Best Practice Review of Whole School Approach (WSA) within MHSTs in the South-East and East of England

Evaluation Report

Tanya Procter[a], Lucy Roberts[b], Ian Macdonald[c], Alice Morgan-Clare[d], Becca Randell[a] and Robin Banerjee[b*]

[a] NIHR Applied Research Collaboration Kent, Surrey and Sussex
[b] School of Psychology, University of Sussex
[c] The Charlie Waller Trust
[d] West Sussex Mental Health Support Teams

* *Address for correspondence:*
Professor Robin Banerjee
School of Psychology
University of Sussex
Falmer, Brighton BN1 9QH

Email: robinb@sussex.ac.uk

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Glossary

CAMHS	Child and Adolescent Mental Health Services
CBT	Cognitive Behavioural Therapy
CPD	Continuing Professional Development
CYP	Children and Young People
DSL	Designated Safeguarding Lead
EWMH	Emotional Wellbeing and Mental Health
KPI	Key Performance Indicator
MHST	Mental Health Support Team
PHE	Public Health England
PRU	Pupil Referral Unit
PSH(E)E	Personal, Social and Health (Economic) Education
RSE	Relationships and Sex Education
SEL	Social and Emotional Learning
SENCO	Special Educational Needs Co-ordinator
SEND	Special Educational Needs and Disabilities
SMHL	Senior Mental Health Lead
SOP	Standard Operating Procedure
WSA	Whole School Approach

1. Overview of the Best Practice Review

This report documents a review and evaluation of best practice on work undertaken by Mental Health Support Teams (MHSTs) to support whole school approaches (WSA) to emotional wellbeing and mental health (EWMH). The review and evaluation took place between November 2020 and October 2021 and was led by the Kent, Surrey and Sussex Academic Health Science Network (AHSN) in partnership with the Applied Research Collaboration for Kent, Surrey and Sussex. Academics from the School of Psychology at the University of Sussex undertook the field work and analysis. Charlie Waller Trust led pupil voice input to the review. Funding was received from local areas across the South-East and East of England.

The review was commissioned in part due to concerns about a gap in current national monitoring and evaluation measures for MHSTs, which are weighted towards clinical outcomes. The review aims to provide clear data on the ways in which local teams are developing the WSA element of MHSTs and what impact this might be having.

The best practice review and evaluation undertook the following steps:

- A review and summary of the literature associated with WSA to EWMH;
- A process for mapping the ways in which WSA is being developed and rolled out as part of MHSTs across the South-East and East of England;
- Pupil voice work to gather pupil views on how an effective WSA may impact on their practical help seeking, their development of healthy coping, and their sense of a school ethos around mental health;
- An analysis of the measures currently in use to measure impact of WSA work with MHSTs;
- An analysis of the nature and impact of WSA work delivered as part of MHSTs.

The review sets out a number of ambitions for future implementation, development and monitoring of WSA work within MHSTs.

2. Mental health support in schools

2.1. Overview of mental health support in schools

Schools and colleges have increasingly been recognised as important settings to support children and young people (CYP) with their EWMH and many settings are providing support for CYP's mental health in a range of ways. CYP spend a significant part of their day in school, and staff in those settings are potentially in a strong position to develop a rounded picture of who they are, their struggles and their successes. School staff are also likely to have established relationships with parents and carers. The 2017 Green Paper "Transforming Children and Young People's Mental Health Provision" (Department of Health/Department for Education, 2017) describes the role of school and colleges within a progressive universal approach where: CYP are able to access mental health promotion opportunities; CYP at risk can be identified and supported at an early stage; and specially trained staff (both school staff and outside visitors) can provide specialist interventions to those who need it.

National initiatives such as the Healthy Schools Programme (Department of Health/Department for Children, Schools and Families, 2007), and Social and Emotional Aspects of Learning (Department of Children, Schools and Families, 2007) provided support directly to school staff in developing both whole-school and curriculum-based support for CYP. A number of frameworks have been developed to support schools and colleges with this work, perhaps most well-known of which has been developed and promoted by Public Health England (2021). Ofsted also describe what they expect schools to provide (Ofsted, 2020). In particular, every school is expected to identify a Senior Mental Health Lead (SMHL) to coordinate EWMH support within school, and training is being offered for those undertaking this role.

Teaching staff are not generally provided with training in EWMH as part of their initial teacher training, in part due to the very limited time that trainee teachers have on university campuses before going out on placement. Opportunities to train cohorts of students through the Teach First programme can be easier as these students tend to work in the same academy trusts and are less geographically dispersed. Some staff may access specialist training as part of continuing professional development (CPD) and schools may also recruit pastoral staff with specialist training and qualifications. While it is recognised as good practice to have specialist Personal, Social and Health Education (PSHE) teaching teams in schools, the reality is that many schools rely on other non-specialist teaching staff to deliver PSHE. This means that there is a patchy picture in schools in terms of staff confidence and skills to delivery curriculum-based EWMH work. The requirement for all schools to identify a SMHL should ensure that all schools have at least one person who coordinates and leads whole-school work on EWMH but training for these staff members has been delayed due to the COVID-19 pandemic and is beginning to be rolled out in the Autumn of 2021.

For most young people, schools and colleges will provide them with the skills and knowledge to support and promote their EWMH. For a smaller number of CYP, school staff will identify that they need some additional support, either on a short-term or ongoing basis. Many in this group will be ably supported by pastoral staff, but there will be some CYP who will benefit from input from specialist mental health staff, either in school or at a service outside school.

2.2. Mental Health Support Teams

The development of MHSTs in schools is a core component of the Government's 2017 Green Paper (Department of Health/Department for Education 2017). The model is based on three main functions:

- Delivering evidence-based interventions in schools for mild to moderate mental health issues;
- Supporting the SMHL in each education setting to introduce or develop their whole school or college approach;
- Giving timely advice to school and college staff, and liaising with external specialist services, to help children and young people to get the right support and stay in education.

MHSTs are intended to enhance and not replace existing services. There is a national target that 35% of schools will be covered by a MHST by the end of March 2024.

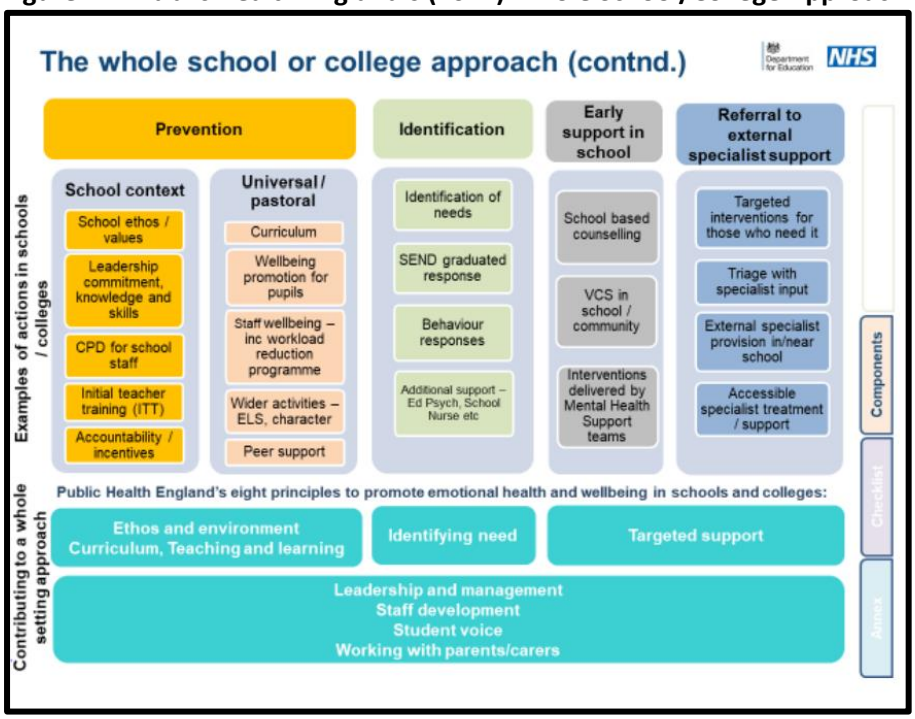
The development of MHSTs began in 2018 with the selection of 25 areas as Trailblazers. There were 4 Trailblazer areas in the South-East and 2 in the East of England region. A further 57 local areas were selected to develop Wave 1 MHSTs from September 2019, and Wave 2 began in January 2020 (123 teams across both waves). From this set, 18 teams are in the South-East (2 of which were Trailblazer sites) and 15 teams are in the East of England region. Further waves have continued to roll out in September and January each year in spite of the COVID-19 pandemic, with an anticipated 10 waves in total.

The present review focused on Trailblazers and Waves 1 and 2 because these were the most developed teams. However, it was understood that all teams had been inevitably affected in their development by the impact of the COVID-19 pandemic. This is not the primary focus of the present review but should be taken into account as an important backdrop to all work described.

2.3. Whole School Approach to mental health in schools

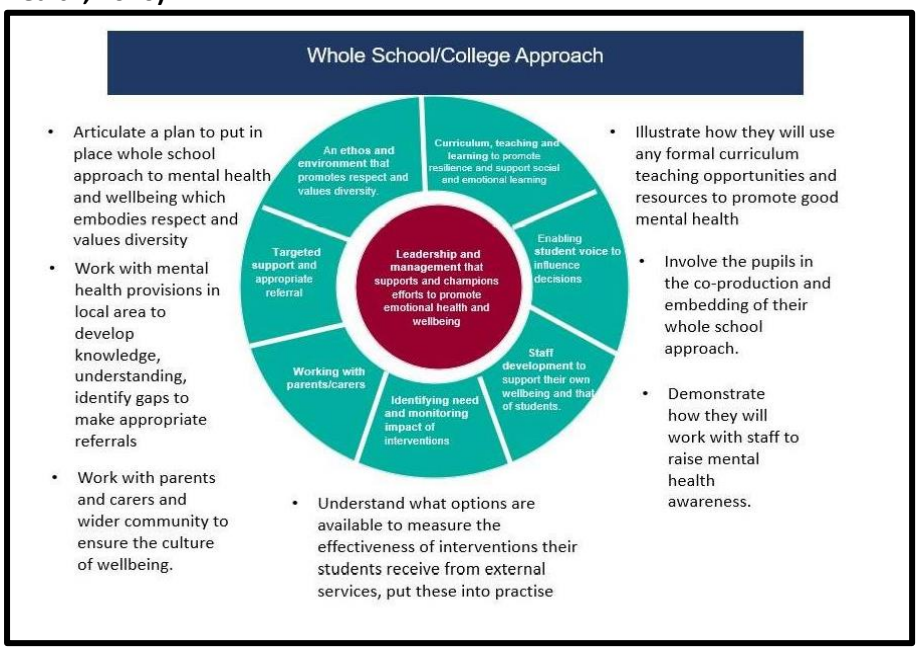
A whole school approach to mental health and wellbeing is a co-ordinated approach across an educational setting to promote emotional wellbeing, identify emotional and mental health difficulties at an early stage, and provide support to those who need it (either in school or by signposting to external agencies). Public Health England (2021) describe a progressive universal approach and provide examples of the actions that can be taken by schools and colleges to support each stage (prevention, identification, early support in schools, referral to external specialist support) as shown in Figure 2.1 below.

Figure 2.1. Public Health England's (2021) Whole School/College Approach



A whole school approach should be seen as an incremental change-management process covering all areas of school and college life. Public Health England (2021) describe 8 principles for this work, as shown in Figure 2.2 below.

Figure 2.2. Elements of a Whole School Approach (Department for Education and Department of Health, 2020)



3. Overview of the Best Practice Review evaluation

3.1. Key strands of the Best Practice Review

The Best Practice Review involved a number of distinct methodological strands led by different members of the evaluation group.

A review of the literature (led by Tanya Procter and Alice Morgan-Clare)

An initial literature search was undertaken in January 2020. This was added to and enhanced throughout the course of the Best Practice Review and had a focus on WSA to EWMH. The literature review includes systematic reviews and meta-analyses, policy frameworks, evaluations of specific programmes and a number of practical how-to toolkits.

Pupil voice input (led by Ian Macdonald)

This creative project targeted pupils in Year 5 and Year 8, so that the voices of both primary and secondary school-aged CYP were heard. Schools were asked to provide demographic data and to undertake a body-mapping activity with pupils which gathered data on how effective WSA might support help-seeking behaviour, build coping strategies and be supported by a positive school ethos. This exercise elicited the views of 266 children and young people. The review team are extremely grateful to these young people for sharing their views, as well as to the school staff who supported them in doing so.

Analysis of MHST data returns (led by Robin Banerjee and Lucy Roberts)

This formed part of an engagement process with a sample of MHSTs in the South-East and East of England, focusing on Trailblazer, Wave 1 and Wave 2 teams.

The first stage of this contact was with local MHST teams and was undertaken as part of quarterly reporting (Q3). Local areas were asked open-ended questions as part of their data return to describe work being undertaken to support schools and college whole school approach work, mapped against the sections of the Public Health England (PHE) framework described above.

The second stage of the engagement process with local areas approached both teams and schools in the final quarter of the year (Q4). Participants were again asked to map their activity against the PHE framework, but this time used graded descriptors of 17 different aspects of WSA as well as providing comments.

A combination of quantitative analysis and thematic content analysis of comments was used to elicit key insights.

Analysis of in-depth interviews about WSA (led by Robin Banerjee and Lucy Roberts)

Fieldwork interviews were conducted with clinical and educational staff in individual areas to evaluate how MHSTs are developing, as well as how WSA work is being designed and implemented within these structures. The interviews captured data on the nature of MHST activities in schools, facilitators of success, and barriers or obstacles that staff have encountered. They also addressed questions about how local areas are measuring impact of any whole-school work.

All primary data collection (fieldwork interviews) and secondary data analysis (of pupil voice outputs and MHST data returns) received ethical approval from the University of Sussex Sciences and Technology Cross-Schools Research Ethics Committee.

3.2. Steering group membership and role

The Best Practice Review was guided in its work by an active and dynamic steering group. The group met four times over the lifetime of the project, provided advice on key design and analysis issues, and effectively monitored progress and advised on next steps. Steering group membership was rich and varied, and included local school staff as well as operational and strategic leads for WSA in MHSTs. Members were also drawn from local, regional, and national bodies, including Department of Health, Department for Education, Public Health England, and Health Education England. The Principal Investigator for the national evaluation of Trailblazer MHSTs was also a steering group member. The Best Practice Review would like to take this opportunity to thank all members of the steering group for their enthusiastic support and engagement with the project.

4. Literature Review

The literature review was undertaken as the first stage of the Best Practice Review and Evaluation of Whole School Approach (WSA) within MHSTs in the South-East and East of England between November 2020 and October 2021.

4.1. Background

The Mental Health Survey for Children and Young People (NHS Digital, 2020) places prevalence of mental health disorders for children and young people at 16% (1 in 6). This figure was an increase from the previous survey in 2017 and was based on evidence from part way through the COVID-19 pandemic. Increases in referrals to child and adolescent mental health services suggest that this figure has increased further between 2020 and 2021 (BBC Shared Data Unit, 2021).

There has been increasing recognition over the past thirty years of the interconnectedness of health and wellbeing on educational and other outcomes for children and young people. Initiatives such as the National Healthy Schools Programme (Department of Health/Department for Education and Employment, 1999) stressed the need for multi-component programmes including but not limited to curriculum content, pupil voice, staff wellbeing and leadership and management. More recently, the Ofsted Inspection Handbook (2020) describes what evidence inspectors look for to measure the pastoral care being given alongside education so that children and young people are resilient and mentally healthy. This relates to the 2017 Green Paper "Transforming Children and Young People's Mental Health Provision", which set out a range of developments to support and improve children and young people's mental health and wellbeing, of which MHSTs in schools are one.

MHSTs are strongly evidence driven in their design and are based on a Cognitive-Behavioural Therapy (CBT) informed clinical model (1:1 and group-work) as well as support for WSA to EWMH. Routine Outcome Measures are used to quantify clinical work and measure distance travelled but there are currently no consistently used tools to assess the quantity or impact of the contribution of MHSTs to whole-school work to improve EWMH.

4.2. Research questions

At the outset of our project, there was no published literature on the impact and added value of MHSTs on WSA specifically. Our literature review questions were therefore, by necessity, broader in scope and considered definitions, delivery, impact and measures of success relating to WSA. Previous initiatives such as the impact of Targeted Mental Health in Schools (National Child and Maternal Health Intelligence Network, 2011) are included because some elements bore similarity to the goals of MHSTs.

Our overarching research questions were, "What do we mean by the Whole School Approach work to support emotional health and wellbeing and mental health and how is this delivered? What is the evidence for effectiveness and how is it measured?"

4.3. Approach to literature review

In conducting the literature review we undertook the following process:

- We worked with Surrey and Sussex Library and Knowledge Services to identify search terms and parameters and undertake an initial search on our behalf. The details of the search (history, inclusion and exclusion criteria, sources) are set out below.
- We reviewed sources from initial literature search to include references that were not included in the initial electronic search.
- We then reviewed those sources, excluded less relevant documents, and sub-categorised references to support readers to navigate the nature of WSA to EWMH and its delivery, and recommendations for future practice/research. Sources are listed in Appendix 1.

It should be noted that this literature review is not intended to serve as a formal systematic review of the entire body of work relevant to this area. Rather, it should be regarded as a synthesis of the key insights emerging from scrutiny of key sources in the area over recent years.
Members of the steering group emphasised the need to consider practical "how to" documents, which may not have been formally published but are available on organisational websites. A number of these were therefore also included in our review.

The key findings and conclusions arising from the review of the literature are presented below. In addition, it should be noted that three project outputs have been generated by the literature review element of the project: a complete list of the references in a Word document, with abstracts; a summary list of all references in an Excel document; and a summary of all references in a Word document.

Inclusion and exclusion criteria

The initial search was not restricted to England and contains research from the whole of the United Kingdom, Ireland and other countries in Europe, the United States of America, and Australia, where various initiatives and interventions involving WSA to EWMH have been trialled with differing degrees of success. A number of case studies and interventions from the UK are also incorporated. Although the date range applied to the original search was 2016-2021, one study from 2009 was included and later work by the project team also led to the inclusion of a number of important earlier studies.

The initial literature search used the following search terms: Emotional; mental; health; wellbeing; "whole school approach"; cognitive behavioural therapy (CBT); coping; resilience; interventions; help-seeking; schools; social skills; young people, children; students; adolescents; education; identification; screening. The review of references from the initial search also included some broader whole-school approach work to reduce aggression, violence and bullying and to improve relationships. These studies had very similar findings in terms of the need for a multi-component approach.

4.4. Description of sources consulted

The following sources were used for the initial literature search: Cochrane, Ebsco Medline, Ebsco Psychology, Google Advanced, Google Scholar, King's Fund, NICE Evidence Search, Ovid Embase, Ovid Medline, Ovid Emcare, HMIC, Medline, PHE, ProQuest PsycInfo, PubMed, and TRIP PRO. Subsequent searches included websites focused on young people's mental health, such as Young

Minds, Anna Freud, and National Children's Bureau. Local websites were also consulted, including the Sandwell Charter Mark and the Leeds-based Healthy Schools website.

4.5. Key findings and conclusions

This section breaks our research question into its component parts. First, we summarise the literature that defines a whole school approach. We go on to describe how it is delivered and the evidence for effectiveness, using the headings from the Public Health England (PHE) framework (Public Health England, 2021) to provide a structure for the discussion. Measures used to monitor effectiveness are included where there is literature available. We conclude with a short discussion of missing elements from the literature.

What do we mean by a Whole School Approach?

It is widely recognised that schools have a role to play in facilitating pupils' success by supporting them to be resilient and mentally healthy (Faculty of Public Health and Mental Health Foundation 2016; Ofsted et al. (2020). Aston (2014) sees this through the lens of an ecological framework operating at macro, meso and micro levels: wider societal influences are the macro; the Whole School Approach is the meso; and positive individual developments are the micro.

Banerjee et al. (2016) describe an interaction of mental health, psychological, pedagogical and systems perspectives as to how best to promote wellbeing within a school context. The mental health emphasis might include approaches that are meant to reduce the prevalence of already identified and measurable mental health problems (such as the clinical work delivered by MHSTs). The psychological perspective focuses on use of evidence-based programmes to promote and improve EWMH (such as use of 'social and emotional learning' [SEL] curricula to promote children's skills in self-awareness, self-management, and social relationships). The educational perspective tends to focus in depth on the dynamics of different teaching and learning approaches (such as use of group work and peer collaboration). Finally, the systems perspective has a focus on school leadership and management, pupil involvement, and links to wider community and organisations such as NHS and local authorities.

A number of frameworks have been developed to support whole school approaches to emotional health and wellbeing. As described earlier, the PHE (2021) framework is perhaps the best known, but there are others that are widely used (Anna Freud 2020; Langford, 2014; Stirling & Emery, 2016; Young Minds, 2021), as well as nationally respected local resources. What all have in common is an underlying commitment to improving children and young people's wellbeing through a whole-school, multi-component approach. Each of the approaches describe a number of inter-dependent elements, whereby whole school approaches to emotional health and wellbeing:

- Take into account the **ethos and environment** of the school as well as **curriculum, teaching and learning**. This means that the commitment to developing a whole school approach needs to be championed both by **leadership and management** as well as by **teaching staff**.
- Include the whole school audience. This means paying true attention to and including the **voice of pupils**; recognising that **parents and carers** have a wealth of knowledge and need to be part of the work; and involving and taking care of the **wellbeing of the whole staff team**, including teaching and non-teaching staff, junior staff and school leaders.
- Recognise the strength of **universal, targeted and specialist** work to support children and young people's emotional health and wellbeing.

How can a whole school approach be delivered effectively?

This section summarises literature as to how best to deliver whole school approaches to emotional wellbeing, using the headings from the Public Health England (2021) framework.

As described above, a multi-component approach rather than a single project or element is the most effective approach to take. WSA work should not be seen as a short-term, quick fix solution to all difficulties concerning children and young people's EWMH. Interventions which will impact on school culture and environment may take some time to be fully realised (Public Health Institute, 2019). Weare and Nind (2011) reviewed evidence of effective approaches to mental health promotion and concluded that going beyond the curriculum to consider the whole school (such as changes to school ethos, teacher education, liaison with parents, parenting education, community involvement and coordinated work with outside agencies) is needed for maximising positive impacts. Weare (2015) explains this as ensuring consistency between curriculum delivery, any targeted approaches, and the way in which the school is led and managed. The school's over-arching ethos and environment must not clash with individual programmes or initiatives.

Leadership and management

Schools need to provide leadership if they are to promote young people's resilience more effectively (NICE, 2009). The adoption of a whole school approach to emotional wellbeing and mental health can helpfully be seen as a change management process, and the challenges of undertaking such work should not be under-estimated (Banerjee et al., 2016). The total commitment of the senior leadership team will be essential as will realistic expectations and planning in a way that connects rather than competes with other priorities at school and that builds up incrementally (Weare, 2015). The school leadership team will need to commit to promoting both staff and student wellbeing (Glazzard, 2019).

Staff commitment to professional development and new ways of working and interacting is essential for ensuring the success of complex initiatives (Wells, 2003). It is also important to recognise that alignment of the school's policies and practice around behaviour, diversity, and the challenging of prejudice around ability, disability, gender, race, sexual orientation and perceived social status will be particularly significant for school wellbeing (Weare, 2015).

Many of the self-assessment and improvement tools that have been developed to support WSA recognise the critical function of commitment and leadership of this work from the senior management. Stirling and Emery's (2016) self-assessment and improvement tool describes the changes that need to happen, provides a framework, and offers critical questions to map starting points and progress. Some local areas have developed their own frameworks which include practical suggestions as to how to secure sign-up from senior leadership teams and governing bodies.

Ethos and environment

A school's ethos and environment serve as key determinants of wellbeing and mental health in schools (Weare, 2015) and connect many of the other elements of the WSA. Indeed, Wells et al. (2003) suggests that long-term interventions promoting the health of all pupils and involving changes to the school climate are likely to be more successful than brief class-based mental illness prevention.

The literature suggests several core components to building a strong ethos and environment. Policy alignment – connecting and aligning, for example, work on EWMH with policies on behaviour, attendance, and bullying – is an important start but taking policy to delivery is critical in "walking the talk" (Cocking et al., 2020). Beyond policy, however, a school ethos and environment where pupils feel connected and listened to is reported as being central to wellbeing and achievement, with young people reporting a higher degree of well-being if they feel connected and engaged at school (Gray et al., 2011). Cocking et al. (2020) also found that when young people feel listened to, and their opinions are valued, it enhances a feeling of belonging and connectedness.

Promoting and supporting staff wellbeing is an explicit way of making a commitment to wellbeing through ethos and environment. It is important that staff stress at all levels of the organisation is recognised, and that talking about difficulties and celebrating success are commonplace (Weare, 2015). In so doing, staff wellbeing is looked after and strengths-based supportive relationships are modelled and brought to life.

Curriculum, teaching and learning

A number of important systematic reviews, meta-analyses and literature reviews that were included in our search considered the impact of curriculum, teaching and learning as part of a multi-component or single initiative to improve wellbeing. O'Connor et al. (2017) concluded that the impact of programmes to improve wellbeing were limited unless they were delivered as part of multi-component, systemic change. Similarly, Weare and Nind (2011) found that interventions that were most effective were ones that were embedded in a whole school approach to wellbeing and operated over a long period of time. Banerjee et al. (2016) found that both universal and targeted approaches to promoting emotional health and wellbeing are effective, with greater impact being seen where these approaches are integrated within a school system that promotes connectedness.

The evidence on programme content and methodology is mixed but leans firmly towards some types of interventions being more effective than others. An important Early Intervention Foundation review (Clarke et al., 2021) concludes that universal social and emotional learning (SEL) interventions have good evidence of enhancing young people's social and emotional skills and reducing symptoms of depression and anxiety in the short term. Other approaches such as mindfulness, or youth development have less consistent results. Durlak et al. (2011) undertook a meta-analysis of universal SEL programmes and found improvements in skills, behaviour, emotions and even attainment.

Both the quality of the programmes and the consistency with which they are implemented have been shown to have an impact on results. Banerjee et al. (2016) and others describe this in terms of programme fidelity (how closely those delivering the programme stick to the way in which it was designed) and dosage (how much of the intervention work is delivered over what length of time). This is discussed in terms of who should deliver programmes, with some research indicating that programmes need to be "expert led". Researchers explain this in terms of specially trained teachers

within the school or external agencies, who might directly deliver the programmes or provide training to teachers to do so.

Fenwick-Smith et al. (2018) found that teacher-led interventions could be highly effective, but this involved delivery by teachers who had been trained. Weare (2015) recommends that interventions are initially psychologist led, as having an expert leading means that schools are less likely to dismiss the intervention as something they are already doing. Over time the programme builds capacity within the school so that the school takes over ownership and the work becomes embedded as part of routine practice. The links between curriculum content, and other initiatives to improve wellbeing and connectedness are made time and time again (Banerjee et al., 2016; Weare, 2011; Weare & Nind, 2015). Taking a schools system approach to improving wellbeing and mental health through classroom programmes, as well as leadership, training for staff and initiatives to promote connectedness has the greatest effect.

Staff development and support for staff wellbeing

School staff (both teaching and non-teaching staff) are consistently seen as important contributors in supporting pupil emotional wellbeing. Parish et al. (2020) describes this as part of a concerted policy since 2010 to develop a graduated approach to supporting mental health and promoting wellbeing, away from specialist services (such as Child and Adolescent Mental Health Services [CAMHS]). This can be a tall order. The existing literature suggests that school staff need to be equipped with knowledge about child development, the teenage brain, early identification and prevention of mental health problems as well as promotion of emotional wellbeing (Weare, 2015).

Beyond simply increasing the knowledge and skills of staff members in relation to EWMH, Stirling and Emery (2016), Weare (2015) and others recognise the importance of addressing staff members' own wellbeing and stress levels within the context of a WSA. Without this, staff may not be able to provide the support that students need (Public Health Institute, 2019). Weare (2015) argues that wellbeing in school starts with the staff and that if they feel uncared for or burnt out they will be unable to provide the necessary support.

The challenges of improvements to staff wellbeing are recognised (given that many sources of stress are externally driven) and the links to other elements of a WSA (such as leadership and management and ethos and climate) are clearly made (Stirling & Emery, 2016; Weare 2015). There are some practical examples of how improvements to staff wellbeing can be achieved. Anwar-McHenry et al. (2020) describes how use of the Mentally Healthy Schools Framework has had an impact in terms of improved mental health literacy among staff and action to improve their own mental health. Gus (2017) reported similar positive effects on staff wellbeing through being trained in an approach that had as its primary objective improvements to pupil wellbeing.

Enabling student voice

The importance of student voice as an essential component of whole school approach work to improve emotional wellbeing and mental health is well recognised (Anna Freud, 2020; PHE, 2021). Weare (2015) describes pupil voice as being "about genuine consultation and the authentic involvement of all students in appropriate decision making about their own learning and classroom and school life". When undertaken well, pupil voice work can improve sense of belonging and connection, and in so doing improve wellbeing and behaviour (Cocking et al., 2020). Involving students in decisions that impact them can improve a sense of control and foster a belief that individual opinions matter (PHE, 2021).

Kostenius et al. (2020) led a study with the aim of describing and understanding how mental health can be promoted in school from young people's perspective. The study's recommendations included suggesting that initiatives to promote mental health in schools should value and appreciate young people's experiences and views, and should build a listening culture. Weare (2015) also encourages schools to be inclusive and creative in their pupil voice work, so that they are listening to the views of all students, not just those who are more articulate.

Schools need to do their own engagement with students because of the evidence that this improves a sense of connectedness and wellbeing. They also need to take into account findings from studies such as Cortina et al. (2021), which reported students saying both that they wanted mental health to be talked about more, as well as that they would talk to a teacher or other trusted adult in a school setting if their pre-existing relationship was good.

Linked to, but not the same as, pupil voice work is peer support or peer education. A systematic review undertaken to support the development of NICE guidance on promoting emotional and social wellbeing in secondary schools (Blank et al., 2009) concluded that peer mediation is an effective way of promoting prosocial and behavioural skills in the long term. This finding is unsurprising given how highly young people value support from each other. Recent research during the COVID-19 pandemic found that one in five young people said that having a friend or peer for support was the main benefit of discussing mental health topics in school (Cortina et al., 2021). Weare (2015) has argued that with appropriate training and support, peer support initiatives enable young people to become active players in the educational process rather than passive recipients.

Working with parents and carers

NICE guidelines to support social and emotional wellbeing among young people in secondary education (NICE 2009) have as a key recommendation that schools work with parents and carers. The Dataprev project (Weare & Nind, 2011) recommended that liaison with parents and parenting education formed part of a multi-component whole school approach to improving mental wellbeing.

The research shows that this work with parents and carers can take place in a range of ways. Blank et al. (2009) identified strong evidence to support parent training/education in the implementation of interventions to promote prosocial behaviours. Weare (2015) characterises parent and carer involvement in terms of a partnership between schools and parents and carers, whereby family life can reinforce messages from school and schools can support parents and carers to develop their own skills and attitudes. According to this model, schools need to work inclusively with the values and attitudes held by their school community, taking a strengths-based approach so that parents and carers do not feel excluded, blamed or stigmatised. This can happen through involving parents and carers in policy development, through a wellbeing offer that includes parents and carers, and through direct delivery of parenting support programmes (Stirling & Emery, 2016).

Targeted support and appropriate referral

There is clear agreement in the literature that some young people are at greater risk of mental health difficulties and/or may need increased levels of non-stigmatising support. Banerjee et al. (2016) describe two ways of identifying young people who are "at risk" or "vulnerable" and who may benefit from targeted support. Some groups of children and young people are at greater risk of developing mental health difficulties due to life circumstances or adverse childhood experiences. There may be other (sometimes overlapping) groups of children who show early signs of mental health difficulties for whom targeted support may be appropriate.

Weare (2015) and Stirling and Emery (2016) place targeted work firmly within a WSA and recommend that schools start early to identify those who may at risk and those already experiencing difficulties and deliver evidence-based interventions to these young people. They recommend that this should take the form of both curriculum-based and 1:1 or smaller group work. Banerjee et al. (2016) argue that whole school interventions may have a positive effect for children and young people already identified as having difficulties, and that in fact the effect of WSA may in some cases be greater than establishing specific targeted approaches. Reddy et al. (2009) suggest that interventions for higher risk young people are likely to have the greatest impact. Targeted prevention programmes will therefore need to be delivered in ways that do not further stigmatise participants.

As with whole-school curriculum-based approaches, targeted interventions need to be robustly evaluated and strongly evidence based. The CASEL guides (2013; 2015) and Early Intervention Guidebook (Early Intervention Foundation, 2021) summarise and rates programmes for effectiveness. As with curriculum-based approaches, both fidelity to the underlying principles and methodology and dosage will be important, as will training for those involved in delivery.

Identifying need and monitoring impact

Shucksmith et al. (2007) recommended early identification and intervention in a review of targeted/indicated activities in primary schools. Weare (2015) also emphasised the need to intervene early in a child's life and early in the onset of difficulties in order to avoid problems becoming too entrenched, recognising that the identification of need will rest with teachers. This in turn highlights the need for relevant training and staff development to enable this.

Identifying general levels of need within a student population can take place through pupil voice work, audits and questionnaires, and/or opportunities within the curriculum. To identify specific individual need, use of validated screening and assessment tools are recommended (PHE, 2021), as well as sharing information between agencies that may be working with an individual young person and/or their family. Knowledge of the child or young person by pastoral staff should be used alongside screening and assessment tools.

Schools evaluate the impact of teaching and other interventions on a regular basis, both to provide evidence of impact for Ofsted as well as to learn about student progress and teacher impact. In the same way, the impact of WSA to EWMH should be measured in order to ensure that time is being well-spent and that those who need targeted interventions are receiving it. In a measurement toolkit (Deighton et al., 2016), the writers suggest the use of a logic model to plan monitoring and evaluation and to help consider what individual interventions are aiming to achieve. Tools such as feedback boxes, wellbeing surveys, focus groups, and questionnaires can all usefully be used (PHE, 2021).

4.6. Directions for future work

An inspection of the literature reveals a number of issues that need to be investigated in more depth:

- **Covering the full age range.** Although considerable work has been undertaken with both primary and secondary school-aged young people, a full developmental analysis of WSA activities is needed. For example, in relation to work in the secondary phase, the majority of reviews addressed the needs of 12- to 15-year-olds, and more work is needed to understand how WSA can support older adolescents.
- **Extending the scope of evaluation to track long-term change.** Although some longitudinal cohort studies (e.g., Avon Longitudinal Study of Parents and Children; Millennium Cohort Study) provide valuable information, detailed work to follow the long-term impacts of school-based mental health work is lacking.
- **Connections between social and emotional learning, anti-bullying/violence reduction, and mental health programmes.** National and international databases (e.g., Be You Programs Directory in Australia; CASEL Program Guide in the USA; EIF Guidebook in the UK[1]) offer a powerful and detailed set of resources regarding programmes across a wide range of topics concerning socio-behavioural and emotional dimensions of life at school and in the wider community. However, research still needs to evaluate how the insights we have gained regarding effective intervention converge and diverge across different areas of focus (e.g., what works for anti-bullying, emotional coping skills, anxiety reduction etc.).
- **Implementation science to generate improvements to everyday, informal experience at school.** This has particular relevance to recommended changes to ethos and culture as part of a WSA, and we recognise that this can be difficult to capture. Numerous studies and reviews have highlighted the importance of *how* programmes are implemented, beyond the qualities of the programme content itself (e.g., Banerjee et al., 2016; Durlak et al., 2011). It is also clear that beyond measuring fidelity and dosage in relation to intervention activities, there is wider scope for considering the everyday experience of CYP in school environments as a whole. Although there are systematic reviews of school environment effects on students' health in general (e.g., Bonell et al., 2013), the specific ways in which mental health interventions affect the everyday experience of all stakeholders in the school community need to be studied, with attention to the interplay between different components of the whole school system (particularly ethos and culture). For example, Cappella et al. (2012) have demonstrated that specialist mental health professionals can influence everyday classroom interactions through teacher consultation and coaching processes.

This takes us to the focus of the present Best Practice Review, namely how MHSTs are engaging with educational settings to co-develop a WSA to EWMH. There is clearly a need to learn more about how WSA is being conceptualised, designed, and delivered through the work of MHSTs in schools and colleges.

The interim report on the national evaluation of the Children and Young People's Mental Health Trailblazer programme (Ellins et al., 2021) indicates that key stakeholders reported a high level of commitment to WSA. In fact, survey data of educational settings in the Trailblazer sites indicated

[1] CASEL Program Guide: https://pg.casel.org/
EIF Guidebook https://guidebook.eif.org.uk/
Be You Programs Directory https://beyou.edu.au/resources/programs-directory

that well over 90% reported being committed to each of the eight PHE principles for WSA work. More specific data on activities suggested that most settings "reported that they organised activities to raise awareness of mental health and reduce stigma (80%), and taught mental health and wellbeing issues (77%). The least common activities were engagement with parents to develop the mental health and wellbeing offer (35%), and peer support for mental health (24%)" (p. 5).

Notwithstanding the positive engagement and commitment, it was also clear that, in practice, there were substantial variations in the implementation of work to take forward meaningful WSA as part of the operation of MSHTs. A core focus in the present Best Practice Review, therefore, is to understand more about how this has developed in the South-East and East of England regions, particularly through the work of Trailblazer, Wave 1, and Wave 2 MHSTs. In the remainder of this report, we focus first on capturing key insights from the voices of pupils, before turning to the views of staff through their comments and ratings in data returns and through their responses to questions in our in-depth interviews.

5. Pupil voice

5.1. Overview

With 'enabling of pupil voice' being a core component of PHE's model of developing whole school approaches to mental health in schools (Public Health England, 2021), and recent reports highlighting the importance of gathering pupil voice effectively (Cortina et al., 2021), an examination of pupil voice, with children and young people directly contributing, was considered a key priority for this review.

It was recognised by the project team that it is not feasible, or even helpful, to tap into pupil voice with respect to precisely what WSA actually is. Rather, it was considered more relevant to gather pupil views on how an effective WSA may impact on their practical experiences of help seeking, developing healthy coping, and their sense of a school ethos around mental health. To help elicit these views, a short activity was developed which could be delivered quickly and effectively in school by school staff.

5.2. Participants

We focused on pupils in Years 5 and 8 for a number of reasons. In primary settings, Year 5 pupils would have greater experience of these approaches in their school than those in younger year groups, and in general were expected to be able to engage with the activity to a strong degree. Importantly, these groups would also still be at their current school in the next academic year which would make post review feedback easier to reach them. Year 8 pupils were chosen for secondary schools as older age groups were likely to be engaged in end of year assessments during the period the project was running. While those older groups would have very useful perspectives to hear share, we judged that it would be hard to expect schools to devote the time needed to run the activity with these groups.

Schools were approached in a variety of ways including existing links developed by the project team, local MHST leads, and area commissioners. They were asked to complete a short demographic table to assist with the analysis, and to send photographs of the completed 'body map' activity (described below) to the project team. They were assured that all feedback would be anonymised.

In all, five schools responded (four primary and one secondary, each from a different area), with multiple pupil groups in each one, giving 30 recorded images to analyse, from a combined total of 266 pupils. Unfortunately, alternative settings (including special educational needs and disabilities [SEND] schools and pupil referral units [PRUs]) could not be actively targeted in the timescale for this review, but local areas are strongly encouraged to access these settings to elicit more targeted feedback from these pupils – in particular as pupils in these settings are more likely to experience poor mental health, and therefore coould potentially benefit most from effective WSA and improved school cultures.

5.3. Pupil voice activity

This strand of work centred on a short 'body map' activity which encouraged pupil groups to create their own 'persona' to explore how they experience their school's whole school approach. This drew upon best practice in terms of adopting distancing techniques to PSHE activities (PSHE Association, 2018), which are considered to encourage safe discussion and exploration of issues, at a level

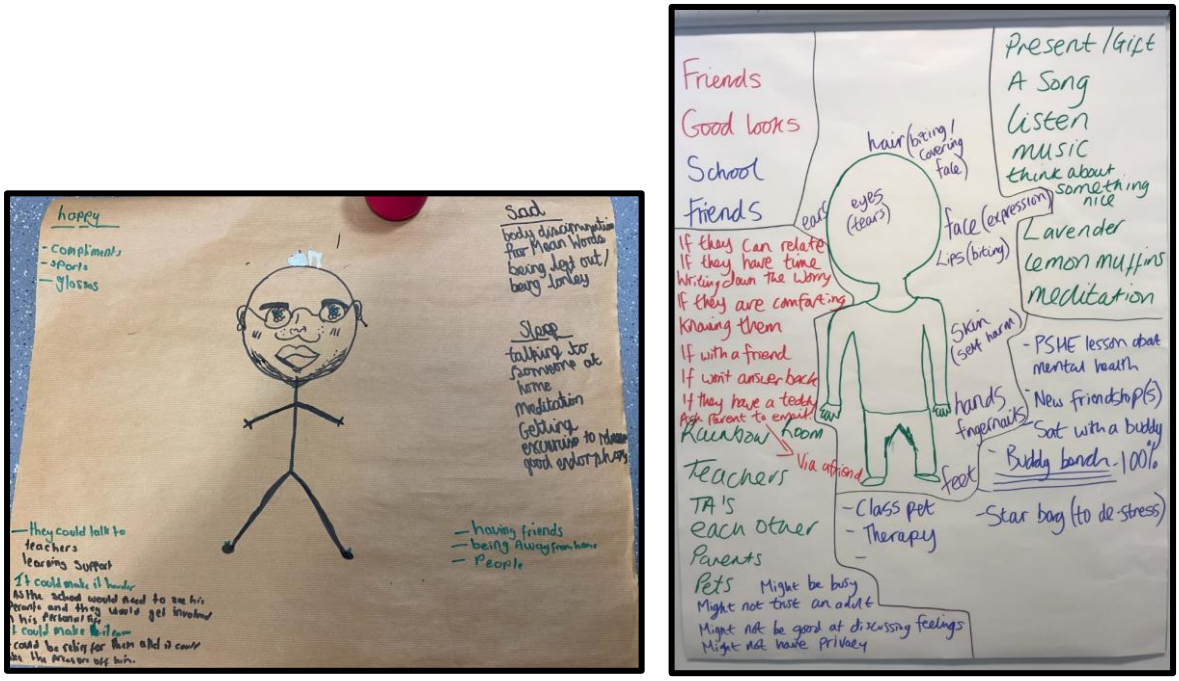
greater than with first-person activities. The activity involved asking pupils to discuss: a) what can impact on that persona's wellbeing; b) what can improve it; c) what can enable or be a barrier to accessing support; and d) what specific things their school does which may be of use. The activity thus allowed us to tap into elements of the PHE whole school approach model, such as curriculum, targeted support, staff development, and ethos and environment, although we left it entirely open to the pupils to decide spontaneously what areas to focus on.

Schools were provided with a PowerPoint slide deck with clear instructions for pupils (key content shown in Appendix 2), including detailed notes on each slide for anyone delivering the activity. An information sheet was also provided, which collected some basic demographic information to aid analysis of the results. Schools were encouraged to use groups of 5 or 6, to maximise the chances of quieter pupils being able to offer their views compared to delivering to the whole class. We asked each group to record their answers on a sheet of flip paper, and school staff to then take pictures of each completed sheet to return to the project team.

5.4. Thematic content analysis

School contacts were asked to follow the activity as planned, making adjustments as necessary to meet the needs of their pupils. For each question, they were asked to direct pupils to answer in different corners of the sheet to make identifying responses easier. This meant each image had a drawing of a body in the middle, and a collection of answers or statements in the four corners of each sheet – each one being a distinct response to one of the questions set. Examples can be seen in Figure 5.1 below.

Figure 5.1. Example pupil voice images from a Y5 group (left) and a Y8 group (right)



Each image was analysed and inputted onto a spreadsheet where the different responses to each question could be collated across all schools. This made it easier to identify themes and frequency of responses across each answer, and subsequently identify how they related to each of the PHE principles for WSA, as described above.

For some responses, there were subtle differences in the language used by pupils, for example if they used 'friends' or 'mates', and discretion was used about whether these could then come under the same umbrella term of 'friends'. There were also examples where some responses were more generic or more specific in nature – for example when talking about what impacts wellbeing responses could be as wide as 'school' or more specific in terms of 'tests'. Responses like these were analysed separately as they could reflect the influence of general ethos of their school, or very specific practices within it. This meant these intricacies were not lost.

On occasion, the same response was given for being both a positive and negative influence on wellbeing or help seeking – for example 'teacher' or 'family'. These were not viewed as errors or misunderstandings by pupils; rather, they were seen as reflecting how practice and behaviour can vary within the same groups of staff in single schools. Importantly, we should see these examples as highlighting how good practice in schools can be utilised and normalised to help support those staff who are yet to receive CPD or other guidance on pupil mental health and wellbeing.

5.5. Key findings

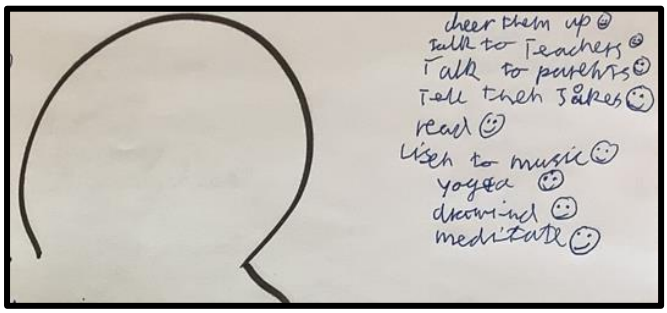
School ethos
This element was commented on via questions about what things in school help make people feel more positive. There were very strong threads around personal relationships here, with most groups commenting on teachers, pastoral staff or friends. This was especially the case in the secondary school responses, with primary school responses focusing on more tangible objects – including worry boxes, buddy benches and wellbeing pets. This suggests a potential difference in need between settings, with primary pupils acknowledging practical ideas more, and secondary pupils acknowledging the personal relationships made within the school community. Recent evidence highlights the importance of school ethos and climate in supporting the wellbeing of pupils (Patalay et al., 2020), so this is an area which schools should be supported to develop and monitor.

Curriculum
Pupils' responses to this activity provided valuable information relating to what could or should be prioritised in a curriculum to promote mental health and wellbeing. These emerged particularly in response to questions around factors that impact on wellbeing, elements that can help us feel more positive, and where relevant, different labels pupils put on their body maps. In terms of things which impact our wellbeing negatively, bullying was a common theme across all schools which was experienced in a variety of forms. Comments like "people being mean", "hurtful comments" and "calling someone ugly" were mentioned. Interestingly, one primary response included "being toxic", which demonstrated more recent terminology around this issue.

In the secondary setting, school pressures were mentioned in their feedback and arguably could be expected as exams approach. Again interestingly, a number of primary responses also mentioned school pressures and issues such as "too much homework" and "bad test results" were raised. Another key theme which cut across both year groups was the idea of "loneliness".

In terms of coping mechanisms, the importance of friendships was very common across all groups, although this would need further exploration to fully understand any nuance involved in this. Only a few groups mentioned specific strategies such as mindfulness, exercise or reading, although activities such as yoga and meditation were clearly important to some pupils (Figure 5.2). Pupils from one primary who had wellbeing pets for pupils to access commented that these were something they can access to help them too.

Figure 5.2. Extract on coping strategies from one Y5 group's pupil voice image

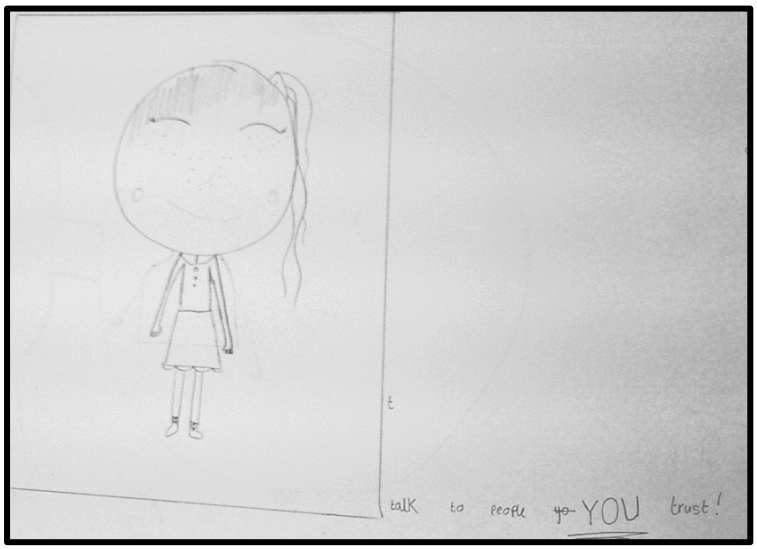


Targeted support

Information relating to this element of WSA came from focusing on how pupils may seek and access support within their setting. Across all schools a common theme of trust, or lack of it, was commented on by pupils. This ranged from general comments around trusting relationships, to more detailed fears such as "school will tell parents". Additionally, some groups mentioned a worry of "not being believed" or their school having "no private space". It is important to note the importance of adults in helping children and young people access support, especially around anxiety and depression (see Radez et al., 2021). With this in mind, finding ways to build trust between pupils and staff should be a key component of any WSA to EWMH. In the light of concerns raised around what would happen following a disclosure or attempt to seek help, a focus on clarifying what happens after someone seeks help should be encouraged to help calm these worries.

On the plus side, a range of positives were highlighted by pupils on how and when they might access support. Supporting some of the suggestions above, where pupils felt and experienced trusting relationships with staff, this seemed to really resonate as a source of support. Comments which highlight the importance of this included "knowing the people giving support" and importantly, "seeing a teacher help someone else". This was emphasised further by one group who raised the importance of "talking to someone YOU trust" (Figure 5.3). Their emphasis of "YOU" in capital letters here reinforces that pupils will seek help from someone they have a connection with, rather than just a named person in their school. Again, this raises the importance of whole staff training on supporting pupils and having those early conversations.

Figure 5.3. Selection from one Y5 pupil voice image



Staff Development
The importance of contact with staff in school was observed across multiple activities and schools, often in relation to having "someone to talk to" alongside the need for staff to be trustworthy. Recent data suggests that teachers are the most common source of professional support for children with a mental health disorder (NHS Digital, 2017), so the comments from pupils here underline the importance of school staff being confident in having early conversations around mental health. This is particularly important in the context of issues around lack of trust and "school telling parents" being cited as barriers to help-seeking behaviours.

5.6. Summary

Key themes across all whole school approach elements described above included the need for pupils to feel that a culture of mutual trust exists between staff and pupils, often supported by pupils feeling like they 'know' the staff members from whom they may seek help. This was demonstrated through pupils expressing fears of 'being talked about', of school staff telling their parents, or of just not being believed. These views were common whether a school was receiving current MHST support or not.

Friendship and peer relationships were a common theme for pupils, both in terms of what can negatively impact their mental health, as well as providing mechanisms for support. Responses from each school often had similar themes in terms of coping mechanisms, suggesting a strong correlation between school delivery on this topic, and pupil awareness of what strategies they can use to improve their wellbeing when they do not feel great. This all highlights the importance not just of discrete initiatives like buddy schemes and peer support, but also effective delivery of the new Relationships and Sex Education requirements (Department for Education, 2021).

Overall, this short activity suggests that schools and MHSTs should actively seek out the views of pupils in order to inform the design and implementation of optimal practice in schools. Pupil voice from non-mainstream settings is also needed in order to ensure that the needs of all pupils are reflected in the development of WSA within and across schools and MHSTs.

6. Data returns

6.1. Overview

This strand of work for our Best Practice Review involved analysis of data returns from a variety of MHSTs in the East of England and South-East of England. This activity was undertaken at around the same time as local MHSTs were being asked to complete quarterly returns for NHS England for Quarters 3 and 4 in 2020/21. Part of the Quarter 3 (Q3) MHST data return involved a series of open-ended questions about WSA. The Quarter 4 (Q4) MHST data return involved a series of 17 standardised ratings about different aspects of WSA, along with space to record comments about each one. These were completed by MHSTs, but additionally, individual schools in the MHSTs were invited to complete ratings for their own educational setting.

Below, the questions for each of the two data returns are listed, along with information about the sample of respondents. This is followed by an analysis of the quantitative ratings from the Quarter 4 return, followed by a thematic analysis of the open comments from both time points.

6.2. Description of data returns

At Q3, the MHSTs were asked to supply information and comments in response to 7 open-ended questions, listed in Appendix 3. The questions related to support for the development of MHST staff teams, the different ways in which MHSTs were working with the local educational settings (broken down into core areas of WSA), measurement of impact, and plans for the future.

Responses were received from 16 MHSTs: 7 from the East of England, and 9 from the South-East.

At Q4, MHSTs and individual educational settings were presented with 17 aspects of WSA and asked to make a quantitative rating for each one, using a set of graded descriptors. These included questions about: the engagement of different stakeholders; the ethos and environment of the educational setting; leadership and management; staff development and wellbeing; different aspects of mental health work in schools; integration with curriculum and pedagogy; integration with other approaches to behaviour and wellbeing; the use of data to support the work on mental health; and the perceived integrated working, governance, and leadership of the MHST overall. All questions and graded descriptors are shown in Appendix 3.

Ratings were received for 22 MHSTs (including one Wave 4) and for 28 schools (including a mix of primary and secondary settings) from 9 MHSTs.

It is very important to note that each MHST was asked about their experience across their area, and all the constituent schools/colleges, as a whole. Thus, they were asked to give overall indications of progress, recognising that educational settings could be in very different places in their own WSA work. The 28 schools/colleges returning Q4 ratings are clearly a small and non-random selection of schools that were able to find resource/capacity to complete the returns, during a very busy period of time.

6.3. Key findings

This section begins with a quantitative analysis of the Q4 ratings of different aspects of WSA, before moving onto a thematic content analysis of the comments made in response to the Q3 open-ended questions and the Q4 ratings.

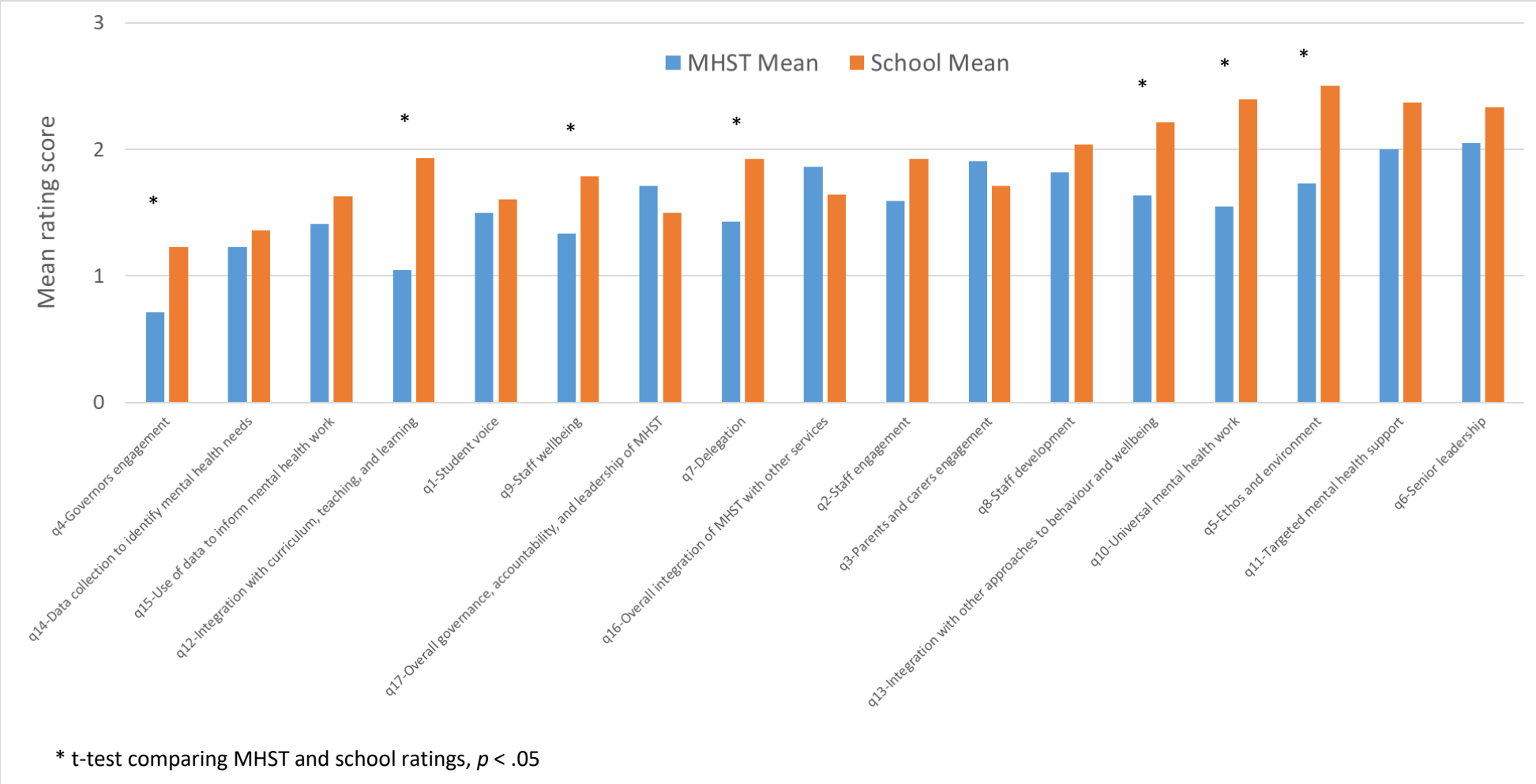
Quantitative analysis of Q4 ratings

Figure 6.1 shows the mean ratings given by the 22 MHSTs and 28 schools for each of the 17 areas, on a scale from 0 (broadly indicating that work in that area not yet under way) through to 3 (broadly indicating that work in that area is strongly embedded). The 17 areas are ordered from left to right in order of the overall mean rating given by the 50 raters, but there are clear differences between MHST and school ratings for some questions.

Overall, engagement of school governors and collection and use of data for mental health purposes were generally rated low, both among MHST and school ratings. Targeted mental health support and supportive senior leadership were generally rated highly in both subgroups.

In general, school ratings appear to be higher than MHSTs. The biggest gaps relate to the integration of mental health work with curriculum and pedagogy; universal mental health work; and school ethos and environment. However, these differences are not surprising given that the MHSTs were asked to rate across their respective areas, where schools likely showed large amounts of variability in practice, whereas the small and self-selected group of schools returning the ratings may have been schools with more effective practice.

Figure 6.1. Mean ratings of different aspects of WSA provided by 22 MHSTs and 28 schools, from Q4 data returns



* t-test comparing MHST and school ratings, $p < .05$

Although the sample was small, an inspection of patterns of correlations and exploratory factor analysis suggested a reduction of the 17 ratings to two key dimensions, as shown in Table 6.1. However, note that the ratings of governors' engagement and overall governance, accountability, and leadership of the MHSTs did not show satisfactory intercorrelations with other variables in the school ratings. These were therefore excluded from the data reduction.

Table 6.1. Item-total correlations and internal consistency estimates for the 17 areas of WSA

Area of WSA	Orientation and approach	Intervention and data
Student voice	.50	
Staff engagement	.64	
Parents and carers engagement	.41	
Ethos and environment	.60	
Senior leadership	.63	
Delegation	.72	
Staff development	.63	
Staff wellbeing	.70	
Integration with curriculum, teaching, and learning	.73	
Overall integration of MHST with other services	.53	
Universal mental health work		.62
Targeted mental health support		.72
Integration with other approaches to behaviour and wellbeing		.71
Data collection to identify mental health needs		.65
Use of data to inform mental health work		.68
Cronbach's alpha	.88	.86

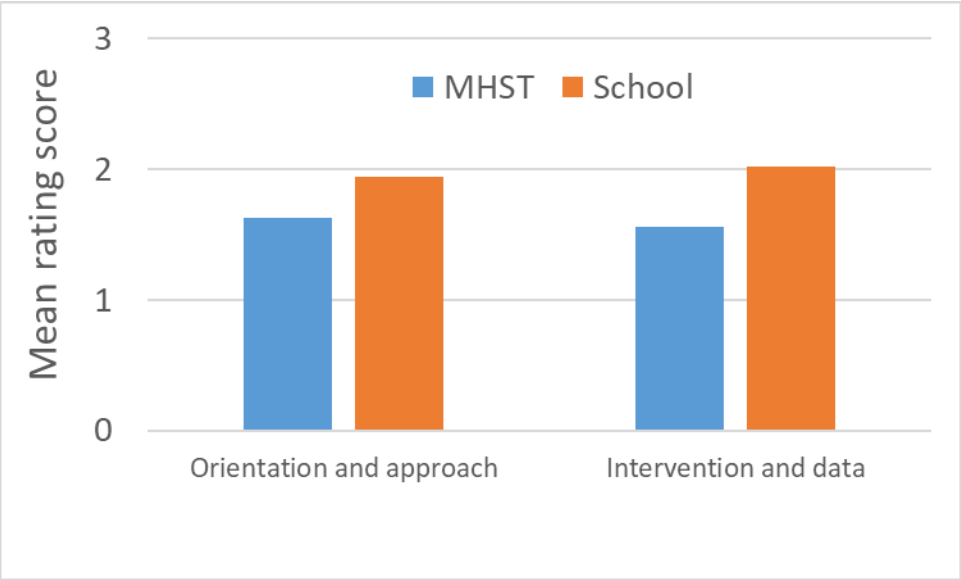
This analysis should be treated with caution given the small number of ratings, but the two sets of items had very good Cronbach's alpha and strong item-total correlations (correlation of scores on a given item with the total score across all other items in that set), indicating that the two scales are internally consistent. Thus, two reliable scores were formed based on this pattern. Figure 6.2 below shows the mean scores of the MHST and school for these two dimensions.

A two by three mixed-design analysis of variance, with WSA score (Orientation & Approach vs. Intervention & Data) within subjects, and Region (East vs. South-East) and Rater Type (MHST vs. school) between subjects. The analysis revealed only a main effect of Rater Type, $F(1, 46) = 5.92$, $p = .01$, partial eta-squared = .11. This relates to the general tendency for this non-random selection of schools to be scoring higher than the MHSTs scored their respective cluster of settings as a whole.

It is worth noting that there were no significant differences between region, neither in terms of a main effect nor in terms of interaction effects. Furthermore, there was no significant overall difference between the scores for Orientation & Approach vs. Intervention & Data.

Overall, it is clear that the average ratings tended to lie somewhere between 1 and 2 for most items and for the two dimensions overall. This reflects the fact that some work was clearly underway in each of the key areas of WSA but also that there was some distance to go before that work could be considered strongly embedded.

Figure 6.2. Mean MHST and school ratings of two dimensions of WSA, from Q4 data returns



Thematic content analysis of MHST comments in data returns

A hybrid model of thematic analysis was undertaken on the comments given by MHSTs in response to the Q3 open-ended questions and the Q4 ratings. The analysis was guided by a consideration of the different areas of WSA described above in the quantitative ratings, but the voices of the leads from the MHSTs provide a clear sense of the profile of work occurring across different areas. Themes are highlighted in bold print and subthemes are underlined.

One key theme for building stakeholder engagement in educational settings (pupils, staff, parents/carers, and governors) relates to **regular communication, induction, and information-sharing**. In many cases, there were clear references to the value of <u>induction</u> activities at early stages of involvement:

> *All teams have an intensive and robust induction process with each of their schools. There is ongoing support through supervision.*

> *MHST staff are starting virtual inductions in schools to meet school staff and understand their roles and responsibilities…. They are shadowing meetings as well to understand school process and joining staff team meetings to get to know roles and structures within the school.*

This also often involved <u>attending school meetings</u>, both dedicated MHST links as well as routine attendance of regular school meetings such as safeguarding panels, special educational needs co-ordinator (SENCO) cluster meetings.

> *There are weekly meetings with the pastoral/safeguarding teams within the school to help understand the current structure. We have access to all the school policies and these are embedded within our standard operating procedure (SOP) as well for ease of access.*

Teaching staff are invited to regular MHST information sessions for schools. Discussion/"break-out rooms" are used to encourage open dialogue about developments that schools would like to see in the mental health provision provided to them.

We organise Termly Planning Meetings. These meeting happen once per term between the supervisor/lead, the trainee attached to the school and the MH lead of the school.

In some cases, respondents emphasised the quality of the relationships between individual members of the MHST and the individuals within the school setting.

I feel confident in the procedures around this having worked in schools before, I think it's hugely dependent on the relationship you have with the school and being visible to them and I've noticed they are then happier to have us involved in meetings and issues within school with clients.

Structures that bring key stakeholders into these meetings were less common, but some examples were cited:

Carers are included within the MHST Partnership boards to support collaborative working.

Held [pupil] focus groups in primary and secondary schools; through work with [area name] Youth Council and future work with School Councils.

CASE STUDY

West Sussex MHSTs
Establishing two-way collaborative relationships

This area developed a Reflective Tool to support schools to develop their WSA in a coherent and effective way. It was based on the 8 principles of the PHE model and used a best practice example for each principle, followed by a series of prompt questions to stimulate discussion about: how a school can improve their WSA to mental health and wellbeing; and specific ways MHST support can help to implement the agreed actions.

The Reflective Tool is designed to be used throughout the school hierarchy, including a pupil version has been created to gather student voice on the eight areas of WSA which is differentiated for primary and secondary schools.

Three key benefits of using the Reflective Tool are:

- A co-produced piece of work between the MHST and the education setting, which is ongoing, but also generalisable because it links back to a core model;
- A better working relationship with schools because their own answers reveal the school's priorities;
- A coalition for change within the school because of a greater sense of ownership and commitment to change.

Another major theme related to the importance of **gaining an understanding of the school environment**. This happened through informal visits, specific tasks completed by EMHPs, and audits.

We completed audits on a few schools to identify their needs and when consulting with school and setting up the MHST ask for a tour of the school, can often pick up on the environment, talk about the needs of staff, students and families. I always ask about diversity and socio-economic struggles of the school to give and idea of what is needed.

This quarter, the EMHPs were tasked to research their allocated school's demographic, Ofsted Report, policies and get a feel for a school's environment as they returned to in-person clinical work. They reviewed how visible Mental Health and Emotional Wellbeing was around the school, analysed any themes in clinical work around issues in schools and held regular conversations with their link person/Senior Mental Health Lead.

Surveys completed via schools with parents to explore their needs and in line developing suitable workshops and groups.

At Q4, there was a noticeable expansion of opportunities to build participation from different stakeholders in order to develop a shared understanding. This happened not just through specific programmes introduced around mental health support among young people, but also through investing in training on the topic of participation itself.

Peer mentoring programme has allowed students to be a part of influencing how this is taking place in their school.

We are in the early stages of students becoming wellbeing ambassadors.

All staff have attended participation training and plan to develop a participation strategy with our YP representatives next term.

A major focus was **upskilling stakeholders in relation to mental health** to create a strong collaborative team to promote the WSA. One major element was training different stakeholders. The main focus was on training offered to staff in educational settings:

MHST has delivered training to staff on promoting resilience for students returning to school after lockdown.

Offering webinars to all staff including support and pastoral team members to inform about mental health needs.

We have also run SMHL training programme on all WSA principles and will be providing supervision for schools shortly too.

Senior Educational Psychologist or Practitioner is able to provide training around neurodiversity of students and supports EMHPs at MHST surgeries to consider needs. MHST has recently completed some gender identity training and has circulated the [area] transgender policy.

CASE STUDY

Mid and South Essex MHSTs
Team Around the Learner

The Team Around the Learner (TAL) initiative fostered education staff members' professional development by creating a consultation space for all school staff. The three main areas in which the MHST provided consultation at these meetings were:

- Pupils, parents or caregivers that staff have concerns about;
- Triaging potential referrals and signposting;
- Teacher well-being and supervision (i.e., mentoring, supervision, curriculum development or collaboration with MHST).

Overall, the TALs have helped build a better understanding of mental health and wellbeing for the whole school community. Specifically, staff are more precise in the language they use, which guides thinking and broadens understanding; are better able to tease apart what is a mental health need; and have ways to hold the responsibility and support children and families.

"We have great conversations about how we move things onto the next stage and think with the schools about how these things evolve and it's not just a one size fits all. The most valuable thing is that everyone around the table is thinking of the child as a whole"
Clinical and Strategic Lead.

In addition, there were clearly emerging efforts to engage with parents and carers through a variety of means. The picture was quite varied, suggesting that rather than having a single recommended approach, different strategies are being used to suit different local contexts.

> *Specific workshops, events and pre-recorded materials are offered to parents and carers, and uptake is good.*
>
> *Signposting for parents as well as children and young people. Sending out resources/information on children's difficulties. Try to engage the hard-to-reach families through flexibility such as providing an audio version of books, making use of interpreters and working closely with schools to gain parents' trust.*
>
> *Developing and recording psychoeducational videos for parents to access.*

In contrast, engagement with governors was very limited and generally did not involve direct contact:

> *We have developed a partnership agreement which outlines the relationship between the school and the team. This is then signed by the Headteacher and Chair of governors as well as the MHST to establish expectation.*
>
> *We would hope that they are aware of our team and the support we offer, however we have not explicitly confirmed this.*
>
> *Have offered to attend Governor's meetings but offer not yet taken up.*

Work on **staff wellbeing** has been an increasingly important focus of attention:

> *School staff webinars provided by Improving Access to Psychological Therapies (IAPT) for school staff focussing on their wellbeing, stress and anxiety.*
>
> *Staff wellbeing workshops have been offered and are further being requested - feedback has been positive.*

However, it is clear that there is still some way to go to ensure staff members' own wellbeing and mental health issues are fully understood and addressed:

> *A key feedback … from school staff is around lack of supervision (re. mental health support).*
>
> *This is the most challenging area to support schools with at the moment, particularly due to the pandemic and the reality of staff needing reduced workloads and regular breaks, which has not been possible.*
>
> *This is not something we have actively worked with schools on.*

It was clear that interventions are a strong part of the direct provision, and **targeted work with selected pupils** appeared to be the major focus, with many examples of such work provided by respondents. A wide range of issues were being addressed, and MHSTs had worked hard to clarify systems for referrals:

> *Working with schools to identifying appropriate referrals to either MHST or other agencies, supporting with onward referrals where needed. This has been done through sharing appropriate case criteria as well as create resources to capture child voice.*
>
> *This is supported by the 'request for support' process whereby parents or young people can 'self-refer' for support. Timely and effective identification also takes place through the enquiry review meetings/emotional wellbeing & mental health forums in each school.*
>
> *We have a clear system in place to receive referrals for individual or group support in our schools which enables us to identify CYP who require support and deliver evidence-based interventions for these young people.*

There was also clearly an effort to engage with other services in order to develop a more joined-up provision, although it was noticeable that the specific arrangements were highly variable across different MHSTs.

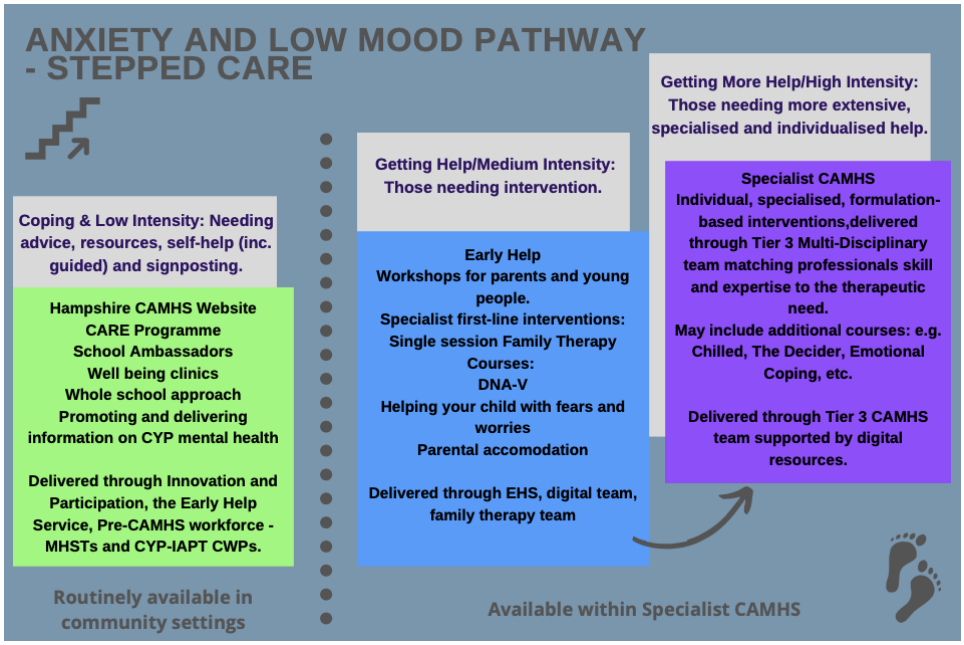
> *We have consulted with parents regarding their child's mental health and have signposted to other support organisations where necessary.*
>
> *Networking with other services in the school and outside the school to offer more joint and collaborative working through local multi-agency Early Intervention Meetings are completed.*

CASE STUDY

Hampshire MHSTs
Investing in a joined-up approach to support children and young people's mental health

The mental health support model in this area is that MHSTs are working alongside and adjoined to Tier 2 level of CAMHS. The aim of working together is to fully integrate support from the MHST, from the school and from CAMHS for children and young people and families. "We've really focussed on building those relationships", Clinical Lead.

Through those relationships, staff from the MHSTs in this area worked closely with other mental health services and had input into a central hub, through which all referrals come. Through the Single Point of Access Service, the mental health support team are part of a connected system of support which follows a stepped care pathway. An illustration of the stepped care pathway for anxiety and low mood is included below.



In line with the evidence from the quantitative ratings, **systematic data collection and use of data to inform mental health practice was variable**. There were some good examples of Routine Outcome Monitoring (ROM) being systematically collated and analysed to inform practice in schools:

> *All treatments involve the collection of a range of Routine Outcome Measures (ROMS) to assess impact of the interventions. Group Work and workshops provided also use ROMS to assess impact of intervention. We feedback anonymised outcome data from the groups to the schools to share with the SLT.*

However, the monitoring of impact in relation to WSA more generally was more limited and generally did not take a standardised form, although some efforts were clearly being made:

Evaluation forms from workshops, training and webinars provided. Annual meeting with every school to receive feedback about services and inform further development, a written report is produced of each visit and these reports are then collated and analysed. Feedback from Network meetings. Reviewing the online Healthy School Check regularly.

Audits, staff feedback forms, MH surgery record forms. Working on this.

Evaluation of training – pre and post scales in knowledge, skills and confidence, things valued from training, what would make session more useful, next steps and overall rating of training; evaluation of consultation.

This is an area that needs developing as currently we are not using any particular measures.

We sent a survey to all parents, staff and students at our schools, and fed this back via a 'you said, we will do' poster. This was a one off.

Nonetheless, there was an **overriding sense of understanding the work to be done with WSA**, and there was a sense that engaging with universities around training courses played a positive role in this:

Feel like I know about the whole school approach well, it's something that is also being covered at uni at the moment. I think having the time in the Easter holidays to pull together ideas for groups and training will help us see as a team how we can put this into practice.

EMHPs and Supervisors have covered the WSA module at [university] and have regular contact with mental health champions, pastoral staff, SENCOs and teaching staff. They've offered consultations to staff as well as psychoeducational workshops and assemblies. EMHPs have been supported in this work through close supervision, keeping the WSA on the team meeting agenda and group discussions.

It was clear that there was an enthusiasm for engaging with schools around WSA, including integration of mental health work within the general school curriculum, but this was tempered by a recognition that practice was highly variable:

The MHST model how we would expect a school's culture could promote respect and value diversity in all communications with schools and how we promote mental health and wellbeing.

Regularly send resources and information to support the schools in curriculum planning.

We encourage the schools to integrate EWMH in all curriculum areas, not just PSHE or RSE (Relationships and Sex Education). This is an ongoing piece of work and we are providing resources and activity ideas to encourage this more in schools.

Very variable across schools. We work closely with many senior leaders, but not all schools are fully engaged with us.

In all schools, senior leadership have shared communication about the MHST but more engagement is needed with wider school staff.

CASE STUDY

St Richards Catholic School, East Sussex
Co-ordinated teaching and learning about mental health and emotional wellbeing

In this school, PSHEE was described as being taught through a spiral programme of learning. The curriculum was complemented by themed assemblies, topic days and cross curricular links. Each department in school linked in with the cross-curricular programme by auditing their own curriculum to show where they covered learning about wellbeing and how to support good mental health.

Specific topics related to EWMH were repeated in age-appropriate ways across the year groups, and the individual lessons in each area were carefully sequenced. The delivery of the different schemes of work was flexible, to allow teachers to respond to the needs of their class and the current climate. In addition, there were stand-alone resources to use during other contact time such as tutor time and registration. There was a student rep for PSHEE and a 'question and response' box to ensure student voice is incorporated into the planning of the curriculum.

"As a school we take an evidence based, best practice approach to the teaching of PSHEE which we map out and departmental staff self-audit to show where mental health and wellbeing are addressed in their schemes of work."
Vice Principal

Several MHSTs recognised the considerable work that needed to be done, but also reported a solid set of structures for facilitating future expansion of good practice.

> *Clear supervision and line management structure to ensure safe clinical practice and professional development. Good links with university. Attendance at MHST best practice meetings. Clear management structure. Management posts all filled. Regular team meetings. Appraisals. MHST Management Strategy meeting.*
>
> *We have clear operational processes and procedures to respond to need in different areas and with multiple MHST sites we have flexibility to cover areas dependent on need.*

6.4. Summary

Both the quantitative analysis of Q4 ratings and the qualitative analysis of comments from Q3 and Q4 data returns show a consistent pattern of achievement and development along many dimensions of the WSA. However, the clear message is that while much progress has been made, there is still considerable distance to go in order to achieve consistently high level of whole-school engagement with a mental health strategy. Efforts to engage stakeholders have increased, but there is still variable practice in engaging staff, pupils, and parents/carers, while engaging with governors is generally very limited. Some strong steps have been taken to support staff members' professional development in relation to mental health, as well as to support their own wellbeing, but this is a work in progress, particularly in relation to potential supervision needs. In addition, while there is a recognition of the need for data to monitor outcomes and track impact, the extent to which this takes place is variable, and monitoring improvements in WSA is generally unsystematic.

Overall, there seems to be a clear consensus that mental health is regarded as important and is valued across different settings, with a great deal of work taking place not just to strengthen

referrals and deliver targeted interventions but also to foster a climate and ethos that promotes mental health. However, developing the WSA across all settings in a way that systematically engages all stakeholders, supports wellbeing for all involved, and gathers evidence of impact is still a work in progress.

7. Staff interviews

7.1. Overview

This strand of data collection focused on interviews with key members of staff in the MHSTs and members of school staff. Between April and September 2021, we interviewed staff from MHSTs and from selected schools about their WSA to mental health and wellbeing. Our aim was to gather experiences of best practice in this area, clarify what support was being provided, evaluate its impact and effectiveness, and identify the factors that facilitated or hindered the success.

We sampled MHSTs from four different models, namely those set up within an Education service, a Health service, an integrated Health and Education service, and a Voluntary and Community Services provision. The focus was on Trailblazer, Wave 1 and Wave 2 of the national roll out across the South-East and East of England. Some participants were also involved with newer waves, either as part of strategic oversight or because they had recently moved across, having built up experience of WSA work in an earlier wave team. School staff were recruited from selected flagship schools across the Primary and Secondary age range, including special schools.

7.2. Participants

Interviewees represented 11 areas in the South-East and 8 areas in the East of England. A total of 29 people participated in interviews. All interviews were conducted individually except for two interviews where a pair of interviewees participated together because of participants' preference to include colleagues (e.g., because someone had been temporarily absent).

Interviewees included 12 managers with responsibility for the team service delivery of WSA[2], 6 MHST practitioners with day-to-day responsibilities in schools (Educational Mental Health Practitioners and Senior Mental Health Practitioners), 5 MHST clinical leads for different areas, and 6 senior school staff members with leadership responsibility for mental health work (one primary head teacher, one assistant headteacher for a secondary special school, and three mental health leads in secondary schools).

7.3. Interview schedule

The key questions in our interview schedule (adapted as appropriate depending on the professional role of the interviewee) can be found in Appendix 4. The questions were designed to:

- Provide an in-depth understanding of the way support for WSA is designed and delivered at the local level;
- Understand what underpins judgements and decisions about the range of support offered, who provides it, how it is delivered and tracked (service plan);
- Explore decision making about how service activities are integrated with other school or college provisions;

[2] Note that some of these managers were in roles not formally structured within the MHST (e.g., they may have been in a pre-existing role funded by Public Health England). These participants were included in the research because they were positioned as an integral part of the MHST offer (e.g., sharing responsibility for running networks, delivering training to Senior Mental Health Leads, contributing to EMHP training, developing tools used by and on behalf of the MHST).

- Understand the facilitators and barriers for delivering a WSA;
- Explore how the workforce have been developed and supported;
- Identify effective, innovative, and high-quality strategies for promoting WSA;
- Understand how top-down reform of health and education systems interacts with bottom-up people- and place-based solutions.

The interviews were between 60-90 minutes in duration and were conducted remotely. They began with a brief reminder of what confidentiality, anonymity and withdrawal mean in the context of this research. We then asked participants for background information to explain their role within the local structure, specific responsibility for supporting the WSA service offer, and the profile of the cluster schools and the wider offer from other services to schools. The questions in the interview schedule were adapted slightly for school staff to shift the focus onto the provision in place in schools to improve mental health and wellbeing and the part the MHST played in introducing and developing that.

7.4. Thematic analysis

We transcribed and analysed the interviews using dedicated qualitative analysis software (NVivo). Note that this coding was undertaken separately for interviews with MHST team managers, MHST practitioners with day-to-day responsibilities in schools (e.g., EMHP), and school leads.

We used a hybrid approach with deductive elements based on insights from other strands of work already undertaken (including literature review and analysis of data returns) and inductive elements based on new ideas emerging from the voices of the interviewees. Key steps were in line with recommended practice, including:

- Familiarisation (i.e., listening to recordings and reading through all transcripts).
- Open coding (i.e., identifying initial codes from each recording)
- Reviewing initial codes in conjunction with insights from existing theory and knowledge from other strands of the project
- Collapsing across codes and/or separating into new themes and subthemes
- Reviewing analysis and defining themes and subthemes
- Finalising themes and subthemes

The next section provides an overview of the key themes in relation to the original aims, with illustrative extracts from the transcripts. Note that this is not a comprehensive list of all themes and subthemes emerging from the interviews. Extracts are identified by the code number associated with the relevant participant (M = manager, C = clinical lead, P = practitioner, SL = school lead).

7.5. Key findings

The interviews revealed a fascinating interplay of issues relating to both Orientation & Approach and Intervention & Data. They are presented below in the context of five major thematic areas that address key questions for WSA work in MHSTs. As before, subthemes are underlined in the narrative.[3]

[3] Although this was not a focus of the current report, it is worth noting that the COVID-19 pandemic posed obvious operational challenges for teams, and this came up in various interviews, particularly

It should be noted at the outset that one overarching issue concerned the fact that **MHSTs were clearly set up in very different ways**, and these in turn intersected with the different ways in which mental health work in schools was structured and configured. Broadly speaking, MHSTs set up in a primarily health-based context tended to get the team working on effective delivery of targeted early interventions for young people considered to be at risk or displaying early indicators of difficulty. Those set up in a primarily education-based context tended to have the pre-existing knowledge and networks to be able to begin engaging with WSA activity at an earlier stage. And those set up in a community and voluntary sector context tended to have stronger partnerships with other local provisions although they tended to be less integrated with the formal health and education services.

Consideration of the optimal configuration of MHSTs was beyond the scope of this project, as this involves different national and local funding models as well as the historical and current demands of the local context. However, it is important to recognise this significant variation in order to understand the experience of MHSTs with work on WSA; as shown below, it is clear that this did not happen in the same way for all MHSTs. This led to different experiences of strengths as well as challenges.

> *We are an integrated team which means some people are employed by the county council and we have some people in the team who are employed the NHS Partnership Trust, which is essentially CAMHS but they are still very much in our team. That works fantastically well. It gives a real rich breadth of experience to the team.* (M)

> *We work alongside a number of different [community] services in our cluster schools who are working around mental health and well-being, especially at the mild to moderate presentation…. we talk a lot with them regarding referrals, especially when a referral isn't suitable for us, to offer the CYP support. That integration with other services works back the other way as well.* (M)

> *As a special school, we build professional but really close relationships with the children and their families. We know their situations well, so the MHST can feed into that too.* (SL)

> *Because we're in between healthcare and education, we don't have a place to sit as a team. So even down to getting my printing done, I drive to a shop near me to do it.* (P)

Overall enthusiasm from schools

Before turning to some of the key challenges and tensions encountered by the interviewees in relation to rolling out WSA work in schools, it is important to recognise that the school leads were consistent in recording an overall positive response to the potential and actual contribution of the MHSTs:

> *Getting MHST support in school is incredible.* (SL)

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in relation to navigating around online delivery during lockdown: "*We had the challenge, 'can we deliver a whole school approach online?' The reality is that we were a lot more successful delivering online support to parents and staff than the young people themselves, just because of the engagement of the group."* (P).

Previously, we've always struggled with various agencies and services we work with. They are always so busy. To have specific support for a child's mental health, which is a pretty broad spectrum, is amazing. In fifteen years of teaching, I've not come across anything like this service offer. (SL)

Having mental health expertise and specialist support is absolutely invaluable to us. (SL)

There was a noticeable appreciation for the more open and inclusive offer of services, including aspects of WSA, in comparison with previous experiences of health services:

Obviously, the financial side of the MHST support has been great because we can broaden out from the individual work with the children and think about staff development without having to take away from other areas of the budget. (SL)

They are so willing to engage with what our school needs and find things that fit. (SL)

Selecting the starting point

One area of complexity revolves around establishing the starting point for MHSTs to engage effectively with schools and colleges in their respective areas. This was generally not seen as straightforward, and it was clear that some MHSTs had experimented with different approaches and were still working out what approaches were best.

Numerous interviewees spoke about the importance of opening up clear lines of communication between different members of the MHST and the school staff.

Within the team, the Seniors [Senior Mental Health Practitioners] and the EMHPs have got really good relationships with their schools – either through the link people, or Designated Safeguarding Lead, or the coordinators, or the Pastoral Team, or whoever the most relevant people are who are making the referrals – and they have ongoing, informal, ad-hoc opportunities with these people that they use to ensure they are having conversations all the time about whole school needs of the school. (M)

It's more about creating touch points – and that includes between schools – which all lead back to the same place, increasing the knowledge on both sides about how to share expertise and work together. (M)

However, it was very clear that establishing relationships was not something that could be taken for granted. Many interviewees – both team managers and practitioners – emphasised the importance of 'starting small', creating space to understand school needs.

We are keen not to be seen as the new kids on the block who are treading on the toes of our colleagues who have been doing great work for a long time. There's been a little bit of finding our place there. It helps that we're starting small. (M)

My experience tells me that focussing on a small step that we can work towards is a good place to start … We don't want to jeopardise anything by bombarding them with everything we offer to develop a WSA. (P)

We can approach a problem the school has identified by saying, we've got this, how would that work, rather than saying, 'oh yes, we'll create something' which is how we started out doing everything. (P)

We can't force ourselves onto the schools in terms of influencing ethos. (M)

Some MHST interviewees clearly felt that they had learned from experience how and when to approach particular people in school settings in order to have the right impact at the right time:

In reality, on some Whole School Approach initiatives the Headteacher is the last person you speak to because the groundwork to make a cultural shift happens before that. When you have the evidence, you bring the Headteacher on board. (M)

To get to the point where a Headteacher will include you in that kind of decision-making stems from the trust, credibility and the relationship that develops over time. And the belief that you really are there for the long haul, to advocate for that entire community. (C)

In some schools, there's scepticism in there about how long you're going to be around as an initiative to support them. And I think we do need to address that issue of trust. (C)

It was understood that this could take time and some interviewees reflected on the need for this to be clarified. This relates to a sense that schools needed to be prepared to be 'vulnerable' about where they needed support.

We need to be a bit more transparent about the set up with our MHST schools about what we need from them. That may be acknowledging that the set up may take a little bit more time while we bring in those factors that create better relationships but once that's in place things shouldn't be so time intensive and labour intensive. (P)

The best examples are where they will just say, we need to improve our system, our system's rubbish. And they are just really open with us…. that environment where that trust between the school or college and mental health support team means they can almost be vulnerable with us and say, we're not doing very well with this, instead of just saying we'd like some training on anxiety. (P)

Interviewees reflected on the fact that optimal MHST engagement required both professional credibility and a non-judgmental attitude regarding the local context of each school:

It's important to have professional status in school, which gives you that level of expertise, so that people feel very confident that you've got that range of skills and knowledge and experience of working with young people across the breadth of complexity. That's one element of working with those staff members, that you bring an immediate sense of credibility. (C)

What I've learned is, every school, even if you're in the same town, is completely different in ethos and culture. And so much of that is often based on the school's history, the demographic of the school, the leadership team, the head…. What I learned very quickly is to be curious and non-judgmental, because some of the things that I initially came in and thought weren't working were actually that way for a good reason. (C)

CASE STUDY

Ormiston Families, Norfolk and Waveney MHSTs
Getting a 'Rich Picture' of educational context

This area uses a 'Rich Picture' methodology to learn about how the school system is working and everything that is going on in it. A Rich Picture is a way to explore, acknowledge and define a situation and express it through diagrams. It helps to open discussion and come to a broad, shared understanding of a situation (Checkland, 2000).

This qualitative approach was used when a school requested support for staff which was loosely framed as, 'staff lack confidence in supporting children who present with social and emotional and mental health difficulties'. The Rich Picture provided a way to explore this in an unstructured way, supporting discussion which fostered a holistic understanding of multiple interacting relationships, to gain a deeper understanding of the situation from the whole staff perspective and empower them to consider their own solutions and ways forward.

It highlighted barriers to do with staff knowledge and training in the role of teachers who qualified to support wellbeing and mental health. Staff were concerned they would make things worse by saying or doing something wrong and they felt they lacked time to become more proficient. Next steps included goal setting, gathering ideas about strategies to meet these goals and an analysis of factors that hinder and facilitate change.

Learning about the unique context in this way enabled the MHST to tailor interventions for individual school setting. With this systemic level of work, the MHST was better able to support organisational change.

Balancing targeted interventions and WSA

A prevalent theme concerns fundamental uncertainties regarding the development of a WSA across school settings given multiple pressures from both schools and MHSTs to focus on targeted early intervention work with individual students.

> *The first area we prioritised with the MHST was identifying children we thought would benefit because we had children who were crying out for that kind of help. We've worked on the referral process.* (SL)

> *Of the 8 principles of the WSA, we're having the most impact in targeted support. For example, we've done a lot of work with our referral form.* (M)

> *There is enormous benefit to placing MHSTs within secondary Mental Health services. In terms of escalation of mental health difficulties we've got a really clear route to step young people up and have the right kind of conversations and access psychiatric consultation if we need it in a smoother way.* (C)

> *One of the things about the MHST that I really value is the way in which it is providing early intervention…. we do CBT, or [we're] cognitive therapists, that's our approach. So I really value our team focusing on that.* (C)

> *When I took this job, I was under the impression it'd be more whole school approach. So I think probably like 75% whole school approach 25% more complex one to one… At the minute, I'd say it's more 50/50.* (P)

However, it was also clear that the attention to WSA could change over time, as the dynamics of the MHST relationships and practices developed:

> *We've been playing catch-up with the WSA because the clinical work took precedence for the first year, whilst the EMHPs were in training.* (M)

> *In our 'Consultation and Liaison Meetings' there had been a sense that we would 'sort out' and 'fix' individual cases and problems. When we've done Reflective Practice session in a school, those dynamics changed and what's happening now is that staff are bringing a young person's presenting problem and talking about what they're doing to support that young person, saying where they're not sure, saying where they think things are improving.* (C)

A major challenge to increasing the focus on WSA is a fundamental tension between deficit and strengths-based approaches, particularly between the focus on manualised interventions for mental health difficulties and a consideration of mental health issues as a natural part of everyday life at school. This was articulated by a number of clinical leads.

> *Whole school approach is always thinking about the child in context and it runs kind of counter to the other function of the MHST around the individual work, where you're sort of locating the problem in the child.* (C)

> *I am concerned that the approach that the mental health support teams offer … forces people to fall into that habit of thinking, 'I've got anxiety, I need to be fixed'. For many young people, their anxiety is a very kind of natural and an important part of where they are in their life right now.* (C)

> *We inadvertently force young people into categories and towards behaviours and they move towards crisis so that they can get a service, rather than saying to ourselves, we have this huge need in a big part of our youth population and asking ourselves, 'What do we need to do as a community?'* (C)

> *Over the last ten years, a lot has been done to tackle mental health stigma but in the process of doing that, a detriment has been we've made emotions really scary for some children and young people, who may have the idea that they can't manage them without support from an expert.* (C)

Data, measurement, and evidence

An issue that contributed to the above tension between WSA and targeted intervention work relates to the significant gap in measuring change and gathering evidence relating to WSA, in order to demonstrate the impact of MHST practices.

> *What's hard is that if we're going in with the Whole School Approach first, in order to facilitate the other core component which is delivering CBT interventions for mild to moderate MH difficulties, we have no way of measuring the impact of that work.* (P)

Our WSA measurement is tenuous to say the least. (P)

So that data [on WSA], we've collected scores but nothing happens with it. So at the moment it's not very meaningful. It sits on a spread sheet. (P)

This issue has had real consequences for MHST practice. Limited measurement of WSA impact has in some cases translated into limited prioritisation of WSA activities. This reflects a serious need for planning of how to capture WSA in both the internal and external monitoring of MHST practice.

We've really found that it's difficult for EMHPs to fit WSA in around their key performance indicators (KPIs) and deliver much when their focus has to be on those KPIs. (M)

When it comes to our evaluation and number crunching the Whole School Approach doesn't yet count for reporting so in the set-up we prioritised services that have measurable deliverables. (C)

Quite a contentious issue … with commissioners it is access targets and how many young people we're seeing. And it's always a bit of an uphill struggle to communicate the value of the whole school approach work, because it doesn't look the same, because it doesn't flow to the mental health data set. (C)

With regard to the impacts of our whole school approach work, we've been quite aspirational in what we want the impact to be but we haven't got a good way of effectively measuring that because we'd be looking at school data as well and we can't confidently say, 'those results are because of our WSA work that attendance has increased'. We can't claim that, we can't attribute it to our work, it's just a correlation at best. (M)

Notwithstanding this, there had clearly been some progress in engaging with data collection to support WSA activity.

From a WSA perspective, we're encouraging schools to sign up to do that Schools Health Check tool… All the WSA questions, based on the PHE model of 8 principles are mapped to the Healthy Schools Audit questions in 4 sections so people can just fill that out easily. (M)

All this has been quite a slow learning curve but now we've got this online system we can actually see who is doing what regarding MH and wellbeing in schools. I'd like to say that it helps us be more proactive. (M)

The EMHPs have created evaluation forms for training, for staff meetings and for consultations. We're able to collate that information around whole school approach work which we can't measure in terms of a young person's symptoms. (M)

CASE STUDY

Lindfield School (Special School), East Sussex
Regular assessment of pupil mental health and wellbeing

When MHST support was first introduced to this school, the number of children and young people referred was high and the school lead worked with individual members of staff to identify need. In the second year of MHST support, the school wanted to identify need in a more systematic way to enhance a whole school approach.

Completing a wellbeing survey was potentially difficult with pupils with a wide range of special educational needs and using electronic apps and digital tools was considered more engaging. This school selected a wellbeing tracking app that was suitable for their purposes which could be used periodically through the year. It included indicators of mental health and wellbeing, and the data could be correlated with other regular assessments of academic progress and social development. The app was used to help teachers focus on areas where the school can provide more support, as well as measure any improvements in relation to changes in practice.

Achieving system change

The interviewees consistently reflected on WSA as requiring system change, and although it was clear that this this was still work in progress, a number of key challenges were identified. Each of these raises important questions about priorities and the sequencing of MHST activity. One issue concerned the culture of the school and considering where EWMH fitted in.

> *If we were to kick off our support in schools with a whole school approach up front, we'd begin with an audit and by spending time really getting to know the setting, immersing ourselves in the ethos and the culture through our consultation work, and focusing on group work and psychoeducation offers from the start rather than working out the referral process and then bringing in the whole school approach.* (C)

> *When we first started the MHST, one person in the team looked at the policies that each of our schools had on their websites and it was quite clear that only one had a mental health and emotional wellbeing policy.* (M)

A frequently cited challenge here concerns the disconnection between work on mental health and behaviour in schools. This was felt to create confusion and difficulties for staff, and MHSTs were seen as having a role to play in addressing this issue.

> *The language around emotion coaching is not about punishment. But the Behaviour Policy says, if a CYP has done something wrong, they will be sanctioned. The language in the Behaviour Policy speaks to a different mindset. If the two are not aligned, it is difficult for staff to know when to follow one kind of approach to problematic behaviour and when to follow the other.* (M)

> *Lots of people are using lots of different types of language to refer to the same concept....when we were setting up the teams, it was actually quite confusing as to what people were talking about, there's quite a bit of miscommunication.* (C)

When you work in an environment where you've got 2000 young people with a limited number of staff to manage and keep them safe, you start to realise that the behaviour policy is an essential part of that community functioning… You can help people move away from the black and white thinking by building in all sorts of support for children and young people to manage the consequences of the behaviour policy that supports their wellbeing and mental health better. (C)

The most commonly cited ingredient in addressing these issues involved staff development, and many interviewees emphasised the successes that had been achieved in this space.

The most useful thing the MHST have done for us is to give staff a better understanding. (SL)

Developing staff understanding of mental health needs can equip them to make a real difference…. When staff have a greater understanding of underlying need and can have proper conversations with young people, they often become the young person's adult who they trust and rely on. (C)

As teachers, we've become accustomed to being a little bit reactive. A problem comes up and we use our experience to try and deal with the situation; often you can't get professional advice. Since we've been part of the MHST team, we've got expertise to give us a clear idea of what can be done in certain situations for young people. We have shifted from being reactionary and crisis management to pre-empting problems. (SL)

We help empower people with a sense that it is the job of every teacher to be talking about mental health, by questioning that maybe it shouldn't be just be the SENCO or the DSL (designated safeguarding leads), or the Mental Health Lead that's identified, it should be everyone talking about this. (M)

CASE STUDY *Thurston Community College, Suffolk (secondary school without an MHST)* *Assessing staff needs to inform practice*
An important element of this college's whole school approach to mental health and wellbeing was a relational approach with young people where staff had the time and resources to develop a relationship that can be a protective factor for mental wellbeing. A supportive environment that enabled staff to work in that way was seen as crucial. To create and maintain a situation in which staff can look after their own wellbeing, this college explored where the pressures and stresses were. They collected data by administering a whole staff survey, and followed this up with focus groups which were run separately with teaching staff and pastoral staff. The findings from the survey and the focus groups gave senior leadership insight into how significantly staff were impacted by certain issues. Realistic solutions were co-produced in workshops which included improvements to structures and processes which were reviewed and reappraised from the staff perspective. Changes were implemented collaboratively and communicated clearly. This process was described as becoming embedded in the school system. Data is now routinely being collected and interpreted to arrive at bespoke solutions that over the last four years have consistently reduced staff stress levels.

The work to support staff understanding was often facilitated by the strong networks in which MHST staff members were embedded:

> *Sometimes we bring in external experts to train the staff up on topics where we feel that's necessary to improve knowledge within the team. For example, our practitioners wanted to put together a Body Image package for schools for young people and parents and although we have the clinical expertise we wanted to make that really accessible to the audience so we consulted with specialists in those areas from CAMHS.* (C)

However, this was recognised as demanding work that required an investment of time and effort that was very different from the work on targeted interventions:

> *A lot of the support schools need is helping staff about making sense of how a young person is behaving, getting them to help a young person to make sense of their experiences and where these are difficult, to have a different experience of relationships and themselves. These whole school initiatives are a lot more difficult to achieve than just offering a standard intervention.* (C)

The majority of interviewees reflected on the fact that the key to enabling this WSA was investing in relationships and 'getting to know' all parts of the school.

> *The way I integrated into the school was that the Headteachers would invite me along to every meeting and I attended as a many as possible to get my face known, get to know the school….. So it was great to be able to begin having those conversations about WSA, to be constantly bringing to mind that we also need to be thinking about a WSA and yes, we want to focus on the individual young people but asking constantly, 'how else can we be supporting and what is the need your school in particular has?'* (P)

> *The key thing is to also be part of the school community, to really be a part of the organisation so that you're able to offer a really seamless, integrated approach.* (C)

> *I am in there already with them at that really key level, being there I met all the people involved, DSLs, SENCOs, people I wouldn't have met if I hadn't turned up to those key meetings. For a whole school approach it is so important that it isn't just one member of staff who is on board with the whole school approach, it needs to be across the whole staff and SLT.* (P)

CASE STUDY *Cambridge MHST* *Cascaded Staff Development*
This MHST organised Senior Mental Health Lead network meetings every term. Each meeting had a component of CPD around themes and topics which were decided at the start of the year. The CPD session was followed by a reflective discussion about practical applications in school and included problem solving by learning from each other's practice. The SMHL cascaded the training to other members of staff in school. In addition, the MHST followed this up by offering schools a 'framing event' on topics raised by the SMHLs that they feel staff need training on. These were run by the EMHPs with expertise in that particular area or who have acquired training in order to deliver that to teachers. Importantly, each event incorporated a reflective space for teachers and support staff to think about how they will apply that to their practice. Examples included specialist support on body image for primary schools, with consultation from clinical psychologists from the eating disorders unit to quality check materials.

One common ingredient emphasised by interviewees was the importance of supporting the mental health and wellbeing of school staff members themselves. However, this was seen as a challenge, with difficult barriers to engagement that were still problematic.

> *I have to try and maintain a healthy balance for staff who are under so much pressure. It's incredible how many facets they've got to juggle. But supporting their mental health in school is a much better way of helping them.* (SL)

> *One of our big pushes is supporting staff wellbeing. Staff know there is an offer from us for a reflective space where they can come and talk to somebody. But there's a real barrier for them in accessing that. We don't quite yet know if that's because there's a stigma or why staff aren't using that offer as much as they could. It's interesting because some of the young people are a lot more open.* (M)

> *We noticed with regard to Staff Wellbeing that the survey questionnaires showed quite a high need for supervision around wellbeing – it was clear the SMHL were dealing with a lot of wellbeing issues within the staff body. Our idea to meet that staff need with supervision was really welcomed. But, when it was offered, there was a bit of a pull back. Suddenly we were met with a sort of resistance, a lot of questions about, 'Well, what is it? What's it going to be like? Who will know?'* (M)

CASE STUDY

West Sussex MHST
Establishing a Wellbeing Working Party in Schools

To support staff wellbeing, this area facilitated a working party in school to engage everyone who works in the school to access support for wellbeing. The Headteacher showed investment by letting people come off timetable and regular duties for that meeting. The MHST uses a Path model to initiate changes to improve staff wellbeing. In the first place, the group describe a vision for wellbeing in that school, from the whole staff perspective. Then they determine how each party's journey to that point will be realised.

The MHST meet regularly with the working party to help them decide next steps and define visible demonstrations of success for that pathway. From these shared goals and group experiences, schools have seen how the impact on wellbeing filters down in how people interact with children and young people and families.

"They are modelling better wellbeing and thinking issues through more carefully and with more commitment to reach a shared goal of better wellbeing for all."
Advisory Teacher for WSA

Interviewees did not always share an understanding of the systemic level of analysis needed for WSA. There was some tension between the need for practitioners to follow a manual but also for the manual to not be too prescriptive.

> *The education mental health practitioners follow the manual quite closely.* (P)
>
> *The weakness of my course was that the CBT training is very specific to the manual but there isn't so much about the wider theories behind it or the wider perspective of mental health.* (P)
>
> *A lot of the delivery falls into the laps of the EMHP but we don't get much input into why that should be done that way or what it should look like in the overall picture.* (P)
>
> *Where do [EMHPs] learn how to unpick mental health issues in schools to know where to tackle them best? Where is that learnt?* (C)
>
> *The WSA is open to interpretation. For example, in the manuals and guidance, WSA isn't mentioned that much.* (M)
>
> *The way every team works is different, from my experience, and the way every school works is different. The MHST manual is purposefully non-directive.* (P)

Nonetheless, it was clear that the Public Health England guidance on WSA was clearly recognised and understood as important, and that approaches to delivering systemic change were being brought in:

> *The main consideration for shaping the whole school approach service is, the Public Health England, model, the eight principles wheel which is a 'go to' for us. That was a sort of jumping off point for us.* (C)

We have a sustainable approach to a whole school mental health and wellbeing. Everything we do with the MHST team works to strengthen school systems, to be sustainable. (SL)

We use the Anna Freud 5 Steps based on identifying areas of development and build that in with schools to notice strengths and what's going well and also ways in which to focus on things to develop in other areas that are not so strong. (P)

We are all part of the THRIVE model for systems change. The THRIVE Framework provides a set of principles for creating coherent and resource-efficient communities of mental health support for children, young people and families. (C)

This was leading to some highly integrated planning of work across the entire school community in some cases:

Each department in school links in with the cross curricular programme of learning about wellbeing and supporting good mental health. As a school we take an evidence based, best practice approach to the teaching of PSHE which is complemented by themed assemblies, topic days as well as cross-curricular links which map out and departmental staff self-audit to show where mental health and wellbeing are addressed in their schemes of work. (SL)

However, hearing the voices of all the stakeholders in this process was very much a work in progress, although some successes had been achieved:

Enabling student voice is probably the weakest area for schools and for MHST support. (P)

Superficial consultation generates superficial responses and a really well constructed pupil voice agenda has to get at the real issues for pupils, in a way they can access and in a way that feels safe. (M)

We've developed a network of Mental Health Governors. We have about 80 Governors involved and we have a separate training programme for them. (M)

CASE STUDY *Dunstable MHST* *Co-creating Whole School Approach ideas with schools*
To design the Whole School Approach support service to meet need, this MHST created 'WSA spaces', which involved a fortnightly consultation with every school to learn about each environment and the needs of their local community. Creating these reflective spaces enabled the team to develop a shared understanding of the issues that were most important to their schools. From these, the team designed whole school initiatives which were piloted and tested, and they measured the outcomes for the children and staff who participated in the summer term. A formal WSA offer was finalised this academic year and presented to schools. In addition, schools were offered the opportunity to discuss a particular need in order that the MHST can continue to co-create WSA events that are meaningful for their school environment and meet need for their children and young people, parents and carers and staff. To ensure the team has the time and resources to plan and run these WSA events, they used a booking system so that requests from schools can be grouped and resources allocated. These included creating a bank of resources that can be used across different schools.

7.6. Summary

The interviews revealed a consistently thoughtful and reflective approach from the variety of staff members to whom we spoke. Although their roles and experiences were very different, there seemed to be a clear recognition of the importance of WSA. It was also evident that schools highly appreciated the contribution of MHSTs and that a great deal of progress had been made. In addition, a relational and non-judgmental approach to the interactions between MHSTs and educational settings was regarded as centrally important.

However, it was also clear that both the nature of system change required, and the mechanisms for delivering this, were a source of great uncertainty. One route to developing a WSA seemed to focus on early intervention for young people currently (or at risk of) experiencing difficulties, and spreading awareness and responsibility in relation to this across all staff. However, this approach does not necessarily align with the more fundamental issues raised by many interviewees about the culture of the school as a whole. A particular challenge lies in lack of clarity and agreement (from all parties – e.g., commissioners, MHSTs, and schools) about precisely what needs to change and how this can be measured.

8. Conclusions and recommendations

The aim of this Best Practice Review was to evaluate the way in which MHSTs in the South-East and East of England were supporting whole school approaches to emotional wellbeing and mental health. This has involved, in a short period of time, bringing together four complex and detailed strands of work. Together they present a compelling picture of both the enormous *potential* of MHSTs for transforming school communities in terms of developing a whole school approach to mental health, and the great distance still to be covered in realising this potential.

Overall, MHSTs are seen as providing an extremely valuable input to the development of schools' capacity and confidence to address mental health issues in children and young people. In general, supported by detailed guidance and input from university training courses, MHST staff are seen as providing something different to schools' previous experience with mental health support, and schools that contributed to our work were enthusiastic about their impacts. Part of the distinctive value of MHSTs relates to an increasing sense of integration between education and health services, particularly for receiving intervention and support in relation to low-level/mild to moderate difficulties, for which many schools previously would not have received adequate support.

The senior leadership was reported to be consistently strongly committed to the development of WSA, but in the best practice cases, this basic commitment was expanded and amplified through a number of strong foundations. These constitute the key elements of best practice found in the current review.

A. Effective groundwork to build relationships
    - A common theme among the most developed WSAs was the way in which staff in MHSTs had been able to invest time in establishing collaborative relationships with school/college staff. This enabled the development of a rich insight into school policies and procedures, as well as informal practices. This in turn ensured a strong, shared understanding of the educational context, which fostered two-way collaborative relationships between MHST and school/college staff.
B. Programmatic approach to supporting staff professional development
    - A great deal of work is being undertaken by MHSTs to train and upskill school and college staff, including SMHLs as well as the wider body of staff members. In the examples of best practice, this was a coherent and well-sequenced programme of work to promote knowledge and skills relating to: the understanding of mental health; early identification of difficulties and confidence in referral processes; and use of strategies to foster EWMH and resilience across the entire school community.
C. Tailored approach to supporting staff wellbeing
    - Emerging strengths in supporting the EWMH of staff members themselves were identified, both in terms of general support for wellbeing as well as specific issues arising from supporting pupils' mental health (e.g., reflective practice and supervision). The most advanced practices in this area had involved MHSTs working collaboratively with educational settings to identify local barriers to engagement, including workload pressures as well as implicit resistance/stigma regarding the expression of mental health needs.

D. Integration of mental health resources in the curriculum
    - While targeted work with pupils identified as at-risk was well-developed, the incorporation of mental health resources into universal provision was more limited. In the best examples, integration of more sophisticated strategies to boost mental health awareness went beyond PSHE and influenced the general pedagogy of teaching and learning across all subjects in the curriculum.
E. Engagement of multiple stakeholders
    - Different levels of success in engaging the range of stakeholders in mental health awareness were found, and the increased use of online technology during the COVID-19 pandemic provided both opportunities and limitations in this regard. In the most advanced programmes of work we saw, the voices of staff members, parents/carers, governors, and CYP themselves were influential in the co-production of WSA practices.
F. Systematic and routine collection and analysis of data on WSA
    - Whereas most MHSTs and educational settings reported using standardised measures for targeted work with individual pupils, the work on systematically monitoring and evaluating characteristics and needs relating to WSA has been lagging behind. However, there were several examples of effective practice in routinely collecting and analysing data regarding WSA, including: aggregation of individual pupil data at the school level in order to detect trends; whole-school survey data on school climate, belonging, and wellbeing; and audits on school characteristics and practices relating to EWMH.
G. Partnership work with other services
    - In the most developed cases of WSA, all of the above elements of best practice involved not just coordination between the MHST and the educational settings, but also the joining up of a wide range of services in the local area, including local authority services (e.g., educational psychologists) and community and voluntary sector providers.

These key elements of best practice clearly encompass, and in some cases cut across, the eight principles of the PHE framework for WSA to mental health discussed earlier.

Notwithstanding the many positive achievements, which are especially impressive in the context of the global pandemic and the operational restrictions this has brought about, there are some fundamental gaps in practice that need to be addressed. These are presented below in the context of seven key recommendations.

1. Maintain a sustainable funding commitment to MHSTs, to ensure that schools, and all associated stakeholders, can trust in the structures and teams, and invest time and resources in order to maximise the likelihood of success. Concerns about investing effort in mental health approaches that might not last or could be withdrawn can and do seriously compromise the effectiveness of developing collaborative work.
2. Provide guidance for, and allocate substantial time for, MHST managers, clinical leads, and practitioners to develop a thorough and rich understanding of school policies, procedures, and practices. Positive clinical outcomes arising from this may not be immediately visible, but it was clear from our review of best practice that this is a crucial investment, necessary for ensuring that practices are aligned across different aspects of school life.
3. Prioritise the establishment of mechanisms for engaging multiple stakeholders who have an impact on the functioning of the school, including CYP themselves, the wider body of school

staff, governors, parents and carers, and other specialist teams in local services (e.g., educational psychologists). Commissioners and managers should consider establishing measurable KPIs for the involvement of stakeholders, and for tracking the follow-through from their views in terms of changes in environment and education/health practices.

4. Systematically gather and collate evidence of the WSA profile, across multiple time points, tapping into how different aspects of WSA are being delivered and implemented. Beyond conducting audits to inform practice, this work should include comparisons over time to monitor change, as well as comparisons across different sites in order to establish counterfactuals for the MHST work in a given setting. Ideally, this should involve multiple informants utilising a standard protocol for evaluating practices with graded descriptors. The approach used in the Q4 data returns for this Best Practice Review could be a helpful starting point for this work, but it should be recognised that this has only be trialled with a relatively small number of respondents.
5. Address the challenge of balancing clinical interventions for mental health difficulties with wider WSA goals of creating a strengths-based school environment that promotes wellbeing. Beyond the fact that there were inconsistencies in understanding and practice between and even within MHSTs and schools, there was a more fundamental conceptual tension that had largely not been addressed. WSA in some cases was seen mainly as a provision of early intervention resources, or a scaling up of knowledge and skills for more people in the school community, in order to recognise and address mental health difficulties at an early stage. But this is only a part of the change needed to transform school communities at a systemic level. Explicit attention to the wider set of issues is needed for informing all facets of MHST work.
6. Draw upon the key aspects of best practice in this review to enhance workforce development regarding WSA for MHST leadership, school SMHLs, and all clinical and educational staff members. This should include detailed inputs to increase knowledge and skills relating to each of the key elements of best practice identified above.
7. Design and undertake a substantive programme of implementation work, using a systematic evaluation process, to select the optimal tools and resources for delivering WSA. This should include a menu of tools and resources to support each of the key elements of best practice identified above.

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Appendix 2. Pupil voice activity

Key questions/instructions as presented to KS2 pupils

(these were slightly adapted for KS3 pupils)

- One-minute warm-up – What is mental health?
    - In small groups, how many things can you think of that relate to our 'mental health'?
    - These things can be positive or negative.
    - GO!

- Draw an outline of an imaginary classmate in the centre of some flip paper
    - On the top left of the sheet write 2 things that might make them feel happy
    - Next to it write 2 things that might make them feel sad
    - Can you now label your drawing with things which help us know how we are feeling different emotions?

- You notice your classmate is looking a little sad at the end of every school day, so you ask them how they are feeling. They tell you they are really tired and can't get enough sleep because they are worrying too much.
    - What things can we suggest that might help them sleep better?
    - What other things might help them feel happier?
    - Write these on your sheet in the top right corner

- Is there anyone within your school who you think your classmate could talk to?
    - What could make it harder for them to talk to an adult?
    - What could make it easier for them to talk to an adult?
    - This could include things like who they feel they can talk to, or where they feel safe in school
    - Write some thoughts in the bottom left corner

- It is a few weeks later, and you notice your classmate is feeling much happier!
    - Is there anything about their experiences in your school which might have contributed to this?
    - Have a talk in your groups and write down your top 3 things in the bottom right corner

Appendix 3. Key questions used in analysis of data returns

Q3 open-ended questions

Question	
1. How are MHST staff teams being supported in their learning about what a whole school approach (WSA) to emotional health and wellbeing is?	
2. How are MHST staff teams being supported to understand school structures and responsibilities , including, exclusions, behaviour policy, pastoral care, safeguarding, governance, leadership and management?	
3. How are MHST teams working with schools to identify support requirements in developing their WSA to emotional health and wellbeing (audit tool, school improvement plan, surveys, MHST planning meetings, attending governor meetings, SLT, staff meetings, providing examples of good practice, training etc.)	
4. Can you provide specific examples of how the MHST is providing support to settings in developing their WSA in the following areas:	a. In providing visible senior leadership for emotional health and wellbeing.
	b. In assessing the needs of students and the impact of interventions to improve wellbeing.
	c. In their focus within the curriculum on social and emotional learning and promoting personal resilience, and how learning in this area is assessed.
	d. In supporting school staff in relation to their own health and wellbeing and to be able to support student wellbeing.
	e. In how their school culture promotes respect and values diversity.
	f. In working in partnership with parents and carers to promote emotional health and wellbeing.

	g. In ensuring that all students have the opportunity to express their views and influence decision.
	h. In ensuring timely and effective identification of students who would benefit from targeted support and ensure appropriate referral to support services.
	i. other
5. How are MHSTs is measuring the impact or any outcomes of their WSA work? Please list any approaches or tools.	
6. What plans do you have for Quarter 4 and 2021/22 to take forward MHST work to support settings with developing their WSA?	
7. Do you know of any non-MHST schools in your local area that have well-established or strongly developing work on whole schools approaches to emotional health and wellbeing? Please provide details of the work and a name and email address for us to contact.	

Q4 ratings with graded descriptors

Implementation dimensions	Rating	Description
Q1 Whole school engagement: Student voice	0	None of the work described below is happening
	1	Some awareness of the importance of pupil participation in mental health policies and procedures, but pupils currently have little participation or impact in their school
	2	(1) + clear structure for enhancing pupil voice and engagement with mental health issues that concern them, with some commitment to that vision (e.g., reflection and feedback such as 'you said, we did')
	3	(2) + significant evidence that pupil views regularly inform decisions/policies related to mental health and well-being, which are communicated clearly and underpin what the whole school does
Q2 Whole school engagement: Staff	0	None of the work described below is happening
	1	Work to promote positive mental health is seen as essentially the responsibility of a few dedicated staff (e.g., MHST manager and SMHL, well-being team members)
	2	(1) + staff (including support staff) are involved in specific teaching and learning opportunities to do with mental health (e.g., such as assemblies, tutor time)
	3	(2) + most or all staff are clearly engaged in mental health strategy and involved in related activities to enhance emotional well-being
Q3 Whole school engagement: Parents and carers	0	None of the work described below is happening
	1	Some contact relating to mental health is made with parents/ carers, beyond standard parent-school liaison (e.g., provide relevant information in home-school communication or on website)
	2	(1) + consultation with parents on decisions/policies, and some direct work (e.g., parenting workshops and/or individual session)
	3	(2) + substantial direct work with parents, with strong evidence of partnership with families and the wider community to promote consistent support for children's mental health (e.g., proactive engagement in a graduated response to need)

Q4 Whole school engagement: Governors	0	None of the work described below is happening
	1	Governors are aware of support for mental health but have little involvement themselves (e.g., information about MHST shared with school governors)
	2	(1) + clearly defined roles and shared responsibilities with governor(s) specifically focused on mental health and wellbeing (e.g., facilitating relationship with mental health lead)
	3	(2) + proactive engagement with the wider governance relevant to children's health and wellbeing
Q5 Ethos and environment	0	None of the work described below is happening
	1	Some discussion of the characteristics relevant to the particular setting and the mental health and wellbeing needs of their pupils
	2	(1) + the school ethos clearly supports 'connectedness', a feeling of being accepted, respected and bonded to the school environment, but there may be tensions with specific areas of delivery (e.g., academic or behaviour agendas) that are not fully resolved
	3	(2) + visible commitment to the wellbeing of children and young people and staff conveyed consistently where all staff, pupils and parents/carers know the expectations and can play their part as much as they are able. (e.g., mental health is promoted through the 'hidden' curriculum, including leadership practice, values and attitudes, together with the social and physical environment)
Q6 Leadership and management: Senior leadership	0	None of the work described below is happening
	1	Senior leaders are aware of core function to support positive mental health but not clearly engaged themselves
	2	(1) + senior leaders are responsible for mental health and emotional well-being programmes, but this is not shared across the whole school community as a priority (e.g., not all staff, pupils, students, parents and carers made aware of the part they play)
	3	(2) + senior leadership team drive positive mental health and well-being as a highly prominent priority (e.g., by ensuring it features within improvement plans and the school's policies, systems and activities are linked and regularly monitored and evaluated)

Q7 Leadership and management: Delegation	0	None of the work described below is happening
	1	Mental health is viewed as responsibility of the Senior Mental Health Lead or confined to a small number of activities that draw on select staff (e.g., referral pathways)
	2	(1) + responsibility for mental health and wellbeing are clearly articulated and delegated across the education setting at various levels (e.g., staff and pupils are encouraged and empowered to participate)
	3	(2) + clear management structure and an effective process for engaging staff at different levels with approaches to promoting positive mental health, reflected appropriately in everything the organisation does
Q8 Staff development	0	None of the work described below is happening
	1	One or two CPD sessions with a focus on mental health and well-being for some or all staff (e.g., training video on 'what is mental health?')
	2	(1) + additional CPD opportunities relating to mental health and well-being, restricted to selected staff (e.g., no obvious system for cascading)
	3	(2) + ongoing programme of regular CPD opportunities to ensure all staff are aware of common symptoms of mental health problems, as well as building knowledge and confidence to ask for and/or give help
Q9 Staff well-being	0	None of the work described below is happening
	1	Crisis management – work to support emotional health and well-being for individual staff members identified as having difficulties
	2	(1) + established system for monitoring emotional health and well-being of all staff (e.g., peer reflection, dedicated time for discussion)
	3	(2) + regular programme of activities for all staff to support and promote awareness of own mental health and emotional well-being needs (e.g., supervision)

Q10 Universal mental health work	0	None of the work described below is happening
	1	Some awareness of mental health and emotional well-being across the school, but most activities are restricted to specific pupil groups and staff (e.g., to address problems such as exam stress)
	2	(1) + clear cross-school awareness of mental health but only some evidence of specific learning opportunities (e.g., some pupils may know where to go if they want help about own, peers, family's mental health but not all staff are confident or skilled to help).
	3	(2) + well-organised programme of cross-school engagement in mental health learning opportunities in most or all years, which emphasises the importance of promoting positive social and emotional wellbeing and uses various strategies to support pupils (e.g., through curriculum, counselling, positive classroom management, developing social skills, working with parents/ carers or peer support)
Q11 Targeted mental health support	0	None of the work described below is happening
	1	Processes provide routes to escalate via referral, with accountability and feedback as well as outcome monitoring, including to specialist services (e.g., pupils with mild to moderate mental health needs receive evidence-based support in school)
	2	(1) + clear system for identifying, supporting and monitoring emerging issues and mechanisms to help pupils with additional needs access appropriate support (e.g., group work delivered by non-specialist staff)
	3	(2) + strong follow-through from targeted work to universal provision, with effective staff communication (e.g., range of support provided by other professionals working in school)
Q12 Integration with curriculum, teaching, and learning	0	None of the work described below is happening
	1	Some awareness of links between mental health and pupils' learning, with some consideration of emotional and physical well-being needs when planning curriculum (e.g., RSE and physical education)
	2	(1) + using the curriculum to develop children and young people' knowledge about mental health and well-being, with clear links to developing teachers' knowledge and skills to support pupils' mental, social and emotional health more effectively in the classroom.
	3	(2) + specific evidence of cross-school focus on mental health and related skills to achieve pupils' learning targets

Q13 Integration with other approaches to behaviour and well-being	0	None of the work described below is happening
	1	Some awareness of links between mental health work and other programmes relating to behaviour and emotional well-being (e.g., attachment and trauma)
	2	(1) + links made between mental health and targeted work with particular pupil groups on behaviour (e.g., graduated response to behaviour seen as a result of mental vulnerabilities)
	3	(2) + evidence that most or all staff have an integrated understanding of how policies/processes regarding mental health, emotional well-being and behaviour link together (e.g., active in looking after the interests of the 'whole child' and know how to identify areas of concern with regard to their development and the school policy for responding to these concerns)
Q14 Data collection to identify mental health needs	0	None of the work described below is happening
	1	Some use of audits regarding pupil attitudes, safety and wellbeing
	2	(1) + regular programme of audits/ surveys regarding pupil experiences of mental health and emotional well-being provision across the school
	3	(2) + co-ordinated engagement in data collection process, including staff and parents
Q15 Use of data to inform mental health work	0	None of the work described below is happening
	1	Data is used to provide summary information mainly for reporting purposes
	2	(1) + data used to evaluate school strategies, identify vulnerable pupils and inform planning (e.g., use data to inform policies and their objectives)
	3	(2) + results and impacts fully disseminated so there is whole-school ownership of the process

Q16 Overall integration of MHST with other services	0	None of the work described below is happening
	1	Shared understanding of the current mental health provision in the local area (including online and face-to-face groups and forums), potentially including a directory of services and resources to assist in this process
	2	(1) + established ways of joint working to reduce gaps in the current provision by learning from other services and assessing local priorities as well as how to make the best use of existing provision
	3	(2) + clear evidence that the mechanism for joint working is addressing need in the local area to the fullest extent
Q17 Overall governance, accountability and leadership of MHST	0	None of the work described below is happening
	1	The MHST service offer adequately reflects the needs of the education setting and builds upon rather than replaces provision
	2	(1) + support is provided around reviewing performance, setting priorities and objectives in line with the employing organisation, to work effectively within education settings
	3	(2) + assessment include the views of children, young people, and families and carers, with timeframes for regular review to ensure it remains up to date in order to address inequalities.

Appendix 4. Semi-structured interview schedule for MHSTs/School staff

Key questions in the interview schedule

(selected and adapted as appropriate depending on the role of the interviewee)

- Details of participant background (context for MHST, local community, roles and responsibilities, profile of schools/colleges)
- What were the main considerations that shaped the design of the service you have developed for delivering the WSA function of MHST support?
- Overall, how do you support education settings to deliver their WSA for emotional health and well-being?
    - What do you do engage your cluster schools/ colleges to support a Whole School Approach for emotional health and wellbeing? How widely/ how high profile is this knowledge disseminated across the area?
    - What strategic approach does your MHST take to working with an education setting to introduce or develop their WSA?
    - What operational approach does your MHST take? How is this organised?
- How do schools/ colleges access the support for introducing/ developing their WSA to emotional health and well-being? What plans do you have to develop or expand the WSA service offer?
- How easy has it been to engage education settings? What worked best for engaging staff, students/ parents?
- What challenges and resistance have you encountered? How did you address and overcome these?
- What outcomes do you use, if any, to measure your progress on WSA initiatives? How does this link, if at all, with how education settings measure their emotional health and wellbeing outcomes?
- To what extent have you established shared understanding and common reference for a WSA to emotional health and wellbeing with your cluster schools/ colleges, so far? Why is this, do you think?
- How is a Whole School Approach included in the following 5 actions MSHTs take to engage with education settings to improve MH and wellbeing provision?
    - Map what WSA provision is in place to identify and respond to MH and Wellbeing need.
    - Analyse the existing provision within the context of the 8 principles of a WSA
    - Understand needs and gaps better for a WSA.
    - Identify specific areas which should be prioritised for a WSA.
- Of the 8 elements of a WSA to emotional health and wellbeing (Public Health England), where is your service most effective and why do you think that?
    - Ethos and environment
    - Leadership and management
    - Curriculum, Teaching and Learning
    - Staff development
    - Identifying need and monitoring impact
    - Targeted Support
    - Student Voice
    - Working with parents/ carers

- Which areas of support for WSA are your cluster schools engaging with most to develop their WSA? Why is that do you think?
- In what ways do you track schools that are at different stages of developing their WSA?
- How do you ensure appropriate mechanisms are in place to identify emerging issues and to help a WSA to emotional health and well-being?
    - Further information about the local implementation of MHSTs:
        - Co-production with education settings : Where have education settings have been involved in the design and delivery of the MHST service?
        - Supervision of EMHPs: How do you supervise the second element of EHMP practice: Whole school approaches to mental health in education settings?
        - Expertise and knowledge about WSA in governance: Within the leadership, oversight, and governance structures, where is the expertise and knowledge about WSA to MH in education settings?
        - Information sharing systems for MHSTs and settings
        - Digital systems: technology and digital resources