box/ drop-in for advice and signposting
- Sessions on particular issues
- Peer-mentoring/support
- Activities to reduce stigma around mental health issues
- Nurture groups
- Emotional Literacy Support Assistants (ELSA)
- Other (please specify)

How do you identify pupils with particular mental health or emotional wellbeing needs? (please tick all which apply)

- Ad hoc based on teachers concerns
- Ad hoc based on other staffs concerns, e.g. school nurse
- Ad hoc based on behaviour monitoring
- Ad hoc based on information received directly from children
- Ad Hoc based on information received from parents/carers about issues in their life (e.g. bereavement)
- Use of information from external agencies
- Assessment of MH needs alongside other assessments
- Use of admin data collected for other purposes
- Targeted screening
- Universal screening
- Other (please specify)

Which of the following mental health support services are available in your school? (please tick all which apply)

- Emotional health and wellbeing worker (No Limits - Southampton Healthy Ambition)
- Early help nurse (No Limits - Southampton Healthy Ambition)
- Primary mental health worker (CAMHS - Early intervention team)
- Early intervention practitioner (CAMHS - Early intervention team)
- School nurse
- SEN (Special Education Need)
- Educational psychologist
- Signposting to counselling and support services (in school)
- Signposting to counselling and support services (outside school)
- Cognitive Behavioural Therapy (CBT)
- One-to-one support for specific issues
- Support groups
- Peer support
- Saints Foundation sessions
- Solent Mind sessions
- STAR Yellow Door (domestic and sexual abuse) sessions
- Other (please specify)
If there is a counselling service run directly within your school as part of your pastoral care to pupils, what qualifications do the counsellors hold? (please tick all which apply)

- Registered with professional body
- Diploma in Counselling
- Other professional qualification or registration
- None of these
- N/A (the school does not have a directly run counselling service)

If there is a counselling service running within your school, what is the usual waiting time to be seen?
- Within 24 hours
- 1 to 7 days
- 1 to 4 weeks
- More than a month

How many pupils on average self-report mental health and wellbeing issues per month?
How many pupils on average are referred to Child and Adolescent Mental Health Services (CAMHS) per month?
- Fewer than 5
- 5-9
- 10-14
- 15-19
- 20-24
- 25-30
- More than 30

Does your school monitor the impact of the mental health support provided to pupils?
- No, it does not monitor
- Yes, it monitors the impact of some support
- Yes, it monitors the impact of all support
If you have answered monitors some or all, please specify how

[Comment box]

Are you accessing the School Mental Health Forum facilitated by Solent CAMHS?
- Yes
- No
If yes how useful do you find the School Mental Health Forum?
- Very useful
- Quite useful
- Neither useful nor useless
- Not very useful
- Useless
What are your reasons for this? [Comment box]

We recognise that there is a lack of support in some schools for mental health and wellbeing needs. To address this would you consider...

Pooling resources with other schools and health/local authority to provide joined up/co-ordinated support?
- No/ Yes
Buying additional services over and above those already provided by others to extend/expand existing services in a co-ordinated way?
No/ Yes

CURRICULUM
Who delivers learning relating to mental health and wellbeing curriculum in your school? (please tick all that apply)
Teachers
Other school based staff
External provider (please specify)

Which of the following aspects of mental health and well-being are addressed? (please tick all which apply)
Mental and emotional wellbeing
Anxiety
Dealing with feelings
Relationships and sex education
Consent and respect in relationships
Bullying
Friendship
Strategies for saving face while saying no
Road safety
Drugs and substance misuse
Alcohol
Smoking
Online safety
Body image
Domestic violence
Personal hygiene
Diet, exercise and mood
Financial literacy and debt
Gambling
Addiction
Preventing extremism
Oral (dental) health
Promoting good sleep
Immunisations, antibiotic resistance and infection control
Accessing healthcare including appropriate use of emergency care
Other (please specify)

Does your school require any support preparing for statutory Relationships Education from September 2019?
Yes
No
Not applicable (primary or special school)
If yes, please tell us more below.

Does your school attend the Southampton Teachers PSHE Network, or receive its resources?
Yes
No
Are you aware that the Southampton PSHE Teachers network has been working with Public Health commissioners and other organisations who can support schools in the teaching and delivery of PSHE/ RSE to develop a City specific PSHE/ RSE Curriculum of Study covering Key Stage 1 to Key Stage 4?
Yes
No

If no to the last question, would your school be interested in hearing more about the Southampton PSHE/ RSE Curriculum of Study once it has been completed?
Yes
No

PARENTS
How do you engage parents/care givers with mental health and wellbeing at your school? (please tick all which apply)
Do not engage
Interventions for pupils/students that include parents/caregivers
Face-to-face sessions for parents/ caregivers about young people mental health
One-to-one support (e.g. counselling) for parents/caregivers
Provision of information/advice about supporting pupil’s mental health to parents/ caregivers
Sharing information about the institutions mental health plan and provision
Other (please specify)

STAFF
What support is there for the mental health and wellbeing of teachers and other staff working in your school?
Signposting to community health services
Counselling support line
Professional supervision
Other (please specify)

What sources of mental health training do teachers and other staff in your school have? (please tick all which apply)
Provided internally
Provided by CAMHS
Other local mental health/wellbeing services other than CAMHS
Other registered training provider(s)
Free online course
Online training course purchased externally
Other (please specify)

Which package do you use for mental health training?
Mental health first aid
Emotional First Aid
Next Steps Cards
Connect5
Assist
Other (please specify)
What support for teachers on mental health and wellbeing would be useful in your school? (please tick all which apply)
On-site training for all staff
On-site training for targeted staff
Online/ e-learning
Other (please specify)

Please indicate which three training themes would be most useful for your staff.
Mental and emotional wellbeing
Anxiety
Dealing with feelings
Relationships and sex education
Consent and respect in relationships
Bullying
Friendship
Strategies for saving face while saying no
Road safety
Drugs and substance misuse
Alcohol
Smoking
Online safety
Body image
Domestic violence
Personal hygiene
Diet, exercise and mood
Financial literacy and debt
Gambling
Addiction
Preventing extremism
Oral (dental) health
Promoting good sleep
Immunisations, antibiotic resistance and infection control
Accessing healthcare including appropriate use of emergency care
Other (please specify)

Do you have any other comments or ideas for further support for pupil’s mental health and wellbeing in your school?
[Comment box]

Thank you. The results of the Needs Assessment should be available by August 2019 and will be communicated to schools via email and the Southampton Education Leadership Forums meetings.

We may wish to contact you to further talk about mental health and wellbeing within your school. If you are happy to talk to us, please leave us your email address below:
Appendix B | Search Strategy and PRISMA flow diagram

MH school intervention lit search v1 - January 2018

PRISMA flow diagram

Records identified through database searching (n = 53)
  Medline & PsychINFO

Additional records identified through other sources (n = 19)
  Journal articles 7
  Grey literature 12

Records after duplicates removed (n = 72)

Records excluded, with reasons (n = 41)
  Not UK 31
  Opinion piece 5
  Outside inclusion dates 5

Full text articles assessed for eligibility (n = 72)

Studies included in final analysis (n = 20)
  Quantitative studies 11
  Qualitative studies 2
  Systematic reviews 5
  Grey literature 12

Full text articles excluded, with reasons (n = 1)
  Not UK 1

Titles and Abstracts assessed for eligibility (n = 31)
Appendix C | Population data for Southampton
Population pyramid for Southampton LA (HCC Resident Population), 2018

Population numbers by age group for Southampton LA (HCC Resident Population), 2016 and 2018

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Male</strong></td>
<td><strong>Female</strong></td>
<td><strong>Total</strong></td>
</tr>
<tr>
<td>0-4</td>
<td>8314</td>
<td>7776</td>
</tr>
<tr>
<td>5-9</td>
<td>7707</td>
<td>7214</td>
</tr>
<tr>
<td>10-14</td>
<td>5874</td>
<td>5692</td>
</tr>
<tr>
<td>15-19</td>
<td>10124</td>
<td>9817</td>
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<tr>
<td>20-24</td>
<td>15770</td>
<td>14739</td>
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<tr>
<td>25-29</td>
<td>11558</td>
<td>10230</td>
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<td>30-34</td>
<td>10464</td>
<td>9250</td>
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<tr>
<td>35-39</td>
<td>8622</td>
<td>7725</td>
</tr>
<tr>
<td>40-44</td>
<td>7781</td>
<td>6982</td>
</tr>
<tr>
<td>45-49</td>
<td>7314</td>
<td>6766</td>
</tr>
<tr>
<td>50-54</td>
<td>7353</td>
<td>7092</td>
</tr>
<tr>
<td>55-59</td>
<td>6314</td>
<td>6225</td>
</tr>
<tr>
<td>60-64</td>
<td>5129</td>
<td>5227</td>
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<td>65-69</td>
<td>4901</td>
<td>5226</td>
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<tr>
<td>70-74</td>
<td>3811</td>
<td>4153</td>
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<tr>
<td>75-79</td>
<td>2861</td>
<td>3296</td>
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<tr>
<td>80-84</td>
<td>2053</td>
<td>2820</td>
</tr>
<tr>
<td>85+</td>
<td>1794</td>
<td>3533</td>
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<tr>
<td><strong>Total</strong></td>
<td>127,754</td>
<td>126,811</td>
</tr>
</tbody>
</table>

Figures may not sum due to rounding

Data Sources: Resident populations have been taken from the Hampshire County Council’s 2016-based Small Area Population Forecasts for Southampton. The England comparator has been taken from the ONS 2015 Mid-Year Population Estimates. Some figures may not sum due to rounding.
Appendix D | MH prevalence data

Hospital admissions as a result of self-harm: DSR per 100,000 population aged 10-24, HES data 2016/17 42

<table>
<thead>
<tr>
<th>Area</th>
<th>Value</th>
<th>Lower CI</th>
<th>Upper CI</th>
</tr>
</thead>
<tbody>
<tr>
<td>England</td>
<td>404.6</td>
<td>400.7</td>
<td>409.6</td>
</tr>
<tr>
<td>Plymouth</td>
<td>696.6</td>
<td>596.9</td>
<td>742.1</td>
</tr>
<tr>
<td>Southampton</td>
<td>625.1</td>
<td>561.6</td>
<td>693.5</td>
</tr>
<tr>
<td>Bristol</td>
<td>608.6</td>
<td>566.9</td>
<td>660.8</td>
</tr>
<tr>
<td>North Tyneside</td>
<td>603.3</td>
<td>520.4</td>
<td>605.7</td>
</tr>
<tr>
<td>Salford</td>
<td>571.2</td>
<td>503.3</td>
<td>645.7</td>
</tr>
<tr>
<td>Bournemouth</td>
<td>654.6</td>
<td>480.0</td>
<td>637.3</td>
</tr>
<tr>
<td>Portsmouth</td>
<td>646.7</td>
<td>400.3</td>
<td>617.2</td>
</tr>
<tr>
<td>Brighton and Hove</td>
<td>640.9</td>
<td>467.2</td>
<td>605.1</td>
</tr>
<tr>
<td>Tameside</td>
<td>476.5</td>
<td>412.2</td>
<td>564.7</td>
</tr>
<tr>
<td>Coventry</td>
<td>430.0</td>
<td>392.2</td>
<td>460.7</td>
</tr>
<tr>
<td>Derby</td>
<td>429.0</td>
<td>374.4</td>
<td>490.7</td>
</tr>
<tr>
<td>Liverpool</td>
<td>491.0</td>
<td>361.4</td>
<td>443.7</td>
</tr>
<tr>
<td>Newcastle upon Tyne</td>
<td>369.7</td>
<td>323.5</td>
<td>418.0</td>
</tr>
<tr>
<td>Leicester</td>
<td>311.9</td>
<td>274.9</td>
<td>362.4</td>
</tr>
<tr>
<td>Sheffield</td>
<td>257.6</td>
<td>229.6</td>
<td>288.1</td>
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Trend for hospital admissions as a result of self-harm: DSR per 100,000 population aged 10-24 (black = England, blue = Southampton) 42

CAMHS referral sources for 2016/17 in Southampton. Data from CAMHS NHS Solent

<table>
<thead>
<tr>
<th>Referral source</th>
<th>Number (%) of referrals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other</td>
<td>134 (14%)</td>
</tr>
<tr>
<td>Community Mental Health Team</td>
<td>64 (6.7%)</td>
</tr>
<tr>
<td>Social Services</td>
<td>46 (4.8%)</td>
</tr>
<tr>
<td>Community-based Paediatrics</td>
<td>38 (4%)</td>
</tr>
<tr>
<td>Education Services</td>
<td>197 (20.6%)</td>
</tr>
<tr>
<td>General Medical Practitioner</td>
<td>477 (49.9%)</td>
</tr>
</tbody>
</table>

CAMHS referrals and outcomes from 2014-2018 in Southampton. Data from CAMHS NHS Solent

<table>
<thead>
<tr>
<th>Year</th>
<th>Number of referrals accepted</th>
<th>Number of referrals declined</th>
</tr>
</thead>
<tbody>
<tr>
<td>2014/15</td>
<td>324</td>
<td>124</td>
</tr>
<tr>
<td>2015/16</td>
<td>1,351</td>
<td>1,574</td>
</tr>
<tr>
<td>2016/17</td>
<td>429</td>
<td>1,098</td>
</tr>
<tr>
<td>2017/18</td>
<td>414</td>
<td>1,341</td>
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Appendix E | Existing survey results on MH and wellbeing

Proportion of pupils who worry by year group and type of problem, 2012. Taken from the Southampton Pupils Attitude Survey.²⁸

Number of year 7 pupils being bullied or feeling scared/worried in Southampton, 2017

How year 7 pupils rate their mood in Southampton, 2017
Appendix F | Risk and protective factors for MH data

Ethnicity of School Pupils in Southampton 2010 to 2016. Data from SCC 46

![Ethnicity Bar Chart]

**Notes:** Does not include Oasis Academies for 2010 & 2011

Top languages spoken (exc English) by pupils in Southampton schools, 2016. Data from SCC 46

![Language Bar Chart]

Number of school children identified as having social, emotional and MH needs as a percentage of all school pupils, 2017. Taken from DfE SEN statistics 42

### Primary school age:

<table>
<thead>
<tr>
<th>Location</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>England</td>
<td>212</td>
</tr>
<tr>
<td>Plymouth</td>
<td>419</td>
</tr>
<tr>
<td>Salford</td>
<td>318</td>
</tr>
<tr>
<td>Southampton</td>
<td>315</td>
</tr>
<tr>
<td>Medway</td>
<td>293</td>
</tr>
<tr>
<td>Swindon</td>
<td>252</td>
</tr>
<tr>
<td>Nottingham</td>
<td>246</td>
</tr>
<tr>
<td>North Tyneside</td>
<td>239</td>
</tr>
<tr>
<td>Portmouth</td>
<td>236</td>
</tr>
<tr>
<td>Newcastle upon Tyne</td>
<td>230</td>
</tr>
<tr>
<td>Bristol</td>
<td>223</td>
</tr>
<tr>
<td>Derby</td>
<td>222</td>
</tr>
<tr>
<td>Coventry</td>
<td>220</td>
</tr>
<tr>
<td>Brighton and Hove</td>
<td>210</td>
</tr>
<tr>
<td>Bolton</td>
<td>206</td>
</tr>
<tr>
<td>Sheffield</td>
<td>192</td>
</tr>
<tr>
<td>Peterborough</td>
<td>160</td>
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</table>

### Secondary school age:

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<th>Location</th>
<th>Percentage</th>
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<tr>
<td>Southhampton</td>
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</tr>
<tr>
<td>Salford</td>
<td>364</td>
</tr>
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<td>Plymouth</td>
<td>335</td>
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<tr>
<td>Swindon</td>
<td>324</td>
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<tr>
<td>Medway</td>
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<td>Portsmouth</td>
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<td>Derby</td>
<td>311</td>
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<tr>
<td>Nottingham</td>
<td>298</td>
</tr>
<tr>
<td>Brighton and Hove</td>
<td>296</td>
</tr>
<tr>
<td>Bolton</td>
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<tr>
<td>Bristol</td>
<td>246</td>
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<tr>
<td>Sheffield</td>
<td>230</td>
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<tr>
<td>Coventry</td>
<td>214</td>
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<tr>
<td>Peterborough</td>
<td>183</td>
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<tr>
<td>North Tyneside</td>
<td>181</td>
</tr>
<tr>
<td>Newcastle upon Tyne</td>
<td>180</td>
</tr>
</tbody>
</table>
Appendix G | Summary and quality assessment of literature review

‘++’ = Indicates that for that particular aspect of study design, the study has been designed or conducted in such a way as to minimise the risk of bias, ‘+’ = Indicates that either the answer to the checklist question is not clear from the way the study is reported, or that the study may not have addressed all potential sources of bias for that particular aspect of study design, ‘-’ = Should be reserved for those aspects of the study design in which significant sources of bias may persist, ‘NR’ = not reported, ‘NA’ = not applicable

<table>
<thead>
<tr>
<th>First author (year)</th>
<th>Selection bias</th>
<th>Performance bias</th>
<th>Attrition bias</th>
<th>Reporting bias</th>
<th>Other bias</th>
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<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Comiskey et al. 2012</td>
<td>++</td>
<td>++</td>
<td>++</td>
<td>+</td>
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<tr>
<td>Stallard et al. 2014</td>
<td>++</td>
<td>++</td>
<td>++</td>
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<td>++</td>
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<tr>
<td>Clarke et al. 2010</td>
<td>++</td>
<td>+</td>
<td>NR</td>
<td>++</td>
<td>+</td>
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<tr>
<td>Kuyken et al. 2013</td>
<td>+</td>
<td>-</td>
<td>NR</td>
<td>++</td>
<td>-</td>
</tr>
<tr>
<td>Naylor et al. 2009</td>
<td>+</td>
<td>-</td>
<td>NR</td>
<td>++</td>
<td>-</td>
</tr>
<tr>
<td>Humphrey et al. 2016</td>
<td>++</td>
<td>++</td>
<td>NR</td>
<td>++</td>
<td>++</td>
</tr>
<tr>
<td>Collins et al. 2013</td>
<td>+</td>
<td>-</td>
<td>NR</td>
<td>++</td>
<td>+</td>
</tr>
<tr>
<td>Proctor et al. 2011</td>
<td>+</td>
<td>-</td>
<td>NR</td>
<td>++</td>
<td>+</td>
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<tr>
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<td>+</td>
<td>-</td>
<td>NR</td>
<td>++</td>
<td>+</td>
</tr>
<tr>
<td>Humphrey et al. 2010b</td>
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<td>-</td>
<td>NR</td>
<td>++</td>
<td>+</td>
</tr>
<tr>
<td>Ohl et al. 2012</td>
<td>+</td>
<td>-</td>
<td>NR</td>
<td>++</td>
<td>-</td>
</tr>
<tr>
<td>First author, year, program</td>
<td>Country</td>
<td>Study design</td>
<td>Type of school</td>
<td>Sample (baseline)</td>
<td>Type of intervention</td>
</tr>
<tr>
<td>-----------------------------</td>
<td>---------</td>
<td>--------------</td>
<td>----------------</td>
<td>------------------</td>
<td>---------------------</td>
</tr>
<tr>
<td>Comiskey et al. 2012</td>
<td>Ireland</td>
<td>Cross-sectional</td>
<td>Primary</td>
<td>552 from 7 schools. Urban disadvantaged children aged 4 to 12 years.</td>
<td>Universal-whole school</td>
</tr>
<tr>
<td>WHO Health Promoting Schools</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stallard et al. 2014</td>
<td>England</td>
<td>Cluster RCT</td>
<td>Primary</td>
<td>1339 children from 45 schools. Aged 9 to 10 years old</td>
<td>Universal-curriculum-based</td>
</tr>
<tr>
<td>FRIENDS</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clarke et al. 2010</td>
<td>Ireland</td>
<td>Cluster RCT</td>
<td>Primary</td>
<td>730 children from 44 schools (523 in intervention and 207 in control group). Aged 5-8 years.</td>
<td>Universal-curriculum-based</td>
</tr>
<tr>
<td>Study</td>
<td>Country</td>
<td>Design</td>
<td>Setting</td>
<td>Sample Size</td>
<td>Description</td>
</tr>
<tr>
<td>-----------------------------------------</td>
<td>---------</td>
<td>-------------------</td>
<td>---------</td>
<td>-------------</td>
<td>------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Kuyken et al. 2013 (Stop-Breathe-Be) Programme</td>
<td>England</td>
<td>Non-randomised, controlled trial</td>
<td>Secondary</td>
<td>522 young people from 12 schools. Aged 12 to 16 years old.</td>
<td>Currently implemented in the UK. 9 week mindfulness in Schools Program based on mindfulness-based stress reduction and mindfulness based cognitive therapy.</td>
</tr>
<tr>
<td>Naylor et al. 2009</td>
<td>England</td>
<td>Non-randomised, cluster, controlled trial</td>
<td>Secondary</td>
<td>416 young people from 2 schools. Aged 14 to 15 years old.</td>
<td>Currently implemented in the UK. MH teaching program (six 50 min lessons on issues common to CYP: stress; depression; suicide/self-harm; eating disorders; bullying; and intellectual disability). Teaching methods used included discussion, role-playing and internet searching.</td>
</tr>
<tr>
<td>Humphrey et al. 2016</td>
<td>England</td>
<td>Cluster RCT</td>
<td>Primary</td>
<td>4516 children from 45 schools.</td>
<td>Universal and targeted (at risk individuals) US evidence based intervention. The whole school curriculum is designed to promote</td>
</tr>
<tr>
<td>Study</td>
<td>Country</td>
<td>Design</td>
<td>Setting</td>
<td>Participants</td>
<td>Description</td>
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<td>---------------------------</td>
<td>---------</td>
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<td>---------</td>
<td>--------------</td>
<td>-------------</td>
</tr>
<tr>
<td>Promoting Alternative</td>
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<td></td>
<td>Aged 7–</td>
<td>were those</td>
<td>social and emotional thinking in primary aged</td>
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<tr>
<td>Thinking Strategies</td>
<td></td>
<td></td>
<td>9 years</td>
<td>who had</td>
<td>Six volumes of lessons - 119 lessons + 30</td>
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<tr>
<td>(PATHS)</td>
<td></td>
<td></td>
<td>old.</td>
<td>elevated</td>
<td>supplementary lessons.</td>
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<td></td>
<td>aggression</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>levels at</td>
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<td>- curriculum-</td>
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<tr>
<td>Collins et al. 2013</td>
<td>Scotland</td>
<td>Quasi-experimental</td>
<td>Primary</td>
<td>317 pupils</td>
<td>10 lessons theoretically grounded in CBT for</td>
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<tr>
<td>Lessons for Living: Think</td>
<td></td>
<td>with 3 groups (psychologist led, teacher led and control)</td>
<td></td>
<td>within 16 classes across 9 schools. Aged 9-10 years old.</td>
<td>curriculum-based</td>
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<td>Well, Do Well</td>
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<td>Universal-</td>
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<td>theoretically grounded in CBT for development of</td>
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<td></td>
<td>coping skills</td>
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<tr>
<td>Proctor et al. 2011</td>
<td>UK</td>
<td>Quasi-experimental</td>
<td>Secondary</td>
<td>319 Students from 2 schools. Aged 12-14 Years.</td>
<td>Currently implemented in the UK. Children complete strengths-based exercises through in-class activities, open discussion and homework activities. 24 lessons.</td>
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<td>Strengths Gym</td>
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<td>Universal-</td>
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<td>and homework</td>
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<td>activities.</td>
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<td>24 lessons.</td>
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<tr>
<td>Study</td>
<td>Country</td>
<td>Study Design</td>
<td>Setting</td>
<td>Sample Size</td>
<td>Population Characteristics</td>
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<tr>
<td>Humphrey et al. 2010a</td>
<td>England</td>
<td>Quasi-experimental</td>
<td>Primary</td>
<td>182 children from 22 schools. Aged 6-11 years old.</td>
<td>Targeted - curriculum-based</td>
</tr>
<tr>
<td>Humphrey et al. 2010b</td>
<td>England</td>
<td>Quasi-experimental</td>
<td>Primary</td>
<td>253 children from 37 schools. Aged 6-11 years old.</td>
<td>Targeted - curriculum-based</td>
</tr>
<tr>
<td>Ohl et al. 2012</td>
<td>England</td>
<td>Quasi-experimental</td>
<td>Primary</td>
<td>385 children from 7 schools aged 7-8 years old.</td>
<td>Targeted – whole school</td>
</tr>
</tbody>
</table>
Summary of included qualitative studies (n=2)

<table>
<thead>
<tr>
<th>First author (year)</th>
<th>Country</th>
<th>Sample characteristics</th>
<th>Aims</th>
<th>Sampling methods</th>
<th>Intervention</th>
<th>Data collection/analysis methods</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pryjmachuk et al. 2011</td>
<td>England</td>
<td>33 school nurses</td>
<td>Explore views regarding MH problems in young people and school nurses potential for engaging work with this client group</td>
<td>Purposive</td>
<td>None</td>
<td>Focus group</td>
<td>Most participants agreed that schools were places where MH work (especially MH promotion) could take place, although the philosophy of the school, the attitudes of the school staff and individual relationships between school staff and school nurses could have a bearing on this. Participants complained about inappropriate facilities (e.g. rooms hidden away or unsuitable for seeing children in) of vague referrals from school staff that were more about the anxieties of the referrer (almost always a teacher) than the child and about issues over confidentiality and the sharing of information.</td>
</tr>
<tr>
<td>Kidger et al. 2009</td>
<td>England</td>
<td>Qualitative student focus groups (27 groups, 154 students aged 12-14) and staff interviews (12 interviews, 15 individuals) were conducted in eight secondary schools</td>
<td>Investigate students and teachers views about current MH and wellbeing provision in schools and areas for development</td>
<td>Random for schools Purposive for students and staff from schools</td>
<td>None</td>
<td>Survey Staff interviews Student focus groups Thematic analysis</td>
<td>Emergent themes: emotional health infrequently and poorly taught in the curriculum (sex and drugs dominated content), stigma around emotional difficulty, lack of confidential, accessible and sympathetic help sources within schools for those in distress, and the physical and psychosocial environment such as poor student-staff relationships, overburdened by exams. Suggested improvements: emotional health lessons should be delivered in small groups, by outside experts rather than teachers, reduce bullying, improving teacher - student relationships by being less strict about what students regarded as trivial matters such as having the correct uniform, increasing rewards and recognition of good behaviour, improving the physical environment, and developing the range and number of extra-curricular activities available.</td>
</tr>
</tbody>
</table>
### Quality appraisal of included systematic reviews (n=4)

<table>
<thead>
<tr>
<th>Author and year</th>
<th>Clear question</th>
<th>Studies</th>
<th>Search strategy</th>
<th>Quality assessment</th>
<th>Publication bias</th>
<th>Outcomes</th>
<th>Meta-analysis</th>
<th>Precision</th>
<th>Harms</th>
<th>Overall quality</th>
</tr>
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<tbody>
<tr>
<td>Ohly et al. 2016</td>
<td>+</td>
<td>+</td>
<td>++</td>
<td>++</td>
<td>NR</td>
<td>-</td>
<td>NA</td>
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<td>Langford et al. 2015</td>
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<td>++</td>
<td>++</td>
<td>++</td>
<td>NR</td>
<td>-</td>
<td>+</td>
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<td>NR</td>
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<tr>
<td>Dray et al. 2017</td>
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<td>Adi et al. 2007</td>
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<td>NA</td>
<td>NR</td>
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</table>

### Summary of included systematic reviews (n=5)

<table>
<thead>
<tr>
<th>Author and year</th>
<th>Aim</th>
<th>Databases (n)</th>
<th>Studies (type and n)</th>
<th>Inclusion criteria</th>
<th>Quality of evidence</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ohly et al. 2016</td>
<td>Understand the health and well-being impacts of school gardens</td>
<td>12 plus 3 grey literature databases</td>
<td>40 studies (21 quantitative studies; 16 qualitative studies; 3 mixed methods studies)</td>
<td>All educational settings up to 18 years. The definition of ‘gardening’ included growing or cultivating any kind of plants (such as vegetables, fruits, trees, shrubs and flowers). OECD countries.</td>
<td>4 quantitative studies reported children’s well-being, only some measures used were valid and reliable scales, including QoL, life skills and interpersonal relationships. Of the qualitative studies only 2 were of high quality.</td>
<td>Two of the four quantitative studies did not find a significant difference between intervention and control groups using their selected measures at follow up. The other two studies did not report their child wellbeing outcomes adequately. Most qualitative studies reported well-being impacts including; children gained confidence and self-esteem especially for those who do not excel in the usual academic setting (e.g. those with learning, ADHD, depression, behavioural and emotional difficulties)</td>
</tr>
<tr>
<td>Langford et al. 2015</td>
<td>Evaluate the WHO Health Promoting School (HPS) framework</td>
<td>20</td>
<td>67 cluster RCTs but only 2 with specific MH and wellbeing outcomes</td>
<td>6,099 CYP aged 4-18 World wide Any date Active engagement in all 3 HPS domains</td>
<td>43% studies high risk of bias</td>
<td>No evidence for an effect on MH, violence or bullying others. The two studies focussing specifically on MH, estimated effect sizes showed intervention school reporting poorer MH.</td>
</tr>
<tr>
<td>Dray et al. 2017</td>
<td>Examine the effect of universal school based resilience-focussed interventions</td>
<td>6</td>
<td>57 RCTs</td>
<td>Aged 5-18 Majority from Australia and America 1995-2015</td>
<td>77% had high risk of bias</td>
<td>Most interventions included cognitive competence, problem solving, communication and coping skills. Other interventions were positive psychology, social and emotional learning, social, life, self-management skills and mindfulness. CBT-based resilience programs were more effective than non CBT-based programs. A significant overall effect was seen for depressive symptoms, internalizing and externalizing problems and general psychological distress, but only the effect on internalizing problems was sustained for more than 12 months. An effect on anxiety was seen in children (5-10 years old).</td>
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</table>
| Adi et al. 2007 | Review universal approach interventions to | 15 | 31 studies (15 RCTs and 16 Majory from America) | Only 4/15 RCTs rated high quality, scoring [+] thought rest: 11/15 scored [+]. Out | | Of the 15 RCTs, 9 showed a positive impact, 5 probable impact and 2 unlikely impact. Of the 16 CCTs, 6 showed a positive impact, 5 probable impact and 5 unlikely. The highest quality evidence relates to multi-
promote mental wellbeing in primary schools, which do not focus on violence or bullying

controlled non-randomised trials (CCTs) )

Published since 1990 of the 16 controlled trials, two scored [++] , ten trials scored [+] and four trials scored [-]

component programmes covering classroom curricula and school environment, together with programmes for parents (improve parenting skills and parent child relationships). The former are on MH and emotional and social development, as well as behaviour management and child teacher relationships and typically offered by teachers who have received a significant degree of training and have access to ongoing supervision. Studies evaluating Health Promoting schools had variable results – 2 showed positive impact, 2 probable impact and 1 no impact. Uni-component interventions including those enabling children to learn to relax and cope with stress, those teaching conflict resolution and involving peer mediation and those teaching social skills and emotional literacy have also been investigated and show promise; they need investigating in good quality trials. No consistent trend was seen for impact relative to length of intervention.

Clarke et al. 2015 Review the effectiveness of school based and out-of-school programs for enhancing social and emotional development in CYP in the UK

8, a search of grey literature and a Call for Evidence 39 school interventions Aged 4-20 years 2004-2014 13/16 studies on universal social and emotional skills interventions were of good quality. 2/5 small group classroom-based interventions were of good quality. Too few studies to draw strong conclusions regarding the effectiveness of mentoring and social action interventions.

The strongest evidence was for universal programmes with an established evidence base either from international and/or UK studies (PATHS, Friends, Zippy’s Friends, UK Resilience, Lions Quest, Positive Action). They had a positive impact on CYPs coping skills, self-esteem, resilience, problem solving skills, empathy, reduced symptoms of depression and anxiety. Broader outcomes include reduced behaviour problems, enhanced academic performance, and improved family relations. There is promising emerging evidence in relation to UK developed interventions including Circle Time, Lessons for Living, Strengths Gym, Rtime & Mindfulness Programme. The Australian developed online cognitive behavioural skills intervention MoodGYM, is well evidenced, and is currently being implemented and evaluated as part of the Healthy Minds in Teenagers curriculum in the UK. 3/5 group classroom-based interventions showed a positive effect – part of Social and Emotional Aspects of Learning (SEAL), and Going for Goals, New Beginnings.
<table>
<thead>
<tr>
<th>Title</th>
<th>Type and Organisation</th>
<th>Purpose</th>
<th>Source</th>
<th>Method</th>
<th>Main findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Early Intervention Foundation (EIF) Guidebook</td>
<td>EIF (independent charity) Briefing</td>
<td>Independent information about early intervention programmes that have been evaluated and shown to improve outcomes for CYP. Rates programs based on the strength of evidence and relative costs.</td>
<td>A range of sources. Work with the Education Endowment Foundation and the Behavioural Insights Team</td>
<td>7 step process where EIF issues a call for expressions of interest for programmes that fit within the scope of the review and assesses.</td>
<td>When limited by programs that aim to support health and wellbeing for primary school children, preadolescents, and adolescents and have been implemented in the UK there were 19 programs found.</td>
</tr>
<tr>
<td>MH Services and Schools Link Pilots: Evaluation report</td>
<td>Department for Education Evaluation report</td>
<td>Test the extent to which joint professional working between schools and NHS CYPMHS can improve local knowledge and identification of MH issues and improve the quality and timeliness referrals to specialist services.</td>
<td>Sept 2015, Ecorys (UK) was commissioned by DfE to undertake an independent evaluation. Mixed methods design, incorporating survey research, research observations and qualitative case studies in 10 areas. The data collection took place between September 2015 and 2016.</td>
<td>22 areas, incorporating 27 CCGs and 255 schools, were funded to establish named lead contacts within NHS CYPMHS and schools. They also participated in 2 joint planning workshops, involving other professionals from their local CYPMHS network. These included, but were not restricted to, school nurses, educational psychologists, counsellors and voluntary sector.</td>
<td>Pilots had considerable success in strengthening communication and joint working between schools and NHS CYPMHS. The extent of change varied between pilot areas. At a programme level, the evaluation found quantifiable improvements to the following self-reported outcome measures, between a baseline and follow-up at +10 months in; frequency of contact between schools and NHS; satisfaction with communication and working relationships; understanding of the referral routes to specialist MH support; knowledge and awareness of MH issues affecting children and young people, among school lead contacts.</td>
</tr>
<tr>
<td>Transforming Children and Young People’s MH Provision</td>
<td>PHE PowerPoint Presentation</td>
<td>Update on MH and Schools &amp; Colleges Link programme, MH First Aid training, Evidence and wider related priorities.</td>
<td>Various</td>
<td>Various</td>
<td>• The PM committed to providing MH First Aid training to a teacher in every secondary school by 2019. In 2017 DHSC funded 1000 MH First Aid places; 1/3 secondary schools. Over 1253 schools staff have received 1 day training in 924 schools. Further funding is being provided to extend this over the next 2 years to reach all secondary schools. And training every primary school during this Parliament (by 2022). • PHE are conducting a rapid review on effectiveness of school-based MH lessons. • DfE is leading a pilot of peer support approaches in 100 high need schools and colleges and ten community settings, and RCTs of preventative programmes across 5</td>
</tr>
<tr>
<td>National Study of Health and Wellbeing: Children and Young People</td>
<td>Carried out by NatCen Social Research and the Office for National Statistics on behalf of NHS Digital</td>
<td>Last conducted in 2004. The 2017 survey aims to find out about the health, development and wellbeing of CYP.</td>
<td>Survey</td>
<td>Participants will be a random sample of CYP aged between 2 and 19 years old in England. It will cover around 9,500 children and young people living in private households in England.</td>
<td>It will collate prevalence’s of health, developmental and emotional disorders, social media use, and bullying. Due to be published Autumn 2018.</td>
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<tr>
<td>Promoting children and young people’s emotional health and wellbeing – A whole school and college approach</td>
<td>PHE with the Children and Young People’s MH Coalition (CYPMHC) – 14 charities Briefing</td>
<td>Signposts to practice examples and resources to support implementation. It also highlights action taken by schools link with Ofsted inspection criteria.</td>
<td>Various government guidance and evidence.</td>
<td>Not stated</td>
<td>A diagram presents eight principles to promote emotional health and wellbeing in schools and colleges. Contains a comprehensive list of resources for schools and CYP that can be used in the school setting.</td>
</tr>
<tr>
<td>Youth MH First Aid (MHFA) courses</td>
<td>MHFA England Website</td>
<td>A range of courses tailored for people who teach, work with, live with and care for young people aged 8 to 18. The courses focus on the issues faced by young people today, skills and confidence to spot common signs and triggers of MH issues, as well as the knowledge and confidence to help.</td>
<td>The majority of evaluations have been conducted on adults. Two evaluations have been conducted on CYP in the UK.</td>
<td>Youth MHFA courses include two-day, one-day (‘Schools and Colleges’) and half day (‘Lite’). Every secondary school is entitled to one free place on a Youth MHFA One Day course through our Schools programme funded by the DoH.</td>
<td>MHFA is an international MH awareness and skills programme developed in Australia in 2001 and now internationally recognised in 24 countries. First came to England in 2007. The WISE study (Kidger, J. et al. The Wellbeing in Secondary Education (WISE) Project. University of Bristol &amp; Cardiff University (2016-2019)) was piloted in six schools and was found to be feasible and well received. 25 schools from Bristol and the surrounding area and from South Wales are taking part in this larger study and results will be available in 2019.</td>
</tr>
<tr>
<td>Schools In Mind - MH and Wellbeing in Schools</td>
<td>Anna Freud National Centre for Children and Families Website</td>
<td>A free network for school staff and allied professionals which shares academic and clinical expertise regarding wellbeing and MH.</td>
<td>Various</td>
<td>Various</td>
<td>The network provides a trusted source of up-to-date, accessible information and resources for parents, teachers, CYP, general public, etc. Run events and courses/training. Developed the CASCADE framework to encourage collaboration between CCGs, local authorities and schools to support CYP MH and wellbeing.</td>
</tr>
<tr>
<td>PH12 Social and emotional wellbeing in primary education, and PH20 Social and emotional wellbeing in secondary education</td>
<td>NICE Guideline</td>
<td>Advises on planning and delivering programmes and activities to help children develop social and emotional skills and wellbeing and identifying signs of anxiety or social and emotional problems in children and how to address them.</td>
<td>The Public Health Interventions Advisory Committee (PHIAC)</td>
<td>Informed by reviews of the evidence (searched 14 databases and numerous websites), an economic appraisal, stakeholder comments and the results of fieldwork</td>
<td>• Advocates for principles of a whole school approach • Put in place and evaluate coordinating mechanisms • Schools and local authority children’s services should work closely with child and adolescent MH and other services to develop and agree local protocols.</td>
</tr>
<tr>
<td>Peer support and children and young people’s MH</td>
<td>Independent Social Research Research review</td>
<td>A public benefit foundation dedicated to the promotion of interdisciplinary research in the social sciences. To review research available on peer support for young people.</td>
<td>Various: peer reviewed journals, publications in professional journals and newsletters, reports published by organisations commissioning, delivering or evaluating initiatives or</td>
<td>A review commissioned by the Department for Education on peer support interventions for young people of school age (aged 4-18) was conducted for research conducted from 2006 - 2016.</td>
<td>Only a small number of studies included robust evaluations. It found little evidence for group-based projects, on-line projects or community-based programs, but good evidence for school based one-to-one peer support. One-to-one school projects tend to be universal rather than targeted. Several studies note the importance of a clear focus, strong leadership by a co-ordinator and support throughout the school, including from senior school management and being a formalised project. Specific elements of formalised</td>
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</table>
### Building children and young people’s resilience in schools

**UCL Institute of Health Equity Briefing**

The Institute is led by Professor Sir Michael Marmot and seeks to increase health equity through action on the social determinants of health. This briefing was commissioned by PHE.

Various

Not stated – see research review

The approaches recommended include improving achievements, promoting healthy behaviour, ensuring a smooth transition, supporting parents and carers, supporting teachers and staff, promoting good relationships with peers, adopting whole school approaches and the school acting as a community hub.

### A whole school approach to MH

**Place2Be Report**

Charity and leading provider in school-based emotional and MH services across the UK

Summary of own services and case studies.

N/A

Menu of services including: One-to-one, group work, universal support, a place for parents, support for teachers, safeguarding, SEND, training for staff and volunteers, multi-agency work. Many schools fund through their Pupil Premium.
Focus Group Report
Southampton, May 2018

I. Introduction
Southampton City Council (SCC) Public Health held a series of focus group discussions in conjunction with No Limits with a total of 15 children and young people (CYP) on 29/5/18 and 30/5/18. The focus group was conducted as part of SCC involvement in and mental health and wellbeing needs assessment. The discussion was designed to gather information from the CYP in regard to the following outcomes:

1. To understand how CYP feel the school setting can promote wellbeing and support them when they are experiencing mental health difficulties
2. To understand CYPs views on the current Personal, Social, Health and Economic (PSHE) Education provision and how they would like to see it changed in the future

II. Participant Demographics
15 participants took part in the focus groups:
- Eleven females and four males
- Ages ranged from 12 to 24 years

III. Student Perspectives

Outcome 1: To understand how CYP feel the school setting can promote wellbeing and support them when they are experiencing mental health difficulties

Question asked during focus group:
- What are the key problems/difficult feelings you and other young people you know experience?
- If you have difficult feelings, who in your school who would you go to and why?
- Are there things your school does that help students who are having problems or difficult feelings?
- How do teachers respond to problems that young people face?
- What other things could your school do to help students feel happy?
- What other things could your school do to help people who were having problems/difficult feelings?
- What do you think of peer support?

A need for improvement
Most CYP felt mental health and wellbeing support in schools was poor and needed to be improved. They felt schools were too attendance focussed at the detriment of mental health. They felt exclusion or being sent home from school was detrimental to their mental health.

“There’s discrimination in the school system... there’s more support available to people in the top sets”
“I faced intimidating reactions when I tried to get help”
“I feel failed by people in the school system”
“People were being punished for having mental health problems”

Individualised approaches
Many CYP felt that their individual situation was poorly understood by schools. They often felt that their situations were complex and multi-faceted and that schools were not equipped to deal with
this. They did not want a blanket approach but felt they needed someone who had time to understand the individual person and situation.

Able to take action
As well as someone who listened to them they wanted someone who would actually take action and advocate for them. They felt the most helpful people in schools were those who were in a position of power and so could actually change things and came up with answers and strategies. “They listen to you but they don’t take action”

Independent
The importance of having someone who is independent from the school (i.e not a teacher or friend but an external staff member) where confidentiality is guaranteed was very important to the CYP. They wanted what they spoke about to be completely anonymous and for the person they were speaking to, to be neutral and not biased in anyway. Some CYP even felt targeted by staff as well as students. “They make you feel like you’re the bad person”

Early detection
The importance of early diagnosis and intervening early was raised. They felt that problems often escalated before they were dealt with and that support for low level problems was lacking. They though that staff should have training in how to spot pupils who show signs of mental health problems. “We need help before it’s too late” “They should be proactive rather than reactive”

Accessibility trumps experience
Many CYP felt that teachers are not educated in mental health. Experience of working with CYP and an awareness of mental health problems was desired but the CYP did not feel that the person they spoke to needed to be very highly trained. Access was more important.

CYP liked open access services and there was a mixture of CYP wanting to be able to refer themselves with others having preference for a parent or teacher doing it on their behalf. Participant X: “You know yourself better than anyone” Participant Y: “I don’t think so, my mum knows me better than I know myself”

Some felt mental health support was not available in their school at all and nearly all CYP agreed teachers did not have enough time to help with wellbeing and mental health difficulties. Of those that felt there was support there they said it was not easy to access and that the opening times were too limited. They wanted someone to be available to speak to at any time of the school day. They also felt the service should be open ended and not time limited as support often ended before they felt better. “I was told a mental health team existed but I never met them”

Peer support
Most CYP spoke positively of buddy systems or previous peer support they had been a part of such as an Anxiety Program where Year 11 pupils mentored year 7 pupils. They felt it benefited both the mentee and the mentor. They agreed that more peer support would help. They wanted in focussed on mental health rather than just being general. “I wish I had that when I was in school”
Preferences were:
Run by: Older students who have more experience and won’t judge them
Access: open access/ self-referral
Location: Mixed opinions, some wanted it in school and others wanted it externally such as at No Limits
Frequency: once to twice per week

Table 1: CYP suggestions for how schools can promote wellbeing

<table>
<thead>
<tr>
<th>Suggestion</th>
<th>Details</th>
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<tbody>
<tr>
<td>Anonymous box</td>
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<tr>
<td>Breakfast club</td>
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<tr>
<td>Youth groups</td>
<td>Fun activities</td>
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<tr>
<td>Reduce academic focus</td>
<td>Stress coping techniques</td>
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<td></td>
<td>Less exams</td>
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<tr>
<td>Relaxation area</td>
<td>A private ‘Pod’ or play room</td>
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<td></td>
<td>Refreshments</td>
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<td></td>
<td>Punching bag</td>
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<tr>
<td>Rest breaks</td>
<td>Two minute time out</td>
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</tbody>
</table>

Outcome 2: To understand CYPs views on the current PSHE provision and how they would like to see it changed in the future

Question asked during focus group:
- Tell us about PSHE and/or Relationships and Sex Education (RSE) in your school?
- Does the subject of mental health and wellbeing come up in other lessons?
- Prompts: how many lessons, topics, who teaches, what do they do, what they like/dislike about the lessons, useful or not, are there any topics in particular that would be useful to cover?

Generally feeling towards PSHE were positive although they did not feel it was covered much in school.
“To be fair to PSHE its one of the only lessons which teaches real life stuff”

Content
There was support for several topics already covered in PSHE including smoking, drugs and sex education. None of the CYP felt mental health or wellbeing had been covered in PSHE. One young person mentioned an external session by LifeLab had covered mental health and had been very useful as it was practical including how to spot mental health problems and how to access services.

Table 2: Topics CYP would like included in PSHE

<table>
<thead>
<tr>
<th>Theme</th>
<th>Topic</th>
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<tbody>
<tr>
<td>Smoking</td>
<td>Addiction</td>
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<tr>
<td></td>
<td>E-cigarettes</td>
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<tr>
<td>Drugs</td>
<td>Medicines</td>
</tr>
<tr>
<td></td>
<td>Addiction</td>
</tr>
<tr>
<td></td>
<td>Illegal drugs and drug testing</td>
</tr>
<tr>
<td>Sex education</td>
<td>Sexting</td>
</tr>
<tr>
<td>Mental health</td>
<td>How to spot problems early</td>
</tr>
<tr>
<td></td>
<td>Depression</td>
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</tbody>
</table>
Anxiety
Self-harm
How to deal with physical and emotional bullying
How to access services with contact details

Wellbeing
Self-care techniques, e.g. mindfulness, meditation, yoga
How to manage feelings including anger management
Dealing with exam stress

Staying safe online/ social media
How to deal with / report anonymous bullying
Practical walkthrough, e.g. how to make Facebook private

Life skills
How to save / budget
How to pay bills / rent
Job guidance
Finding accommodation

Crime and law
How to stay safe
How to communicate to the police
Knife crime

Social media
Most CYP felt positively towards social media rather than negatively. Some mentioned that they did not have friends in school but could connect to people online. There was reluctance around any regulating of social media.
“Social media is my safe place”

Structure of PSHE
The CYP felt that PSHE should be covered in every year in school but there were mixed views on doing this spread out through the year or once a year as a whole PSHE day/ one day workshop. Another suggestion was having PSHE as an optional club, either in or after school hours so that those who didn’t want to attend didn’t have to and it would be more useful to those who did attend.

IV. Recommendations
- Accessibility was more important than having highly trained individuals. There is a demand for more low-level support which is open-ended and accessible at all times.
- External individuals and/or a peer support system are preferential to teachers as CYP feel they are less biased, confidential and have more time.
- Staff should be trained to spot pupils who show signs of mental health problems early.
- PSHE should be extended so it is covered every year in school and includes topics CYP feel are important to everyday life such as mental health and wellbeing, life skills, staying safe online and crime and law.
Appendix I | Survey results

Parent mental health survey

This survey was completed by parents of children currently in school. It aimed to find out what parents think of mental health in a school environment and their own confidence in supporting their children’s mental health needs. The survey will be used to inform a Needs Assessment on mental health and wellbeing of children and young people in the city and a University of Southampton evaluation of the impact of mental health and wellbeing interventions in schools. A total of 294 people responded to the survey which was hosted online and distributed via schools and other mailing lists. Because of the way the survey was distributed a small number (28, 5.7%) of respondents had children at schools outside Southampton (including Winchester, Eastleigh and Highlife) and these were not able to be excluded. The following report analyses the result of the survey.

Please note for graphs showing results broken down by the school type that there were significantly fewer respondents who had children attending a sixth form college or special school. This means the sample sizes for these categories were much smaller and are not truly representative. 49 children attend sixth form college and 5 attend a special school.

More about the parents who completed the survey

Parents with children attending a range of schools responded to the survey. When asked which school their children attend, a total of 77 different schools were mentioned. (A full list of the schools mentioned in the survey can be found in the appendices.)

---

### How many children do you currently have at school?

- 1 child: 44%
- 2 children: 45%
- 3 children: 10%
- 4 children: 1%

### What type of school do your children go to?

- Primary: 49%
- Secondary: 39%
- Sixth form college: 10%
- Special: 1%

---
Parents’ confidence at identifying the mental health needs of their children

How confident do you feel in identifying when your child would benefit from mental health support?

- Very confident: 6%
- Confident: 31%
- Somewhat confident: 34%
- Neither: 26%
- Somewhat unconfident: 0.3%
- Unconfident: 11%
- I am not at all confident with this: 2%

How confident do you feel in supporting your child(ren) when they have low level mental health needs (e.g. low mood, stress)?

- Very confident: 21%
- Confident: 30%
- Somewhat confident: 34%
- Neither: 2%
- Somewhat unconfident: 0%
- Unconfident: 11%
- I am not at all confident with this: 2%
Mental health support at school

What impact does your child's school have on their wellbeing?

- Very positive impact: 33%
- Fairly positive impact: 37%
- Slightly positive impact: 13%
- Neither: 4%
- Slightly negative impact: 8%
- Fairly negative impact: 3%
- Very negative impact: 2%

What impact does your child's school have on their wellbeing? (broken down by school type)

- Primary: 90% Positive, 3% Neither, 7% Negative
- Secondary: 76% Positive, 5% Neither, 19% Negative
- Sixth form college: 69% Positive, 10% Neither, 20% Negative
- Special: 100% Positive

Legend: Red = Positive, Grey = Neither, Blue = Negative
There is sufficient support for mental health and wellbeing in my child's school (broken down by school type)

- **Primary**
  - Strongly agree: 10%
  - Agree: 39%
  - Neutral: 34%
  - Disagree: 13%
  - Strongly disagree: 3%

- **Secondary**
  - Strongly agree: 12%
  - Agree: 33%
  - Neutral: 34%
  - Disagree: 15%
  - Strongly disagree: 6%

- **Sixth form college**
  - Strongly agree: 8%
  - Agree: 29%
  - Neutral: 29%
  - Disagree: 23%
  - Strongly disagree: 10%

- **Special**
  - Strongly agree: 60%
  - Agree: 40%

I would know how to get help for my child within their school if they experienced a mental health difficulty

- **Strongly agree**: 18%
- **Agree**: 45%
- **Neutral**: 17%
- **Disagree**: 15%
- **Strongly disagree**: 6%
I would know how to get help for my child within their school if they experienced a mental health difficulty (broken down by school type)

- Primary: 17% Strongly agree, 47% Agree, 17% Neutral, 15% Disagree, 4% Strongly disagree
- Secondary: 18% Strongly agree, 48% Agree, 17% Neutral, 10% Disagree, 7% Strongly disagree
- Sixth form college: 19% Strongly agree, 27% Agree, 17% Neutral, 27% Disagree, 10% Strongly disagree
- Special: 60% Strongly agree, 20% Agree, 20% Neutral, 0% Disagree, 0% Strongly disagree

I know the help I sought from their school will lead to a good outcome for my child

- Strongly agree: 15%
- Agree: 30%
- Neutral: 41%
- Disagree: 6%
- Strongly disagree: 8%

I know the help I sought from their school will lead to a good outcome for my child (broken down by school type)

- Primary: 17% Strongly agree, 34% Agree, 39% Neutral, 8% Disagree, 3% Strongly disagree
- Secondary: 13% Strongly agree, 28% Agree, 43% Neutral, 8% Disagree, 8% Strongly disagree
- Sixth form college: 10% Strongly agree, 19% Agree, 48% Neutral, 15% Disagree, 8% Strongly disagree
- Special: 60% Strongly agree, 20% Agree, 20% Neutral, 0% Disagree, 0% Strongly disagree
What else would you prefer?

a proper mental health strategy with kids, not attendance, at the centre

If it is appropriate I would like to be informed when the school is planning an intervention - but I do not think that intervention should involve me unless that is what my child wants I would also like to be kept informed of the school's mental health plan & provision

Most of the above whichever is appropriate to the child’s need at the time

Our school has a learning support department who have offered myself and my children the best support with anxiety and settling in issues. I have a contact who I can email daily if required. Very impressive support.

The school nurses intervention or a specialist counsellor in the school for one to one with child

Have you ever tried to access pastoral or other support for your child(ren) from their school in relation to a mental health condition before?

- Yes 26%
- No 74%
Do you have any other comments about the mental health and wellbeing support you would expect to see available for children and young people in schools?

<table>
<thead>
<tr>
<th>Mental health provision at mainstream secondary school is non-existent. Special school is great</th>
</tr>
</thead>
<tbody>
<tr>
<td>Teachers do not have a spare minute in their days and evenings, so it needs to be someone else who can take over this for children with big needs</td>
</tr>
<tr>
<td>My child was bullied at that school and it took almost a year for it to be taken seriously as my son was labeled as sensitive.</td>
</tr>
<tr>
<td>It is still such a taboo topic that it is very difficult for people to seek support. Although some support is available in school, it is limited and links to outside organisations isn’t there. The avenues for seeking support outside of school are also limited; GPs can do little more than refer you on, organisations have lengthy waiting lists and private mental health care is very expensive. That said, there is definitely much more awareness of the diversity and scale of mental health which is a good thing but with the NHS not receiving enough funding to support mental health in children many are not being seen by trained staff.</td>
</tr>
<tr>
<td>Less mental health and wellbeing support would be required if the pressure of achievement and attendance wasn’t so all consuming. Less testing would help too. It is constant. For children in the present year 10 and 11, being told it will be hard to cover the whole syllabus for gcse doesn’t help! After school revision classes have started in year 10, so they can cover the work!!! The teacher’s obviously being stressed stresses the children and parents. Children are now being told not to even go away in school holidays (half terms) so that they can work... (not our school another Southampton one where they have classes during half term in year 11.) The new Headteacher at my child’s school is now listening to parents (the previous one didn’t want to know) , we just want better communication between school and parents, so that big problems don’t develop. I would say that teachers could do with some training in dealing with emotional matters too.... my daughter had a close friend in her class whose sister committed suicide ... the tutor didn’t talk it through with the class, teachers didn’t know what to say.... they should have been guiding the children through it.... they should already know how to deal with it if there is a death in their class / connected with the class. Kids need time to chat and relax with the adults in school, so some of the team building type activities and school trips help with that, the children are then more likely to feel they have an adult to go to if they have problems. Flexi-schooling should be more of an option for children who struggle in the school environment, there seem to be so many more children suffering from anxiety now... mostly through the pressure of schooling.</td>
</tr>
<tr>
<td>There doesn’t appear to be enough funding in school for this and there is too much pressure on children with all the testing which is unnecessary. Also, family time is important and schools should be allowed to authorise 5 days of absence for holidays. I do not agree with teaching to the test which is what this curriculum has become adding to increased mental health issues in children.</td>
</tr>
<tr>
<td>Sometimes there is very little available in schools until such there a process of diagnosis. Some of the screenings can take up to 16 weeks until any intervention can be put in place. This is too long for a young person that is in crisis.</td>
</tr>
<tr>
<td>I am unaware of the provision, and I do not think teachers are trained or equipped to deal with mental health issues for Primary aged children.</td>
</tr>
<tr>
<td>Does this apply to all schools in Southampton inc faith and or independents? And ban / stop mobiles at schools. Would enhance and improve e safeguarding and then wellbeing no end. Sch reception more than capable of dealing with urgent messages. This needn't effect use of tech in teaching and paperless communication etc.</td>
</tr>
<tr>
<td>The current headteacher at [school name deleted] likes to gaslight the kids, he is toxic and the reason so many teachers are leaving.</td>
</tr>
<tr>
<td>A first step would be to stop attendance awards and putting so much pressure on children to be at school when they are ill. And those tests that do nothing but cause stress for such young children. Start with removing the sources of stress that are unnecessary. It truly is ridiculous to discuss mental health support when we have so much in place that causes stress that can just be removed/changed.</td>
</tr>
<tr>
<td>More emphasis needs to be put on good mental health and reducing academic pressure</td>
</tr>
<tr>
<td>It should be part of a multi discipline team- speech therapist, mental health, occupational health, counseling etc.</td>
</tr>
<tr>
<td>Just more availability of specialist assistants.</td>
</tr>
<tr>
<td>The last 4 years have been traumatic and devastating for my D, it has had an impact on family life and you always feel that you are being judged by school, social services and camhs, they feel that it is poor parenting, when we have multiple challenges to navigate</td>
</tr>
<tr>
<td>unrealistic expectations from DfE, high pressure on teachers and management, overcrowded schools and classroom and growing debts on schools means that the necessary fool range of resources needed to identify</td>
</tr>
</tbody>
</table>
and support the kids in need of mental health support are not available. There is provision for Special Needs children but none for the More Able' ones, consequently they are not supported and intellectually stretched according to their abilities and this can lead to severe mental health issues. Comment from experience.

Schools do not seem to understand severe anxiety very well. Teachers aren't trained properly in mental health conditions and how to support the child in class. They need to listen to the parents more. Schools should teach about emotional resilience and mindfulness.

There should be specialist staff available and teachers should have support from extra staff

The biggest problem I see with it is lack of available funding. If central government hadn't cut funding for so much, for ideological reasons, councils would have enough money to fulfil their statutory requirements adequately, as it is however I feel that social services in the city are a disaster waiting to happen...

CAMHS are shockingly underfunded and the waiting times are leading to added distress and illness for children and potential family breakdowns and affecting learning outcomes. Local Authorities and the NHS should feel ashamed about their performance in this. As the bar is raised to reduce referrals, the children falling through the cracks are being left with insufficient support leading to increased needs that may meet referral criteria eventually but with a great deal of unnecessary suffering along the way. I myself am having to give up a good job in order to take a less stressful role to support my child. This means selling our home and moving into rented accommodation.

Early intervention CAMHS workers in every 2ndary school, should have got the Headstart bid!

The only mental health help the school has mentioned is the ELSA, but I am not aware of anything other than this.

All school workers should receive up to date information/skills in all areas of mental health

It should be discussed more openly and more often with children and their parents

I don’t know whether it is the school’s responsibility and I’m sure they try their best, but I have a few concerns about my older child’s resilience and mental wellbeing. I have no idea where to find help. I don’t want to make it a big deal, but I do feel a bit lost and not sure whether I should be worried. School is the obvious place to support parents with low level mental health concerns about their child. But poor support is probably worse than no support. I would love to have an opportunity for a ‘triage’ talk on a one-to-one basis.

I think all schools should have access to psychologists (not just educational psychologists) who can help teachers and other staff understand how best to deal with mental health challenges in children. There is too often a behavioural approach in schools without an understanding of underlying issues, which is actively harming children's mental health. My family has significant experience of this.

My child has sought support. I'm not sure how seriously it was taken

It’s difficult to know what’s ‘normal’ for a child and when exactly to ask for help without either making things worse or making a fuss

College students are not helped enough on the impact the extra studies have in their life. They are treated too much like adults when they are still children really. This in turn has a major effect on mental health as they do not get enough support with the transition of secondary to college.

It has usually been a battle to get any real support. The schools say they have a strong commitment to child welfare, but it has taken a lot of time and effort to get anything, especially for the children attending Hampshire schools because we live in Southampton.

A strong eye needs to be kept on the welfare of students especially in the run up to GCSE exams. Sometimes it seems to me that the push for better and better grades takes precedence over the mental health and wellbeing of pupils. Two young people have committed suicide at my son’s school in recent years. This is extremely worrying.

The question above only allows one answer but I would like all of those things to be available to children who need it through school. As a paediatrician I see lots of children with mental health issues that if dealt with in a non-threatening and timely manner, might not get so serious and be manageable through family and school support.

I think that RPCC offers excellent pastoral support and then a good range of mental health and wellbeing support should students need it. I also think that sometimes parents expect the school be responsible for everything rather than attempting to take responsibility themselves.

Keep it in perspective and tailor support to individuals where they clearly have problems. Don’t just jump on it because it is the current bandwagon and try to apply blanket support or policies when they are not necessary or appropriate
Bullying at [deleted school name]. This was not handled well. The bully went on to be appointed deputy head boy, this left my child with a rather cynical attitude to authority.

The provision for children is scandalously poor and feels at time only a crisis will trigger support.

I feel every school should have a nominated and trained member of staff dedicated to pupil welfare issues that is contactable by parents and will be allocated enough time to engage with parents who need help.

I am worried about my eldest child but it is too low level to get CAMHS service so I don't have a clue where to go to get information and/or support.

Good Mental Health is something we should all take more seriously.

You’re child has to be willing to engage before anything is offered which is not always going to happen at first if they are particularly low. I referred my child to brook vale age 14 but because he wasn’t overly willing they said they would not take it on even tho there were trained counsellors who could work with him to help him talk about issues, again not enough funding and serious lack of available help.

There needs to be a lot more support out there for children as it is on a downward path.

Just to know what the school provides as I don’t have any current knowledge of this it is currently patchy, school staff change every 5 minutes, funding gets cut, no consistency, no communication, parent seen as unimportant. if you are going to do it, do it properly or stop pretending and give us all a break.

Schools need to stop testing kids. For every test, 50% will be form below average. That sets these poor kids up to fail. Academic ability is not the only important skill schools should teach, and any testing to assess the academic teaching performance of the school should have pupils results anonymised so pupils cannot be made to feel under stress.

I don’t expect schools to be experts in children’s mental health, but I do expect them to know my child well enough to spot when something is out of kilter, and for them to care enough to work with the child and their parents carers (if they want that) to intervene early to address it.

I would like to see some information in the National curriculum regarding mental health and wellbeing, including some self help strategies.

Not everyone has mental health issues so let’s not create problems that don’t exist.

[deleted school name] SEND unit is brilliant.

Cahms is a very slow referral process when children are in crisis.

More access to no limits. Trained staff on mental health issues. Focus on well being rather than grades.

I think schools are being inadequately supported financially to provide the support that children and young people need. I feel the amount of pressure children are placed under from Year 2 Sats onwards means schools will feel the pinch and be unable to help as much as they should be able to.

We should as a society be investing and focusing on mental health awareness and support in schools. There is not enough funding for schools to be able to do so within their allotted budgets.

Counselling services. access to CBT if needed.

would expect access to in-house counselling and regular drop in sessions available. discussion with children on recognition of conditions in themselves and others, and how to get help- either for themselves or as support for friends.

My son has ADHD and O.D.D and struggles with large group so smaller classes would help.

the question about the impact of the school on my child’s mental health did not have an appropriate answer so I have selected neither this is because it both adversely and positively affects them. All my children went to great schools that worked very positively but the national agenda of targets and progress data is felt strongly by children and has a detrimental impact on their mental health. My children would not want their mental health supported in school no matter how good the service as it is not a place they feel should be dealing with medical issues. They would not want their teachers and their friends to know they were accessing this service. School hours also make it very difficult for working parents to access this help.

Not enough help in schools, Camhs is too slow responding.

Our school is very well supported.

My child is still young (4) and happy, haven’t considered a need for mental wellbeing support yet, but glad that this is being considered. However the question on how I’d prefer to engage is nearly impossible to answer as it will always depend on the situation.

Mental health is a wide area of need, in my opinion and as a mum of 3 children with mental health illnesses I feel school try very hard to meet the needs of the child within school however there are not enough staff to
cover assisting the child when they are hitting a crisis point before they reach the point where things has escalated out of control, unfortunately this means that a a parent the first communication recieved is a demand to collect the child or come into school, ehen in fact with closer monitoring these issues could be picked up long before this point, which is damaging to both staff and pupil relationships and classroom learning and yet also destroys the confidence that the child has to believe in there ability to cope and feel 'able' to cope with the school and classroom set up and surroundings. Little and often a little time and understanding is much more beneficial to help things run smoothly than heavy sanctions and extreme discipline as the pupil then feels staff are more approachable before they hit a 'distraction point causing the outbursts in school that are so often seen.

Teachers can play an important role in supporting children mental health and couselling and support

There should be more support or some one for them to talk to

I feel all children should know there is someone they can talk to and get support no matter the age while in school. Also have chances for parents to connect with their children’s mental health

I think local charities such as no limits should be offering support to junior schools not just senior. Children should have independent people outside of school to talk to.

I think that more of their PSHE should focus on dealing with emotions/ stresses etc to help all develop strategies to manage their own health and well being more effectively.

I do not believe there is enough support for mental health in mainstream secondary schools which is one of the reasons my son attends a specialist mental health school. There is also not sufficient maintained specialist schools for mental health leading to my 1st son requiring to attend a private school

I been to doctor they say its down to school to diagnose, I go to school and they say its down to doctors. My daughter was supposed to be accessed a year later after coming off cin. They have cause problems with kids mental health and anxiety. And kid are under alot of pressure at school and not just the work its other children with mental health who are unbearable to be around and the violent nasty behaviour effects other childrens self a steem and confidence and behaviour the bullied turns into bullies

I have a friend who works within mental health and does work for the BBC too. He would be interested in bringing mental health talks to parents and students within Southampton schools.

I would like to see much more support around exam time.

[deleted school name] needs more than 1 counsellor

I think that the increased emphasis on building mental wellbeing is great, and ongoing information programmes & other things that help to prevent issues should be encouraged. I am not sure how to determine priority of provision of interventions so that it is not just down either to who makes most noise, or who the teachers have a soft spot for, but some system that is clear to the pupils and seen to be equitable needs to be in place

As I run the pastoral team in a Hampshire Infant and Junior school I am very concerned about the rise in children needing support for mental health issues. I am fortunate to have a wonderful centre to work from and have 2 other team members, this isn’t the case in many schools. I feel all schools must see mental health and well being to be as important as results. I believe every school should have a trained mental health first aider. The problems are only going to get bigger and the need is continuing to rise at a worrying rate. Schools now seem to be the answer for everything with GPs, paediatricians and child protection plans all referring to ELSAs and FEIPs practitioners. Much more training needs to be put into place, (something that I would be very open to) with issues around gender identity, LGBT, self harm to name a few. These issues are now starting in primary school. We have to invest in this area but with all the budget cuts all I hear is colleagues in other schools having their pastoral hours cut. This can not be right.

Children need to be able to talk to a teacher they trust, who will not judge them. They should be able to pick a mentor/tutor who could be approached in times of need. The person assigned by the school is not always the best person for ever child.

I think all schools should have properly trained counsellors onsite to assist in mental health well being

No I am happy with the mental help provision at both of my children’s schools. Thankfully, so far I have not needed to really use any of it - but am happy for the info they provide

I think we need more it

My child has no mental health issues, yet many children seem to have anxiety and depression and get alot of allowances made for them such as exit passes and disruption to lesson time. Whilst [deleted school name] is very tolerant and accepting of these things sometimes I feel the children who do not have issues have to put up with alot when their education is just as important.
Teachers should recognise signs of a mental health problem with students and should ensure that support offered is well known within the school, fully accessible and approachable. Teachers should be sympathetic and supportive of students who approach them for help and should do all they can to improve the student’s wellbeing, especially by ensuring the student is believed and listened to, rather than blamed for their own issue.

My second child suffers from severe anxiety and has not really been given the help and understanding I feel she needs, even though the school is aware and I have spoken with them on numerous occasions. Apart from offering a local child’s charity to come in for counselling with her that is it, My child would not benefit from this as she struggles to communicate with other people that she doesn’t know or trust. I feel there should be other options available, like some sort of work shop on tools to help her cope with her anxiety and for us as parents as well so we can help her.

If you include in mental health obesity and the effect it has on self esteem and body confidence Southampton is severely lacking in any support for children and parents in this. It would appear there are no groups to join so that children with this issue can get together and feel they are not alone. Little support exercise wise either until the age of 16.

Schools should be able to help children who have problems with one to one support. All you hear is that the funds are not enough.

We have managed low and moderate level mental health issue for our younger child at home with literature and our own professional expertise, but this child is soon to start secondary school and is likely to require input from other sources over the next few years. We have expertise and literature ourselves, but availability of anxiety management and counselling/mentoring-autism mentor/social skill training for adolescents on autistic spectrum with or without parent involvement as appropriate to age, would be the sort of help we would anticipate needing/benefitting from.

Children don’t always want to access via school, they want some privacy and confidentiality. My middle child has severe mental health or physical problems where she is too tired to attend school and averages less than a day a fortnight, I can’t get meaningful help for her, her GP says “it’s a shame” but can’t offer help, we’ve been waiting for help from CAMHS for about a year, during which time she has deteriorated further and missed over a year of education.

The school need proper mental health professionals such as school nurse, no limits, Camhs staff. Teachers are out if there depth with mental health and have been out of there depth when faced with a child with anxiety. The school nurse was the only one to help and yet you are reducing there numbers!!!!

Being a teenager can be very difficult, also the parent if a teenager. I have NEVER received and information about mental health for my children.

I don’t have any complaints regarding my own children but I know some other families have experienced some problems due to the lack of knowledge some of the teachers have about how to deal with some mental health issues experienced by children. This is not necessarily the teachers fault but I think that more about recognising and dealing with these types of mental health issues for children should be included in teacher training.

I don’t think schools offer any mental health support at all. My kids come and talk to me about things their friends and them are going through but they don’t get support and teachers are not equipped to notice these things in children. I am more alert because I am a psychologist and have worked with mental health patients. But a parent without this background would have no clue of what even mental health is. They only understand mental health in terms of psychosis. For example How many families separate or divorce? How many children are affected by this? when schools get to know what support is there for these sort of children?

It’s not always easy to spot mental health issues with children and there are so many factors that contribute to this. I think having closer contact with parents if often the key issue and many problems stem from family situations. It becomes about the whole family and not just the child so more specialist support that can do this.

My second child was referred by the schools mental health nurse to CAMHS. Both she and I were amazed she was refused help. More provision needs to be made to help children before their problems escalate. Intervention should be at an early stage not when a crisis is reached.

There does not appear to be any support other than for child with an EHC plan and even that is limited. St Anne’s in particular has been very difficult to deal with in respect of the issues my daughter has had during the last year. I found No Limits for myself and they have been very helpful with my daughter in year 7 although [deleted school name] are not happy that she goes out of school for counselling (As on their emotional literacy test she scores highly and they perceived me as an over protective parent who was the cause of her anxiety; no limits assessed her and found school to be the root of her issues). At [deleted school name] my son said he had self harmed which was not the case and he was given no support and it was brushed under the carpet. Both these are my birth children but as a family that foster my kids have been exposed to stuff that their friends no
nothing about and although we support them as best we can it has been impossible to get either of their schools to see that this has an impact on them and they have no provision for checking in on them. (I feel they need an adult they can talk to when they don’t want to say how they are feeling at home as they do not want to burden us further). This was provided with their Primary school but could not continue into secondary school

I feel that I was heard & supported & ideas to help were good. It really helped my daughter.

More information about the support available in the school, is a very difficult time for the children at that age and honestly I don’t think they have the right support in the school. It’s an age group where they think they can do it alone but the results shows different outcome. They’re not ready for the next step in education and the stress that come with it. My eldest daughter started to self harm and I wasn’t aware of it and I spent night encouraging her and no support was available to her before she went to university. I know it was another school but I’m concern that it could happen to my other daughter. Thank you for your effort to prevent this situations to repeat again.

I think children should be given more information in the class & also from posters & leaflets around the school giving them details who they can contact & talk to.

unbalance among staff in understanding mental health and applying strategies

In our case, schools have the challenge of dealing with disruptive children causing an impact on other children and that is difficult to manage.

I would prefer to know who I would need to go to and hopefully the children already know this as a problem shared is always the first step to resolving a problem

I know the school has an ELSA, but have never had to use it. Apart from that I don’t know of anything else the school does.

Our eldest child received one-to-one support and other interventions at the school’s initiative. This has been very beneficial. I am confident this has prevented bigger problems down the line. Our child is currently doing well without extra support.

Every child show anxiety in a different way. The school teachers need to pick up on that and find different techniques to access the child. Even though schools have these enrichment programs it doesn’t really connect with the child. However private information needs to be given to children knowing that they are going to 100% back they child up. Sometimes things need to be shared that others needn’t to know or things shouldn’t be shared for the confidence of the child to rise knowing that others are not going to use it against them.

To much testing with out support for for children’s mental heath.

The support received did not result to a solution via nhs

Schools can educate parent and pupil to identify symptoms identified with mental health

It needs to be easier to access; more provision needs to be available; and it is VITAL that support is not withheld until a crisis is reached - it needs to be be put in before this point

Just to be clear, I think the school supports mental health and well being as best they can with the resources available but all schools need more support in this area. I think the schools does exceptionally well at keeping pressure away from the children with the SAT tests etc but essentially our curriculum is not working as it’s creating mental health problems by adding pressure onto the children which shouldn’t be there.

Teachers and tutors need more awareness of the childrens' wellbeing as well as their grades, so issues can be picked up quicker

If you can offer me a course about this type of Problems-Children Mental health, I will go for. Even if this will be Webinaria-online course.I can realise how important is it for our children.

I believe that meditation in schools might benefit young people with mental health conditions, or for any children with cope issues, before it becomes a problem.

I feel the school are good at saying what they are able to offer pupils but actually offering children the support is another thing.

Schools need to be aware that mental health also includes bereavement. Given that this was the situation for my child, it is heartening to note that with a change of leadership at the school, this is being incorporated much more readily.

There are not enough school counsellors for all the children who need it. It would be good to have a variety of different support options and one size dosent fit all when it comes to complex mental health issues. I would also like to see an emphasis on mental wellbeing and positive thinking for all.

Only support the see my child with teacher on the class

Primary schools are more assessable for communication than secondary.
Would probably go to the Gp and get help this way. If I were to go through the school I would have big concerns that this would label my child and be on a record for the rest of their school life.

Many children are bullied at all schools and the more classes on this the better.

In senior schools, I think it would be good to know there are councillors available when they first start. e.g. in paperwork.

There is massive inconsistency between teachers and quite a few do not seem to understand what autism is and the impact on girls’ mental health.

I would like to think that my child’s school has a stable support and that the school is actually doing some follow ups to check how the children are progressing.

I have no clue about school’s mental health support. Recently someone stole a phone from my daughter’s bag during PT session. She inform the school teacher but she did not get any information or progress on that matter. I can clearly see that she fells not been supportive.

**Schools mental health survey results**

The survey was distributed using an online link sent to head teachers or PSHE leads of schools across Southampton. The survey had a total of 24 respondents. The survey was open 25th May – 29th June 2018.

<table>
<thead>
<tr>
<th>Type of school</th>
<th>Number of respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary</td>
<td>14</td>
</tr>
<tr>
<td>Secondary</td>
<td>7</td>
</tr>
<tr>
<td>Special</td>
<td>3</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Do you have a designated lead for mental health?</th>
<th>Number of respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>Primary: 5  Secondary: 3  Special: 2</td>
</tr>
<tr>
<td>No</td>
<td>Primary: 7  Secondary: 2  Special: 3</td>
</tr>
</tbody>
</table>

**What is the remit of the mental health lead in your school?**

<table>
<thead>
<tr>
<th>Remit of mental health lead</th>
<th>Number of respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Liaising with specialist mental health services</td>
<td>Primary: 2  Secondary: 2  Special: 6</td>
</tr>
<tr>
<td>Coordinating and developing mental health provision</td>
<td>Primary: 4  Secondary: 3  Special: 5</td>
</tr>
<tr>
<td>Teaching pupils about mental health and wellbeing</td>
<td>Primary: 1  Secondary: 3  Special: 5</td>
</tr>
<tr>
<td>Training staff</td>
<td>Primary: 2  Secondary: 4  Special: 2</td>
</tr>
<tr>
<td>Supporting individual pupils</td>
<td>Primary: 5  Secondary: 5  Special: 5</td>
</tr>
<tr>
<td>School type</td>
<td>What training has the mental health lead had?</td>
</tr>
<tr>
<td>-------------</td>
<td>---------------------------------------------</td>
</tr>
<tr>
<td>Primary</td>
<td>Emotional First Aid Trainer and Leading a Mentally Healthy school</td>
</tr>
<tr>
<td>Primary</td>
<td>General SENCo training, no specific mental health training</td>
</tr>
<tr>
<td>Primary</td>
<td>Introduction to mental health run by CAMHS</td>
</tr>
<tr>
<td>Primary</td>
<td>Primary Mental Health Forums with CAHMS, Attachment awareness with EP service</td>
</tr>
<tr>
<td>Primary</td>
<td>Safeguarding training / SENCO training</td>
</tr>
<tr>
<td>Secondary</td>
<td>Mental Health First Aid, EFA for Parents and Young People.</td>
</tr>
<tr>
<td>Secondary</td>
<td>All that has been offered via the mental health forum for both Southampton and Hampshire</td>
</tr>
<tr>
<td>Secondary</td>
<td>DSL training, no specific mental health training</td>
</tr>
<tr>
<td>Secondary</td>
<td>DSL training; CAMHS Mental Health Awareness course; CBT Level 3 E learning; Child Counselling; RSE - Relationships and Sex Education (through Royal South Hants); Domestic Violence and Abuse E learning.</td>
</tr>
<tr>
<td>Secondary</td>
<td>WEEKLY COURSE RUN BY CAMHs</td>
</tr>
<tr>
<td>Special</td>
<td>mental health awareness course/safeguarding courses/first aid mental health course</td>
</tr>
<tr>
<td>Special</td>
<td>A wide variety of courses including emotional first aid, bereavement, anxiety, depression, resilience, self esteem, Nurture Groups, reflective practice, restorative approaches</td>
</tr>
<tr>
<td>Special</td>
<td>Minimal</td>
</tr>
</tbody>
</table>
Note that the Primary mental health workers and Emotional health and wellbeing workers are not available in primary schools so these respondents represent a misunderstanding in terms by those completing the survey.

What sessions and activities to promote positive mental health and wellbeing among all pupils do you have?

<table>
<thead>
<tr>
<th>Activity</th>
<th>Number of respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assemblies</td>
<td>13</td>
</tr>
<tr>
<td>Emotional Literacy Support Assistants (ELSA)</td>
<td>13</td>
</tr>
<tr>
<td>Dedicated timetabled PSHE lesson</td>
<td>8</td>
</tr>
<tr>
<td>Sessions on particular issues</td>
<td>9</td>
</tr>
</tbody>
</table>
| Support services coming into school for specific pupils | 6
| Nurture groups                                | 6                     |
| A worry box/ drop-in for advice and signposting | 7
| Cover mental health and wellbeing in other lessons | 5
| Peer-mentoring/support                         | 4                     |
| Activities to reduce stigma around mental health issues | 3
| Tutor time                                    | 5                     |
| Skills sessions                               | 2                     |
| Other                                         | 1                     |

Which of the following mental health support services are available in your school?

<table>
<thead>
<tr>
<th>Service</th>
<th>Number of respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>SEN (Special Education Need)</td>
<td>14</td>
</tr>
<tr>
<td>School nurse</td>
<td>13</td>
</tr>
<tr>
<td>One-to-one support for specific issues</td>
<td>12</td>
</tr>
<tr>
<td>Educational psychologist</td>
<td>13</td>
</tr>
</tbody>
</table>
| Signposting to support services (outside school) | 7
| Emotional health and wellbeing worker        | 7                     |
| Signposting to support services (in school)  | 7                     |
| Support groups                               | 5                     |
| STAR Yellow Door (domestic and sexual abuse) sessions | 5
| Saints Foundation sessions                   | 5                     |
| Early help nurse                             | 4                     |
| Early intervention practitioner              | 3                     |
| Primary mental health worker                 | 3                     |
| Peer support                                 | 2                     |
| Solent Mind sessions                         | 2                     |
| Emotional Literacy Support Assistants (ELSA) | 2
| Cognitive Behavioural Therapy                | 1                     |
| Other                                        | 1                     |

Other

- Mental Health and Safeguarding weeks in July - work with Solent Mind Charity and MET Hub on esafety alongside school nursing team and workshops for parents
- Non teaching Heads of Year instead of drop box
- Trained staff delivering SEAL lessons every week to every child

Other

- ELSA tick list
  - Strategic opportunities for staff to raise ‘children of concern’ at weekly staff meetings. These concerns are recorded in staff minutes with a plan for action agreed
### Who delivers learning relating to mental health and wellbeing curriculum in your school?

<table>
<thead>
<tr>
<th>School Type</th>
<th>External Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary</td>
<td>Yoga teacher who is a parent/Sports Leaders via Team Spirit/NSPCC lady came in reassembly</td>
</tr>
<tr>
<td>Primary</td>
<td>Various agencies over the year</td>
</tr>
<tr>
<td>Primary</td>
<td>Solent Mind, School Nurses, CAHMS</td>
</tr>
<tr>
<td>Primary</td>
<td>Solent Minds</td>
</tr>
<tr>
<td>Secondary</td>
<td>No Limits also offer group support with Emotional Health and Well Being</td>
</tr>
<tr>
<td>Secondary</td>
<td>STAR, MIND, No Limits</td>
</tr>
<tr>
<td>Secondary</td>
<td>Yellow door, NSpcc and others</td>
</tr>
<tr>
<td>Special</td>
<td>Mental Health Nurse</td>
</tr>
<tr>
<td>Special</td>
<td>Jigsaw trained nurses</td>
</tr>
<tr>
<td>Special</td>
<td>We use many different avenues to met need</td>
</tr>
</tbody>
</table>

### Which of the following aspects of mental health and wellbeing are addressed?

<table>
<thead>
<tr>
<th>Aspect</th>
<th>Number of Respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dealing with feelings</td>
<td>14</td>
</tr>
<tr>
<td>Friendship</td>
<td>13</td>
</tr>
<tr>
<td>Anxiety</td>
<td>13</td>
</tr>
<tr>
<td>Mental and emotional wellbeing</td>
<td>13</td>
</tr>
<tr>
<td>Road safety</td>
<td>13</td>
</tr>
<tr>
<td>Body image</td>
<td>12</td>
</tr>
<tr>
<td>Promoting good sleep</td>
<td>8</td>
</tr>
<tr>
<td>Alcohol</td>
<td>7</td>
</tr>
<tr>
<td>Strategies for saving face while saying no</td>
<td>7</td>
</tr>
<tr>
<td>Financial literacy and debt</td>
<td>5</td>
</tr>
<tr>
<td>Accessing healthcare including emergency...</td>
<td>4</td>
</tr>
<tr>
<td>Addiction</td>
<td>4</td>
</tr>
<tr>
<td>Other (please specify)</td>
<td>4</td>
</tr>
<tr>
<td>Building resilience and self esteem</td>
<td>3</td>
</tr>
</tbody>
</table>
How do you identify pupils with particular mental health or emotional wellbeing needs?

- **Ad Hoc based on information received from parents/carers**: 14 respondents
- **Ad hoc based on teachers concerns**: 14 respondents
- **Ad hoc based on info received directly from children**: 12 respondents
- **Ad hoc based on behaviour monitoring**: 12 respondents
- **Ad hoc based on other staffs concerns, e.g. school nurse**: 12 respondents
- **Use of admin data collected for other purposes**: 10 respondents
- **Assessment of MH needs alongside other assessments**: 6 respondents
- **Use of information from external agencies**: 3 respondents
- **Targeted screening**: 7 respondents
- **Universal screening**: 7 respondents
- **Other**: 1 respondents

How many pupils on average self-report mental health and wellbeing issues per month?

- **Fewer than 5**: 11 respondents
- **5 to 9**: 2 respondents
- **15 - 19**: 2 respondents
- **10 to 14**: 2 respondents
- **20 - 24**: 1 respondent
- **More than 30**: 1 respondent
How does your school monitor the impact of mental health support provided to pupils?

Yes, it monitors the impact of all support

Yes, it monitors the impact of some support

No, it does not monitor

If there is a counselling service running within your school, what is the usual waiting time to be seen?

1 to 7 days

1 to 4 weeks

More than a month

If there is a counselling service run directly within your school as part of your pastoral care to pupils, what qualifications do the counsellors hold?

N/A (the school does not have a directly run counselling service)

Other professional qualification or registration

Diploma in Counselling

Registered with professional body

If there is a counselling service running within your school, what is the usual waiting time to be seen?

1 to 7 days

1 to 4 weeks

More than a month

School type

How does your school monitor the impact of mental health support provided to pupils?

Primary

Communication with child / parents  ELSA work is monitored with before/after checklists.

Primary

tracking attendance, behaviour, in class performance

Primary

Reports from outside agencies eg CAHMS and from staff.

Primary

Review meetings and communication via CPOMS of outcomes of sessions etc

Primary

Discussions with pupil and adults who support child, sliding scales, behaviour monitoring, observations in class and NFERNELSON emotional literacy assessment and intervention toolkit

Primary

ELSA monitoring  Counsellor reports termly

Primary

ELSA support - forms are filled out before and after session to see where person fits on a sliding scale.

Primary

Emotional Literacy Checklists Monitoring of behaviour change in class and around the school

Primary

Use of CPOMs online recording system  Intervention overview and planning records with own monitoring scales Pupil Progress meetings and case studies
<table>
<thead>
<tr>
<th>Primary</th>
<th>In house support monitored thorough SENDCO and HT through outcomes and conferencing with pupils as well as incident reports, parent feedback and child feedback</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary</td>
<td>Pupil conferencing, 0-10 scale</td>
</tr>
<tr>
<td>Secondary</td>
<td>Progress data, behaviour reports, emotional literacy assessments, attendance</td>
</tr>
<tr>
<td>Secondary</td>
<td>Recorded onto CPOMS system any emotional support sessions conducted with in school, mental health concerns, assessments, services contact or being used.</td>
</tr>
<tr>
<td>Secondary</td>
<td>Regular meetings with all providers, where we review the support and the students accessing services. Regular weekly meetings with Head of Year, Support Staff, Attendance, Police and EWS.</td>
</tr>
<tr>
<td>Secondary</td>
<td>Attendance, behaviour and progress data. Conversations with Heads of Year centred around pupil happiness.</td>
</tr>
<tr>
<td>Secondary</td>
<td>Feedback sheets done regularly with the pupils. Conversations with HOYs and Pastoral Team</td>
</tr>
<tr>
<td>Secondary</td>
<td>Track students. Internal RAG system for progress and well being. (New System) Monitoring of Mental Health and Self Harm incidents using CPOMS Communication with the child and family and outside agencies as appropriate Currently considering a new form of online self help/support for students in future</td>
</tr>
<tr>
<td>Special</td>
<td>Individual 'talk' sessions following external CAHMS sessions</td>
</tr>
<tr>
<td>Special</td>
<td>By communicating with agencies. Working with the students and making them evaluate the support offered. SNAP B Profile as a measureable tool to show impact and outcomes. ELSA check list.</td>
</tr>
<tr>
<td>Special</td>
<td>Discussion with staff; assessment of planned interventions on Individual Education Plans, reviewed every six weeks; Review of EHCP plans; consultation with CAMHS specialist staff for individual cases; use of Emotional Literacy screening; use of Nurture Group placements. During CPD sessions delivered by consultants.</td>
</tr>
</tbody>
</table>

How do you engage parents/care givers with mental health and wellbeing at your school?

<table>
<thead>
<tr>
<th>Activity</th>
<th>Primary</th>
<th>Secondary</th>
<th>Special</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provide them with info about supporting pupil’s mental health</td>
<td>6</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Interventions for pupils that include parents</td>
<td>12</td>
<td>12</td>
<td></td>
</tr>
<tr>
<td>Face-to-face sessions for parents on young people's mental health</td>
<td>10</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Sharing info on the institutions mental health plan and provision</td>
<td>5</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>One-to-one support (e.g. counselling) for parents</td>
<td>3</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Other</td>
<td>2</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Number of respondents

- Primary
- Secondary
- Special

Other

- Discussions with parents.
- Parent workshops on supporting children
Are you accessing the School Mental Health Forum facilitated by Solent CAMHS?

<table>
<thead>
<tr>
<th>School type</th>
<th>If no, why is this?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary</td>
<td>Didn't know about it</td>
</tr>
<tr>
<td>Primary</td>
<td>Don't know dates for forum sorry</td>
</tr>
<tr>
<td>Secondary</td>
<td>Don't know what it is</td>
</tr>
<tr>
<td>Primary</td>
<td>Had not been made aware</td>
</tr>
<tr>
<td>Secondary</td>
<td>I would like more information on this. I believe one of my colleagues has attended some CAMHS training/support work but unsure if this is the same program.</td>
</tr>
<tr>
<td>Primary</td>
<td>Not heard of this</td>
</tr>
<tr>
<td>Primary</td>
<td>Only heard about it a few weeks ago from a colleague and unable to attend due to work commitments (meetings already booked in).</td>
</tr>
<tr>
<td>Primary</td>
<td>Our school might be but I personally have no idea what the School Mental Forum is and have had no direct dealing with CAMS. This is usually via SEND request.</td>
</tr>
</tbody>
</table>

How useful do you find the School Mental Health Forum?

<table>
<thead>
<tr>
<th>Usefulness</th>
<th>Number of respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very useful</td>
<td>Primary: 2, Secondary: 2, Special: 1</td>
</tr>
<tr>
<td>Quite useful</td>
<td>Primary: 4, Secondary: 2, Special: 1</td>
</tr>
<tr>
<td>Neither useful nor useless</td>
<td>Primary: 1, Secondary: 1, Special: 1</td>
</tr>
<tr>
<td>Not very useful</td>
<td>Primary: 1, Secondary: 1, Special: 1</td>
</tr>
<tr>
<td>School type</td>
<td>What are your reasons for this?</td>
</tr>
<tr>
<td>-------------</td>
<td>--------------------------------</td>
</tr>
<tr>
<td>Primary</td>
<td>Good for advice and support</td>
</tr>
<tr>
<td>Primary</td>
<td>Networking, resources</td>
</tr>
<tr>
<td>Primary</td>
<td>Opportunities for peer supervision, discussion of current issues / needs seen in schools, opportunities to feedback, talks by professionals on different areas of mental health</td>
</tr>
<tr>
<td>Primary</td>
<td>Really good to keep up with what is happening in CAMHS and useful documents can be shared. Also a chance to talk to other colleagues and receive up to date information about mental health issues. Sometimes it is easier to get answer via the forum than trying to get hold of clinicians at CAMHS.</td>
</tr>
<tr>
<td>Secondary</td>
<td>The mental health forum is perhaps attended by the wrong person in the school and this needs to be reviewed, to ensure that this is the effectively used.</td>
</tr>
<tr>
<td>Secondary</td>
<td>Good to meet other professionals and discuss best practice. Good one stop shop to share information and new practice.</td>
</tr>
<tr>
<td>Secondary</td>
<td>Information shared. Contact direct with CAMHS. Presentations given by therapists within forum. Networking with other schools. supervision support. Awareness and updates of where to signpost.</td>
</tr>
<tr>
<td>Secondary</td>
<td>It has varied in quality but it has recently signposted us to more services which we can then filter back to parents. Gives us an idea of how mental health needs are met in other schools. It has not always been well attended by other schools. We have religiously attended from its outset</td>
</tr>
<tr>
<td>Special</td>
<td>to be able to have ideas and resources open to use. also, giving us information when it is available.</td>
</tr>
<tr>
<td>Special</td>
<td>Very early stages to report either way</td>
</tr>
<tr>
<td>Special</td>
<td>We are aware of both primary and secondary forums and have attended both in the past. However, the needs of our pupils tend to be more extreme, so they don't really meet our need. However, they are really useful for mainstream schools.</td>
</tr>
</tbody>
</table>

---

Would you consider... Pooling resources with other schools and health/local authority to provide joined up/co-ordinated support?

- Yes: 23 respondents
- No: 1 respondent

One secondary school said no

Would you consider... Buying additional services over and above those already provided by others to extend/expand existing services in a co-ordinated way?

- Yes: 19 respondents
- No: 4 respondents

3 primary schools and a special school said no
Does your school require any support preparing for statutory Relationships Education from September 2019?

<table>
<thead>
<tr>
<th>School type</th>
<th>Please tell us more below:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary</td>
<td>I am a new PSHE lead from this year and work 3 days a week. I want to ensure we are covering all that we should do. I am quite out of touch with where to access help within the city so would be keen to catch up or have more training so that I can then promote more about this within school. I have noticed that it is not applicable for primary schools as per the tick list above but feel I need to know what statutory ideas are going to be in place to ensure our junior addresses all the needs of chn before they move on to secondary.</td>
</tr>
<tr>
<td>Primary</td>
<td>Would be very helpful to have a workshop (FREE!) to outline changes required</td>
</tr>
<tr>
<td>Primary</td>
<td>New staff</td>
</tr>
<tr>
<td>Primary</td>
<td>Videos that we use are so out of date. Showing the Channel 4 video is now not appropriate but we have no up to date multi media presentations to use with parents and children. Work with parents</td>
</tr>
<tr>
<td>Secondary</td>
<td>I believe that any support or training would benefit staff in school be it our PSHE coordinator or DSL/Pastoral staff.</td>
</tr>
<tr>
<td>Secondary</td>
<td>We need support with raising awareness of self harm with young people and coping mechanisms around this. This needs to be implemented by PHSE teachers.</td>
</tr>
<tr>
<td>Secondary</td>
<td>It would be useful to standardise the expectations from all schools across the City and share resources. All help and support gratefully received</td>
</tr>
<tr>
<td>Special</td>
<td>It would just be good to ensure what we are doing in school is in line with the latest guidance/thoughts</td>
</tr>
</tbody>
</table>

6 primary schools, 4 secondary schools and 1 special school said they need support to prepare for the statutory relationships education from September 2019.
Why is this?

| Choice/awareness of PSHE subject lead | Currently recruiting new PSHE leader - will attend once in post. |
| Did not know it existed | Did not know they were still occurring as well as overall capacity being a small school. |
| Didn’t know about this | Didn’t know about it |
| didn’t know there was one | Difficulties in accessing due to work commitments. |
| Don’t know anything about it! | Unaware of locations and dates |
| Unsure, so have ticked no. Need to check with subject lead. | |

Are you aware that the Southampton PSHE Teachers network has been working with Public Health commissioners and other organisations who can support schools in the teaching and delivery of PSHE/ RSE to develop a City specific PSHE/ RSE Curriculum of Study covering Key Stage 1 to Key Stage 4?

3 primary schools, 2 secondary schools and 2 special schools have said they are aware that the Southampton PSHE Teachers network has been working with Public Health commissioners and other organisations who can support schools in the teaching and delivery of PSHE/ RSE to develop a City specific PSHE/ RSE Curriculum of Study covering Key Stage 1 to Key Stage 4?
What support is there for the mental health and wellbeing of teachers and other staff working in your school?

<table>
<thead>
<tr>
<th>Support</th>
<th>Primary</th>
<th>Secondary</th>
<th>Special</th>
</tr>
</thead>
<tbody>
<tr>
<td>Signposting to community health services</td>
<td>6</td>
<td>6</td>
<td>5</td>
</tr>
<tr>
<td>Professional supervision</td>
<td>5</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td>Counselling support line</td>
<td>5</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>Other</td>
<td>3</td>
<td>6</td>
<td>2</td>
</tr>
</tbody>
</table>

Other sources

- Mental Health England
- We do not really have any training

What sources of mental health training do teachers and other staff in your school have?

<table>
<thead>
<tr>
<th>Training Source</th>
<th>Primary</th>
<th>Secondary</th>
<th>Special</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provided internally</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Free online course</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Other local mental health/wellbeing services</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Provided by CAMHS</td>
<td>2</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Other registered training provider(s)</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Online training course purchased externally</td>
<td>1</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Other</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

Other support

- Access to specialist staff
- Staff have access to mental health nurse employed by school
- Weekly counsellor available in school
Other packages used

A wide variety including Talkabout materials

Based on course attended by SENCo on mental health, key points will be fed back to staff

Don’t recall any of the above but internally we had a PDM about looking after ourselves via powerpoint internally

EP Service training, Anna Freud Organisation, Emotional First Aid

Unsure as I am not sure what system our ELSA workers use.

We use no package at present

Other useful support

Sharing good practise by participation in peer to peer school reviews; consultation with other specialist schools regionally and nationally, access to specialist advisors for staff. The school already provides the above, but could always use more help!

Please indicate which three training themes would be most useful for your staff.
Gender identity. Two staff have already accessed this, but a whole staff training would be helpful.

<table>
<thead>
<tr>
<th>School type</th>
<th>Do you have any other comments or ideas for further support for pupil’s mental health and wellbeing in your school?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary</td>
<td>Clearer access to CAMHS and CAMHS support in school.</td>
</tr>
<tr>
<td>Primary</td>
<td>Have been trying for years to appoint a school counsellor. With budgets reducing and expectation increasing it would be useful to have access to agencies who can provide training in schools or across schools for minimal cost and if the additional funding given to LAs could be distributed to those schools who are inclusive and do provide support for their pupils.</td>
</tr>
<tr>
<td>Primary</td>
<td>It is very hard to access any mental health support via CAMHS. I have had 2 referrals for early intervention denied because it does not meet the criteria, however we have no idea what the criteria is. School feel in both of these cases some family work is required with the child and their parent and have no other options now this has been declined. Waiting times are too long and even though their is an early intervention service, none of our referrals have resulted in this support.</td>
</tr>
<tr>
<td>Primary</td>
<td>We had a Year 6 pupil last year who lead assemblies and created support posters around the school on mental health issues as a result of her father having CBT and the impact on her and her siblings. She was passionate about this and we supported her to share her story and work to develop children’s understanding of mental health challenges. We need to harness our pupils to lead on aspects of mental health and wellbeing. As this features heavily in our next SIP we plan to have Well-Being Wednesdays where the focus is mental health across the whole school - in assemblies/class/lunchtimes etc to maintain the focus. Our key driver will be developing resilience and we are part of some research with Brighton University and Young Minds on Academic Resilience. This should support us. Thanks</td>
</tr>
<tr>
<td>Primary</td>
<td>Schools need more external support to develop the understanding and strategies to support pupils. Interventions developed by experts that can be delivered by teachers or TA’s that tells that what to do step by step. Also a clear and consistent assessment of needs for all pupils that can be used to personalise the pshe delivered in schools- this needs to show impact as mental health can be so huge and even after an intervention the impact looks minimal for some children and this needs to be explained as can be very demoralising for adults who have supported and the children in how they feel about themselves.</td>
</tr>
<tr>
<td>Primary</td>
<td>There is so little timely outside support for children who have far bigger mental health issues than a school can provide support for. There is such a lack of outside support that many children are suffering with issues, often inherited from parents, that will impact on their adolescent and adult mental health unless dealt with whilst at a younger age.</td>
</tr>
<tr>
<td>Primary</td>
<td>this is a massive area of need, and I have not received training myself in how to address the issues, let alone the majority of my staff. As we have a deficit budget and increasing numbers of children with SEND, this is yet another pressure that we cannot manage.</td>
</tr>
<tr>
<td>Secondary</td>
<td>Nurture / well being lunch drop in Smoking drop in Termly Bereavement drop in / support group (in conjunction with Simon Says)</td>
</tr>
<tr>
<td>Secondary</td>
<td>Provide additional funds in order to meet the needs of our youngster - especially as central systems are not able to keep up with demand.</td>
</tr>
</tbody>
</table>
Secondary  Further support for teaching staff in schools with their own good mental health and well being.

Secondary  We are very pleased with the services offered by our Mental Health Nurse. However, we would welcome any other support available in the City.

Secondary  Would be good to find out the results of this in relation to all schools and attempt to support all schools to provide the same level of support - especially as we now have GPs signposting parents to schools for counselling - with the expectation that it is provided. Equal support from agencies to all schools and fair share of budgets (we bid for mental health support but were not provided with it - other schools were favoured)

Special  This sounds a bit bizarre but doing this survey it has made me think we do not do anything like enough on a formal/planned basis but also I really do believe that we are a school that ensure the emotional wellbeing and mental health of our children (and staff) are well addressed despite this due to our overall positive, nurturing and individualised ethos and approach with people old and young.

Special  We have been offering secondary mainstream school staff the opportunity for a ‘speaking space’ to discuss children in mainstream anonymously so we can jointly explore other possible support mechanisms. Building self esteem and resilience is fundamental to emotional wellbeing, so a system that recognises the importance of character building and a feeling of community, is vital to support schools.

Selection of results to the Anna Freud event question ‘What is your school or setting doing to support staff wellbeing?’

- We are only just starting this journey so are looking for meaningful strategies to support our staff rather than a scatter gun approach!
- Handing INSET over to curriculum teams to give teachers space to think and learn
- Team time during school day
- No emails after 4.30pm
- What’s in the box days
- Send whole staff birthday cards where everyone writes a personal message
- Friday “fank-yous” - emailed into head teacher pa each week and emailed out as a list each week
- Allowing time for family (time off to go to child’s sport day)
- Supporting school INSET around different aspects of support, supervision for school staff, coaching
- Modelling wellbeing from SLT and the small things that make a diff such as emailing after 6pm
- Random act of kindness
- Morning brief, Afternoon debrief, Supervision - individual and group
- Employing a HLTA to provide release time additional to PPA
- Open door policy so staff can speak to SLT
- Listening
- Thank you postcards to be given to anyone by anyone
- Mindfulness
- DBT informed staff
- As a visiting outreach therapist I am careful to be warm, respectful and friendly to staff
- Staff and pupil awards
- Very little
- Phase birthday cards, Pizza on Parent’s eve
- Time out of class when and if needed
- Staff support one another emotionally and physically. Giving people time to listen and share
- Club days
If staff run an after school club we get a day off in lieu (you have to have a certain amount of children and have to plan for it).

Staff shout out board!

·B Mindfulness taught to students and staff
<table>
<thead>
<tr>
<th>Grant</th>
<th>Contact – Name and email</th>
<th>Provider</th>
<th>Age group</th>
<th>Focus</th>
<th>Summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Asperger Support &amp; Social Group Southampton activity grant</td>
<td>Mrs Susan Jacobs <a href="mailto:utility.jacobs@hotmail.com">utility.jacobs@hotmail.com</a></td>
<td>Asperger Support &amp; Social Group Southampton</td>
<td>Both under 11s and 11-18 years</td>
<td>Behavioural support for Autism &amp; Asperger’s</td>
<td>A small grant to provide opportunities for children on the autistic spectrum, to take part in activities, with others like themselves. The funding will be used to cover admission charges to activities such as swimming and trampolining.</td>
</tr>
<tr>
<td>2 Autism Hampshire training programme grant</td>
<td>Mrs Kathryn Cornish <a href="mailto:Kathryn.cornish@autismhampshire.org.uk">Kathryn.cornish@autismhampshire.org.uk</a></td>
<td>Autism Hampshire</td>
<td>Both under 11s and 11-18 years</td>
<td>Behavioural support for Autism &amp; Asperger’s</td>
<td>Autism Hampshire will provide a programme of autism specialist training and support for families and professionals of children and young people on the autism spectrum who live in Southampton. We will provide them with the specialist knowledge needed to make a real and lasting difference to emotional well-being.</td>
</tr>
<tr>
<td>3 Breakout Youth gender non-conforming project grant</td>
<td>Mr Michael Salmon <a href="mailto:Michael.Salmon@breakoutyouth.org.uk">Michael.Salmon@breakoutyouth.org.uk</a></td>
<td>Breakout Youth</td>
<td>11-18 years</td>
<td>Gender identity</td>
<td>2 hour training session for teachers in secondary schools around Southampton, PSHE lessons for pupils in secondary schools and 1-1 Support based work in the area. Additionally access to a youth group and a music group that run in Southampton and other areas of Hampshire. Enable young people to access other services they require through signposting and referrals. Support members with telling people about their gender or sexual orientation and/or gender identity, plus helping them to find ways to cope with challenges in their lives and support them to stay safe in their relationships and community.</td>
</tr>
<tr>
<td>4 Foundry Lane Primary School Zumos grant</td>
<td>Mrs Kathryn Lugg and Cathy Baggott k.lugg@foundrylanepri mary.co.uk senco@foundrylanepri mary.co.uk</td>
<td>Foundry Lane Primary School</td>
<td>Under 11s</td>
<td>Under 11s general MH</td>
<td>Increasingly in school our children are struggling to manage their emotions appropriately and this is manifesting itself through challenging behaviour and extreme anxiety. We are hoping that Zumos will provide us with an additional layer of support and a mechanism for them to develop a deeper understanding of their own emotions and how to manage them in safe, resilient ways. The platform will provide teachers with an insight into some of the issues children are dealing with on a day to day basis and will aid them in identifying patterns and triggers to the children’s emotional wellbeing.</td>
</tr>
<tr>
<td>5 Nature Therapy CIC pop-up theatre grant</td>
<td>Dr Kim Brown <a href="mailto:kim@holecottage.plus.com">kim@holecottage.plus.com</a></td>
<td>Nature Therapy CIC</td>
<td>Under 11s</td>
<td>Bullying</td>
<td>One of the major causes of bullying is that a child is seen to be different in some way. The Kindness programme is a whole school approach to reducing bullying by teaching children we are all different. Each one of us is unique and special in our own way. Through hands on and fun experiences in our innovative Pop Up Sensory Theatre, children can build their resilience to life’s experiences and enhance their compassion towards their peers. The service will work with both local schools and community groups.</td>
</tr>
<tr>
<td>6 No Limits South bereavement project grant</td>
<td>Ms Ana Brankovic <a href="mailto:Ana.brankovic@nolimitselp.org.uk">Ana.brankovic@nolimitselp.org.uk</a></td>
<td>No Limits South</td>
<td>11-18 years</td>
<td>Loss &amp; bereavement</td>
<td>No Limits will provide targeted bereavement support for young people aged 11-16 from No Limits premises. Young people will be identified from existing counselling waiting lists and we will work with colleagues from across other services to generate referrals. Young people affected by bereavement, loss and grief are often vulnerable and may have difficulty in expressing and managing their feelings. Their lives can be affected in many different ways; sleep, mood, behaviour, relationships can all suffer, and the group work provided by No Limits will enable young people to explore the stages of grief and relate these to their own experiences. The groups will be closed, structured and supportive and will give young people an opportunity to explore important and often</td>
</tr>
</tbody>
</table>
overwhelming feelings, giving guidance on how to manage now and in the future. Young people in particular need will be referred for 1:1 support within the counselling service.

<table>
<thead>
<tr>
<th>No Limits South bullying project grant</th>
<th>Ms Ana Brankovic <a href="mailto:Ana.brankovic@nolimits.help.org.uk">Ana.brankovic@nolimits.help.org.uk</a></th>
<th>No Limits South</th>
<th>11-18 years</th>
<th>Bullying</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Limits will work to provide closed group work to 11-18 year olds affected by bullying in schools and colleges. We will work with the SHA and No Limits counselling services to analyse information about bullying we already hold, in order to offer a service to schools and colleges where bullying is felt to be an issue (and the school / college would like support in this area). The service will be provided to young people experiencing bullying, and to those identified as bullies. Where group work is not deemed suitable we will offer targeted short-term 1:1 counselling support from No Limits premises. No Limits will work with school staff to identify young people suitable for support. Group work interventions are designed to: increase YP resilience, enable YP to evaluate their behaviour and impact on others, give YP tools to manage their feelings and behaviour and explore appropriate outlets for difficult feelings, build peer networks within school/college and link into existing support systems.</td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>No Limits South Under 11s counselling project grant</th>
<th>Ms Annabel Hodgson <a href="mailto:Annabel.hodgson@nolimits.help.org.uk">Annabel.hodgson@nolimits.help.org.uk</a></th>
<th>No Limits South</th>
<th>Under 11s</th>
<th>Under 11s general MH</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Limits will be providing short-term (6 sessions) of targeted counselling to children aged 4-10. This will be delivered using age-appropriate methods, providing children with the skills and resilience to promote positive wellbeing and minimise the risk of further distress. We will work to engage families, encouraging parental/carer involvement; so that appropriate adults can continue supporting their child’s ongoing positive mental wellbeing after the intervention has ended. The service will work in partnership with Southampton Healthy Ambition, CAMHS Single Point of Access and Early Help to identify children suitable for referral to the service; counselling will take place in primary schools, at GPs and at the No Limits Avenue building ensuring children referred can access the service in a variety of suitable locations. Children can be referred to the service for a range of issues including: family and relationship issues, low mood, anxiety, low self-esteem, mood management, bullying, self-harm, bullying, bereavement.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Oasis Community Learning (Oasis Academy Mayfield) bereavement training grant</th>
<th>Mr Paul Woodman <a href="mailto:chaplain@oasismayfield.org">chaplain@oasismayfield.org</a></th>
<th>Oasis Community Learning (Oasis Academy Mayfield)</th>
<th>11-18 years</th>
<th>Loss &amp; bereavement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Training for pastoral leaders or equivalent from schools across Southampton to run and deliver a very effective 4-session course for students affected by bereavement (developed and used at Oasis Mayfield). Part of the support will provide them with high quality resources on grief and loss that will help them support their students effectively. Funding is being used for new printed materials and for staff time to promote and lead the sessions. Once trained and with a suitable handbook, the delivery of bereavement courses is fully sustainable across schools in the city.</td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Oasis Community Learning (Oasis Academy Mayfield) Zumos grant</th>
<th>Mrs Karen Dawkins <a href="mailto:Karen.dawkins@oasismayfield.org">Karen.dawkins@oasismayfield.org</a></th>
<th>Oasis Community Learning (Oasis Academy Mayfield)</th>
<th>11-18 years</th>
<th>General MH</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oasis Mayfield is launching a new online student support service, as part of our wellbeing support system for students. Zumos, which is run by Insight4life, is a confidential online information service for all students. It provides them with support on a wide range of issues of concern to young people, and can be accessed online at any time. The programme will promote positive thinking and positive internal dialogue and will enable students to make informed choices, and signpost them towards further help. The programme will also support the academy in identifying areas of concern for our student’s ensuring we can be proactive in addressing these issues, through PSHE/tutor time/assembly’s/ campaigns etc.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Organisation</td>
<td>Contact Person</td>
<td>Project Title</td>
<td>Age Group</td>
</tr>
<tr>
<td>---</td>
<td>-------------</td>
<td>----------------</td>
<td>---------------</td>
<td>-----------</td>
</tr>
<tr>
<td>12</td>
<td>SoCo Music Project ASD</td>
<td>Mrs Marie Negus</td>
<td>SoCo Music Project</td>
<td>Both under 11s and 11-18 years</td>
</tr>
<tr>
<td>13</td>
<td>SoCo Music Project bullying</td>
<td>Mrs Marie Negus</td>
<td>SoCo Music Project</td>
<td>11-18 years</td>
</tr>
<tr>
<td>14</td>
<td>Solent Mind Heads up project</td>
<td>Abby Oakley</td>
<td>Solent Mind</td>
<td>Both under 11s and 11-18 years</td>
</tr>
<tr>
<td>15</td>
<td>Southampton Action for Employment (SAFE) choices course</td>
<td>Mrs Nina Kelly</td>
<td>Southampton Action for Employment (SAFE)</td>
<td>11-18 years</td>
</tr>
<tr>
<td>16</td>
<td>Southampton Voluntary Services bullying</td>
<td>Julie Marron</td>
<td>Southampton Voluntary Services</td>
<td>Both under 11s and 11-18 years</td>
</tr>
<tr>
<td>17</td>
<td>St Anne’s Catholic School Zumos</td>
<td>Mr Julian Waterfield</td>
<td>St Anne’s Catholic School</td>
<td>11-18 years</td>
</tr>
<tr>
<td></td>
<td>The Polygon School Peer mentor project grant</td>
<td>Mrs Anne Hendon-John <a href="mailto:Head@polygon.southampton.sch.uk">Head@polygon.southampton.sch.uk</a></td>
<td>The Polygon School</td>
<td>Under 11s</td>
</tr>
<tr>
<td>---</td>
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<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>18</td>
<td>Weston Church Youth Project group grant</td>
<td>Miss Libbi Beckwith <a href="mailto:libbi@wcyp.org">libbi@wcyp.org</a></td>
<td>Weston Church Youth Project</td>
<td>Under 11s</td>
</tr>
</tbody>
</table>
| 19 | Yellow Door Gender dysphoria project grant | Mrs Jo Pearce jo.pearce@yellowdoor.org.uk | Yellow Door | Both under 11s and 11-18 years | Gender identity | • Therapeutic help for CYP with gender dysphoria & their families, this will be in the form of group, individual and/or family sessions (as appropriate) to Southampton CYP struggling with the psychological impact of gender dysphoria (GD).  
• Training sessions & ad hoc support for relevant Southampton professionals on gender dysphoria, appropriate response & signposting. The service will take referrals from across the city. |
| 20 | Yellow Door under 11’s DSA project grant | Mrs Tara Doel tara.doel@yellowdoor.org.uk | Yellow Door | Under 11s | Under 11s general MH | Development of a new under 11’s therapeutic provision for CYP who have experienced/witnessed Domestic/Sexual Abuse and are evidencing vulnerability to MH problems. The service will take referrals from across the city. |
| 21 | Yellow Door over 11’s DSA project grant | Mrs Tara Doel tara.doel@yellowdoor.org.uk | Yellow Door | 11-18 years | General MH | Development of a new 11-18 year psycho-education provision at YD offering tailored, holistic & needs-led services that identify and respond psycho-educationally to Young People (YP) who have experienced/witnessed Domestic/Sexual Abuse (DSA) and are evidencing vulnerability to MH (MH) problems. The service will take referrals from across the city. |
| 22 | Youth Options John Muir Award grant | Miss Debbie Burns debbieburns@youthoptions.co.uk | Youth Options | Under 11s | Under 11s general MH | Youth Options will be delivering courses to children aged 8-10 in which they will undertake the John Muir Award. The John Muir Award is an environmental award scheme focused on wild places. It supports people to connect with, enjoy and care for nature, landscape, and the natural environment. It is well documented that engagement with nature is beneficial to positive MH and wellbeing, and our course will support participants to build the skills and resilience required to promote this. Youth Options will be linking with a small number of schools to take referrals from. |