Highland Council
Primary Mental Health Worker Service
Standards and Quality Report
2015-16

This report provides a summary of the work undertaken by the Highland Council Primary Mental Health Worker (PMHW) Service from July 2015 to June 2016.

It provides information on staffing, job planning and on processes and structures that support the service. It also includes detail from the service improvement plan, data routinely collected by the service and the data from the various evaluations completed throughout the year.

Bernadette Cairns
Head of Additional Support Services
28 August 2016

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1. SUMMARY

The Highland Council Primary Mental Health Worker (PMHW) Service is part of the Additional Support Needs structure within Highland and provides the Tier 2 service as commissioned by NHS Highland as part of the Child and Adolescent Mental Health Service (CAMHS).

The service works directly with children, young people and their parents/carers where appropriate and also with professionals from a variety of disciplines, to integrate support for children and young people on issues relating to mental health and wellbeing.

The service provided is evaluated in a variety of ways:

- gathering of statistical data to ensure targets set by the Scottish Government are met;
- feedback and reporting to NHS Highland through assurance reports;
- feedback and reporting to Highland Council through reports to the Education, Children and Adult Services Committee;
- formal evaluations of direct work completed by children, young people and parents/carers, who are in receipt of the service;
- formal evaluations of training delivered to practitioners to support their capacity building;
- self-evaluation undertaken within the service to compare the delivery of service with local and national expectations, service specifications and professional requirements

During session 2015-16, the service performed to a high level. Qualitative and quantitative data gathered over the year would indicate that service members work well together as a team (2.3), providing a well-planned service (5.1), in line with government expectations (5.3) and service specifications (5.2). The families who use the service almost all rate their experience as positive (6.1), demonstrating improvements in the presentation of the children and young people referred to the service as a result of the interventions received (6.2). The feedback from other professionals demonstrates that they rate the support of the service highly (6.3), with the training provided being shown to make a positive impact on the capacity of others to support the children and young people they work with (5.6).

The service will continue to monitor the effectiveness of the interventions provided, through the use of a clear methodology for improvement (7.1) and moves into the new session with a range of priorities, highlighted as areas for further improvement through the self-evaluations undertaken in the last 12 months (7.2, 7.3, 7.4).

2. INTRODUCTION and SERVICE STRUCTURE

2.1 Mental Health Statistics

A government report in 2003 reported a prevalence rate of 10 per cent for children and young people with a mental health problem (Scottish Government, 2003). Although there is a significant amount of media coverage relating to the mental health of children and this has become a greater priority for both local and national bodies, the evidence would suggest that overall, the mental health of children and young people has improved or remained stable over the past decade or so (NHS Health Scotland 2013). As would be expected however, outcomes are better for those children who receive support early and manage to make and retain positive relationships with others.

The report from the Scottish Youth Parliament (2016) on Mental Health in Young People provides a summary of the responses from 1453 young people from across Scotland. This report noted that nearly 74% of young people surveyed were unaware of what mental health support services were available in their areas. For those respondents who considered themselves to have a mental health problem, as many as 70% still did not know what services were available to help them.

It would be reasonable to assume in this digital age that in the absence of information or support, young people would use the internet to find out more information. However one respondent noted:

> *"I was feeling sad at the start of the year. I Googled how I was feeling and by the end I was convinced I had paranoid schizophrenia. It was terrifying."*

Reassuringly, in the SYP survey, young people reported that they would seek information from people they know and trust first, before choosing the internet. The three most common sources for information cited were their General Practitioner or other medical professional (52%), a parent (52%), or a friend (51%).

> *"Verbal communication with a person is undoubtedly the most therapeutic and safest way to access information and seek help." (SYP 2016)*

The report therefore recommends that information and services be readily available to children and young people, to support them as quickly and as early as possible and that schools and youth groups should provide high quality information about mental health and mental health services.

For Child and Adolescent Mental Health Services in Highland to be successful in supporting children and young people, they therefore need to have a high profile within the community and be easily accessed when required. Frontline staff such as General Practitioners and teachers need to be confident in identifying and supporting children and young people presenting with mental health issues. They need to have good quality information readily available to pass on to young people and parents. In addition, young people themselves will ideally have an understanding of mental health and be able to discuss their feelings and mental state with friends, families and trusted adults in a non-stigmatising way. Those supporters also need to be confident enough to listen and to know where to signpost the young people to access the support they need.

A Primary Mental Health Worker Service is core to such a system as it can provide a Tier 2 service, working locally within Highland communities, to support and build capacity with local practitioners.

2.2 Highland Council Primary Mental Health Worker Service

The Health Advisory Service in their report *Together We Stand,* used the following model to describe Child and Adolescent Mental Health Services (CAMHS). This can act as a guide when deciding when and where children with mental health problems should be referred into CAMHS (figure 1).

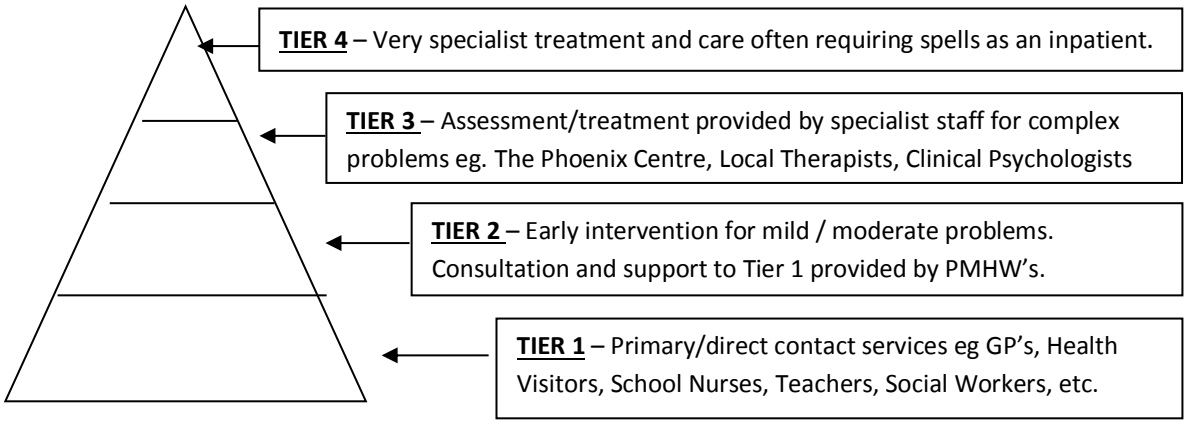


figure 1

In most parts of the UK, all specialist CAMHS are lead and managed by the local NHS Board, with a strong link established with other health, education and social care colleagues at Tier 1. The Tier system still holds true in Highland and is similar to the Staged Approach that would be common to practitioners in education and wider children's services. However, in Highland the management of the various staff working at the different Tiers is quite different.

In April 2012, the majority of staff from NHS Highland working in Children's Services, were integrated with Children's Services staff from Highland Council, to form the

Health and Social Care Team within Highland Council. At that time the management of the Tier 2 Child and Adolescent Mental Health Service (CAMHS) transferred to Highland Council as part of the Commissioned Service from NHS Highland. The PMHW Service became part of the wider additional support needs network of services including Allied Health Professionals (Speech and Language Therapists, Occupational Therapists, Dieticians and Physiotherapists), Educational Psychologists, pre-school home visiting teachers and specialist education support services. This service continues to be managed by the Head of Additional Support Services.

In April 2013 an additional 2 full time PMHWs were appointed as part of Highland Council's preventative spend, to support early intervention and the early years' strategy. In Dec 2014 a Team Leader was appointed to support and lead on professional development and clinical work.

2.3 The Development of Trust

Since the transfer into the Council, a range of activities have been undertaken, focusing on self-evaluation, developing more consistent practice and building trust within the team. This initially helped support the transfer of the team from NHS Highland to Highland Council, but has also helped integrate new members of the team as time has gone on. The evaluation of trust within the team over the past three years has shown a significant increase in the level of relational trust, based on competence, expectations and communication (appendix 1). This indicates great improvements in team relationships and a current level of trust where people feel comfortable to share their practice and support each other's professional development.

2.4 PMHW within the ASN Structure

The PMHW service is part of the additional support needs structure within the Care and Learning Service of Highland Council. Primary Mental Health Workers are based in various locations and are affiliated to areas teams. However, they receive their professional leadership and management centrally. They work closely with Allied Health Professionals, Educational Psychologists and pre-school teachers, who are also part of the ASN structure in their Areas. They also work very closely with school staff and members of the local Family Teams i.e. Children's Service Workers, Health Visitors, School Nurses and Social Workers.

2.5 PMHW within the CAMHS Structure

Although Highland Council is commissioned by the NHS board to deliver the Tier 2 service, there is a clear link with the Tier 3 service, which has remained within NHS Highland. This link is maintained through processes such as joint triage twice a week, shared training and joint team days twice a year. The managers and team leads of both services meet regularly to ensure communication and planning across the services and to plan joint work eg. joint involvement around infant mental health,

shared supervision for Eye Movement Desensitisation Reprocessing (EMDR), a mental health LAC project, joint Tier 2/3 consultation etc.

2.6 CAMHS Triage

In July 2015, a Rapid Process Improvement Workshop (RPIW), focusing on the Tier 3 service, was undertaken by NHS Highland. Several changes were recommended for the Tier 3 service as a result of this process, including a recommendation that the link between the Tier 2 and Tier 3 services should be strengthened. This recommendation was to ensure that there would be greater clarity for parents and practitioners in relation to the referrals that would be appropriate for the various CAMH services, so the waiting times for patients could be reduced. Immediately following the RPIW, new arrangements for triage were established and the PMHW Team Lead has attended triage twice weekly since then to discuss cases and agree those that are appropriate for the Tier 2 service.

A recent evaluation of the new triage system (appendix 2) indicates that there is now greater clarity as to where referrals should be directed as soon as they are received. This has resulted in referrals that are more appropriate to be contained or managed at Tier 1 or Tier 2, being passed on immediately and allocated without delay, ensuring that only Tier 3 cases are placed on the waiting list at the Phoenix Centre (Tier 3 Service). This process has helped the PMHW Service contribute to the principle within the Highland Practice Model of getting the right help to the right child at the right time.

A recent discussion within the PMHW service provided a high level of satisfaction with this process, with the 94 referrals coming to case workers from Triage almost all being considered appropriate for Tier 2 work ie appropriately directed to the correct Tier for intervention. There have been a few exceptions to this over the year, where the PMHW has felt the referral was not appropriate. For these referrals there was limited information provided, to make a clear decision initially. However the consultation by the PMHW has added to the assessment process and provided further information that has then allowed the case to be handled appropriately.

In the previous process, all cases discussed at T2/3 Triage (ie 411 from July 2015-June 2016), would have been passed on to the PMHW Service, although many would have been inappropriate for this input, leading to further delay and dissatisfaction for families as professionals would have taken time to clarify and agree the most appropriate intervention strategy and case worker.

3. STAFFING

3.1 Establishment

The PMHW Service has an establishment of 11.2 full time members of staff. In addition, a further 0.5 FTE has been added to the establishment for two years to support a project focusing on the mental health of care experienced children and young people, previously known as Looked After and Accommodated Children (LAAC). This is a joint project with the Tier 3 CAMH Service and also will require working closely with the Family Teams and residential social care staff within Highland Council.

During session 2015/16 there were several changes of staff within the PMHW service. Vacancies arose as a result of 3 resignations from the service. Four new members joined the team over the same period of time and additionally, two members of the team have reduced their hours. Having had a fairly stable workforce previously, there was no clear path for induction for new members of staff. The Service therefore created a detailed induction plan for new members of staff in summer 2015. This has been piloted by the new members of the team over the year, amended in relation to their comments on the process and is now embedded into the suite of policy documents used by the service.

These significant changes in the staffing of the team has necessitated changes in associated school group patches covered by members of the service and a current list of team members and areas of responsibility can be found as appendix 3.

3.2 Professional Links and Student Support

The PMHW Service has close links with Stirling University and has increased the number of mentors and practice tutors within the service for both nursing and social work students. This has improved access to placements within CAMHS and interest from students working in the community. As a result, there has continued to be interest in new posts that have been advertised and the Service has been able to recruit new members of staff when required.

The service has also recently provided supervised placements for a small number of students completing a counselling course with the University of the Highlands and Islands (UHI). Initial discussions have taken place to formalise this position and establish an agreed process and set of protocols around these placements for the coming session.

The increased number of placements offered to nursing students has led to the NMC external examiners asking the nurses within the Service to provide information to aid the review of the validation process.

Various members of the Service provide direct input to the training courses for undergraduate and post-graduate mental health nurses, health visitors and school nurses. This contribution equates to around 10 days a year and is very well received by the students and lecturers.

4. OPERATING FRAMEWORKS

"The Primary Mental Health Worker Service builds capacity within other agencies and provides early intervention to support the mental health and emotional wellbeing of children, young people and their families, within their local communities, through consultation, direct intervention and training"

PMHW Service Mission Statement

PMHWs are allocated on a patch basis to associated school groups across Highland. Team members are based in various locations, generally where there is a significant population, and work as part of the wider support team in each locality.

They work within the parameters of the Highland Practice Model and also the PMHW Best Practice Guidance, agreed by NHS Highland and Highland Council. http://www.highland.gov.uk/downloads/file/13058/nhs_highland_and_highland_council_primary_mental_health_worker_%E2%80%93_child_and_adolescent_mental_health_best_practice_guidance_december_2013
This guidance will be reviewed and updated by the team during the next school session.

The overall aim of the PMHW service is to support children and young people to achieve their optimum mental health through the delivery of 5 core functions:

1. To support and strengthen Tier 1 CAMH provision through building capacity and capability across children's services.
2. To promote the mental health of children, young people and families.
3. To support the identification of mental health problems early in the life of the child and/or the stage of the problem.
4. To facilitate decision making to support appropriate access to a relevant mental health provision according to the level and nature of need.
5. Where appropriate, to provide a direct therapeutic service to children, young people and their families to address their mental health needs.

A PMHW's time is required to be equally divided between direct therapeutic work, consultation and training. All PMHWs draw from theoretical and practise based evidence in respect of the models they use for consultation, training, direct work and assessment of children and adolescent mental health.

PMHWs are specialist CAMHS workers who are qualified and registered with a professional body and have a duty to work to that body's code of practise and ethical guidelines. To meet the requirements of professional registration, PMHWs are expected to have regular continuing professional development to maintain and update their knowledge and skills base in relation to specialist CAMHS.

In Highland, PMHWs come from a nursing, social work or art therapy background. They provide consultation and training regarding child and adolescent mental health to universal services. They also accept cases directly where focused, targeted, therapeutic intervention at an early stage is likely to have a long term benefit to the mental welfare of the young person and his/her family.

Although PMHWs come from different professional backgrounds, they all have the core competencies as identified by the Scottish Government in the document: 'Child and Adolescent Mental Health Services Primary Mental Health Work, Guidance note for NHS Boards/Community Health (and Social Care) Partnerships and other Partners' (Scottish Executive, 2007). Individual PMHWs also have specialist skills and knowledge dependant on their prior skills and experience and their ongoing professional development.

5. SERVICE DELIVERY

5.1 Service Improvement Plan

Service delivery and improvement is planned and supported by the Service Improvement Plan (appendix 4). This is updated quarterly to take account of improvement activity undertaken by members of the service, with actions and measures reported to the Highland Council ASN Managers meeting, the ASN Improvement Group and the Mental Health Improvement Group. By June 2016, review of the improvement activities of the Service indicated that many of the actions had been completed and the Service began a new phase of planning and development that will inform a revised plan from October 2016.

5.2 Job Planning

At three different stages during 2015/16, all members of the PMHW service were asked to use the job planning tool that has been approved by NHS Highland to record the nature of the work engaged in. In total, data was captured from the whole service for 5 different weeks, from September 2015, November 2015 and March 2016. Individual charts were created for each member of the team and a collation for the team was also created with the overall data (appendix 5). Team members were able to evaluate their own work and the balance of time spent on each aspect in comparison with the team data. The team chart was also compared with the agreed balance of work within the Best Practise Guidance for PMHWs and was found to accurately reflect the agreed range of activities and time allocation.

There has been agreement within the team to complete a similar exercise on an annual basis, to continue to monitor the balance of activity across Highland. The exercise has highlighted the high level of admin undertaken by the Service, some of which is related to clinical work. When the team transferred to the Council in 2012, members worked fairly independent of each other. No local or central admin support therefore transferred with the team. The service manager is aware of the levels of admin undertaken and regular meetings with the Team Leader and individual members of the team are taking place to consider the issues raised during the job planning exercise and to support greater consistency in ways of working that could be less bureaucratic.

5.3 Requests for Service and Waiting Times

Requests for service to the PMHW team follow the Highland Practice Model. Because the PMHW Service is a targeted service, intervention is often requested via a child's plan. The team strongly recommend an initial consultation prior to requesting intervention as this can clarify the issues and whether direct intervention is appropriate or not.

The PMHW service maintains a database of the requests that are received for direct intervention and consultation. From this database, team members provide information on service delivery, which is reported to the Scottish Government via NHS Highland on a monthly basis. This data relates to the waiting time for each request for direct intervention and the detail also enables information to be collated on the source of these requests and the most common reasons for intervention being sought.

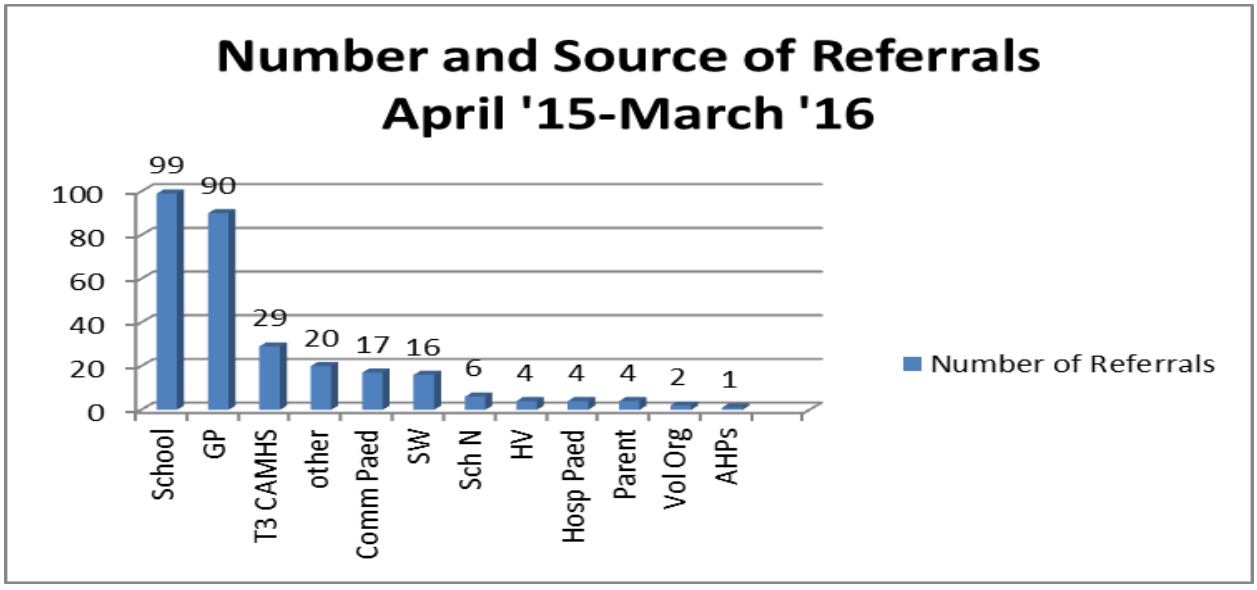


figure 2

It has been helpful to track where requests for service come from (figure 2) and what the main reasons for referral are as this has allowed the team to provide a preventative and supportive consultation service and to target this to those professional groups where most referrals emanate.

Most requests for direct intervention are received from schools (33% of all referrals) and General Practitioners (30% of all referrals). A significant amount of training and consultation has therefore been offered to these agencies, to support them in increasing their own knowledge and skill around mental health. This clarifies the role that PMHWs can play in supporting them with the children and young people they have responsibility for.

The PMHW Service is an early intervention service. Staff therefore aim to see children and young people quickly where possible. There have been several changes in staff during session 2015/16 and so some months when the Scottish Government target of providing direct work to 90% of referrals within 18 weeks, has not been met. However, generally interventions are provided well within the target set, with on average 95.4% of children and young people waiting less than 18 weeks for a service. 69% of children and young people are being seen within 6 weeks of a service being requested (appendix 6). This compares with national figures for CAMHS of 84.2% being seen within 18 weeks and 50% starting their treatment within eight weeks (NHS Scotland 2016).

Each time the wait is longer than the 18 week target, the team member provides information to the service manager, so that lessons from individual cases can be learned and processes adjusted to improve service delivery. The Team Leader also monitors the flow of cases within each team member's caseload on a regular basis.

One example of this is the work undertaken through the year with General Practitioners, as delays were being noted through a lack of clarity in the presenting problem with referrals from GPs. Providing early consultation for all GPs has reduced the number of steps in the chain that were often evident in the referral process and ensured a quicker pathway and more appropriate referrals (appendix 7).

5.4 Early Intervention through Consultation

Providing early intervention through direct consultation has been demonstrated to be an effective intervention in itself (Gillies et al 2015; Al-khatib and Norris 2015) and is one of the main aspects of the work of a PMHW. A recent team discussion about the use of consultation supported its role in providing a timely early intervention to support children and young people with the least intrusive approach.

Most consultations provide the professional/parent with advice and support for them to be able to successfully support the child or young person themselves. Where this is not possible, the consultation supports the gathering of more detailed information

to be able to identify which service the child or young person would be most appropriately referred to. Further consultation can also be delivered to support the parent/professional on an ongoing basis while awaiting an intervention from another service. Data is gathered monthly on consultations provided (figure 3) to track the number and source of requests, which in turn can provide feedback to the Service and also to inform the support given to the professionals and parents receiving this service.

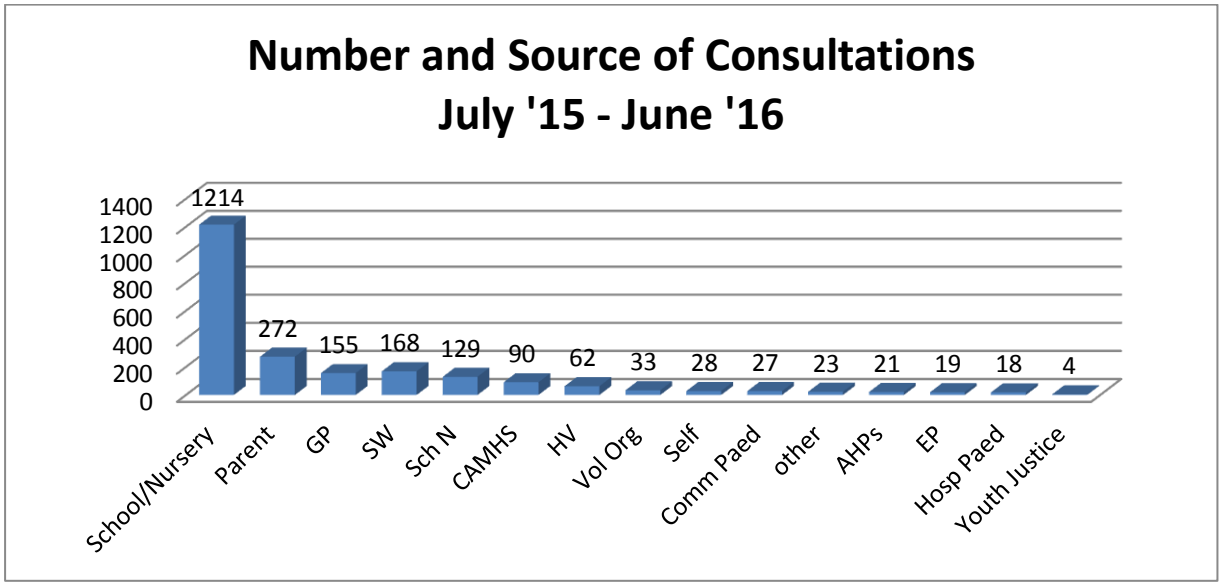


figure 3

Most consultations are provided to school staff, with 1214 being provided during session 2015-16, an increase from 965 during session 2014-15. Overall, the number of consultations has increased from 1967 in 2014-15 to 2394, with a significant increase specifically in the number of consultations offered to parents and to young people themselves.

Several members of the team have attended an 8 day supervision course, which has enabled them to provide more robust consultation and supervision of the practice of other staff working in Children's Services. This has been particularly helpful in supporting Head Teachers and Health Visitors, especially where they have been working in very challenging and emotionally taxing situations. The feedback from staff receiving this supervision has been extremely positive and the newer members of the team will be supported to attend a further course planned for the coming session, to enhance their skills in this area of work also.

5.5 Early Years Interventions

It is acknowledged that for children to have the best possible start in life, both they and their parents need to have positive relationships and good mental health (Holmes and Farnfield 2014). For most, this is supported through family links and relationships and through universal pathways where some lower level support is

required. The PMHW service previously had no consistent role within this age group, but over the past two years has developed a role in providing training and consultation to staff working in the early years. They also now provide more targeted support for parents and children through the use of Video Interaction Guidance (VIG), parental consultation and training and consultation to professionals. 3 members of the team are also members of the NHS Highland Perinatal and Infant Mental Health Group and offer input into the strategic developments of this group. Additionally, 2 members of the team are involved in the strategic group in Highland considering the roll out of the Before Words programme, which has been very positively evaluated as a means of improving attuned relationships between parents and their young children.

Maintaining a focus on the direct interventions for children in the early years has allowed the service manager to track the work in this area (figure 4), and with 319 interventions in session 2015-16 to support families and staff working in the preschool age range, this is providing an area of growth in service delivery for the team.

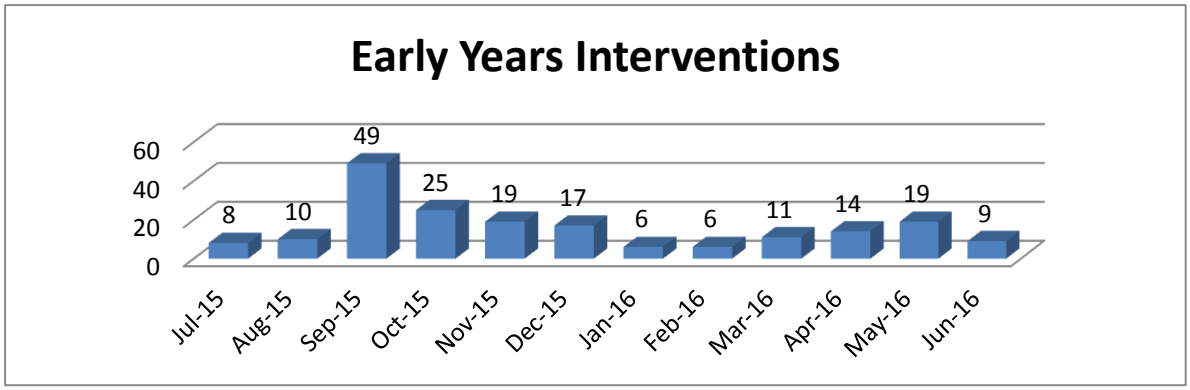


figure 4

Over the coming school session the team have committed to ensure that more health visitors and midwives are utilising the consultation service. The Early Years Development Group within the team has also committed to look at Mental Health awareness raising training for all staff working in the early years.

One member of the team is working on developing a consultation pathway alongside Video Interaction Guidance (VIG) as a therapeutic approach with parents and their children. It is hoped that this will encourage consultation with early years' staff and also to aid identification of those cases that would benefit from using VIG.

Feedback from the various professionals already requesting this intervention has highlighted the positive impacts of this on the lives of children and young people and the effectiveness of VIG as an intervention.

I am just writing to thank you for your input using VIG with one of my families. The VIG enabled a very anxious mother to realise how her anxieties were impacting on her 2 year old daughter whose behaviour had become unmanageable. Over a number of sessions the mother was able to see how her anxiety impacted on her daughter and through using the VIG she was able to see her strengths and work on the difficulties she was experiencing. Since then their relationship has flourished.

I would highly recommend this work and have shared this success story whilst retaining anonymity of the family with HV teams across the west area. I hope this will encourage them to utilise this valuable support for families. Thank you.

I would like to acknowledge the success of the VIG process for the W family. As you well know there are some extremely complicated family dynamics here, despite this the change in R's perception of her relationship with D has been remarkable. A year ago she was unable to envisage change and struggled to see the positives in D's character or in her role as his parent. Through the process of VIG R has been able to see that her behaviour & reactions towards D have an influence on the choices he makes. She recognises that D was unable to read social cues and hadn't had the opportunity to learn to connect feelings with body language. In R's own words she "understands him now". She described him as a "lovely person" and speaks with emotional warmth about their relationship. She realises that before the VIG she never spend any one to one time with D and yet now really enjoys his company. The recent CPM was extremely positive and realistic in terms of its expectations. She's a tough nut to crack and the process has had some real breakthrough moments for her and the family.

5.6 Training

PMHWs have as a key aspect of their work, building capacity in others. One way of achieving this aim is to provide consultation (see above), especially within a remote and rural community, where often it will be nurses, children services workers, teachers etc who provide the initial support to children, young people and their parents (Wilson and Usher 2014). However, a further way of achieving this is through the provision of training.

5.6i Training for Professionals

The PMHW service regularly provides training to others and since April 2016 the training provided has been collated centrally (appendix 8), to help identify what is being requested and to support the development of a more strategic training plan.

The Service is the key training provider within Highland Council of the Scottish Government supported Scottish Mental Health First Aid Training for young people (SMHFA-YP). All the PMHWs in post prior to January 2016 were trained to deliver this course and have begun a programme of rolling this out to school staff and other professionals working with young people across Highland. So far 6 schools have received this training or similar awareness raising training sessions, for example 'Children in Distress' and this will be provided on an ongoing basis, to ensure it is offered to all staff.

Independent of the training day itself for SMHFA-YP, staff who attend are asked to provide feedback on line in a reflective piece, after the session. They have all been positive so far, indicating the benefit of providing an entry level mental health awareness course for practitioners in building capacity in frontline services:

> *'As a guidance teacher I feel that I deal with mental health issues almost on a daily basis. I have an interest in this area and have therefore attended courses and mental health conferences to further my knowledge in all mental health areas but especially in the areas of self-harm, eating disorders, anxiety and suicide. The SMHFA-YP modules and training day have been hugely beneficial to me in furthering my knowledge in all areas. In addition, they have given me confidence to know that I have been supporting young people and parents at my school well and that I can now improve further on how I deliver this support.'*

> *'The group of participants came from a varied background, which was extremely useful when listening to experiences and for positive networking. The content of the course was relevant and used a variety of teaching techniques. I left the training session feeling very positive and enthused. It was one of the few training sessions I have attended in recent years where I feel I have learnt something new and relevant to my role.'*

> *'The ALGEE framework appears to be a useful tool as "Dr ABC" is for First Aid. I believe that if a teacher is in a crisis situation, much of the detail of a course like this will not be recalled, but a mnemonic*

like ALGEE will be remembered. Hopefully this will give me more reassurance and confidence in dealing with mental health episodes in the future and I will be able to deal with the young person in a crisis situation more calmly, sensitively and productively. In relation to all of the mental health topics on the programme; I now realise after doing the SMHFA-YP course how important it is to ask a youngster about if they have had any suicidal thoughts directly in the initial stages of the conversation with the young person. I shall consider doing the ASIST course at some time in the future to improve my knowledge of this issue.'

We all found the SMHFA-YP training valuable as a staff. Questions that we had held to ourselves were given opportunity to be shared and discussed. Key aspects around the principles of discussing mental health issues for the young people we work with were clear and easy to follow. The course provides reassurance without being too "heavy" in terms of work load. I would recommend that all staff working with young adults and teens take the opportunity provided by this course. At the very least, each school should have as many mental health first aiders as they do first aiders.

In addition to bespoke training requested by professional groups, PMHWs also contribute to strategic training developments across Highland. The themes from consultation often give an indication of the training needs required and so sharing these themes across the service allow a coherent approach to this area of work across Highland:

a. A member of the service is a joint provider of the Highland Council emotional literacy programme, an 8 day taught programme delivered to staff working with children and young people, which has been accredited at Post Graduate Certificate level by the General Teaching Council for Scotland and also the Scottish Council for Educational Leadership. This course is run 3 times a year in various locations in Highland and is delivered to around 16 participants from a range of services in each training cohort.

b. One of the team also provides regular training and consultation as part of the support provided by Highland Council to foster/adoptive parents. The training is well received and appreciated by parents and staff alike and the post adoption consultation service is formally evaluated on an annual basis. The evaluation for session 2015/16 was in line with previous years and received excellent feedback. Some of the quotes from the families involved in the consultations provide testament to how useful these interventions are:

"This has been an invaluable support to us as a family. We can talk without analysing ourselves. Wish we could have X at home!"

"This is a really valuable service."
"It's reassuring to hear why the boys may be behaving in a certain way and the utmost importance of having a secure base and that outside influences e.g. school in particular can be a real stress for them."

"A listening ear is fantastic and helping us to understand where the child is coming from."

c. Several PMHWs have provided training in their patches on Mindfulness Based Stress Reduction and this has been very well received by head teachers in particular. Discussion is on-going with the Tier 3 Service Manager as to how this can be further rolled out as part of a strategic plan across Highland.

d. One member of the team is the only trainer in Children's Services for the various suicide prevention packages ie Skills-Based Training On Risk Management for Suicide Prevention (STORM), Applied Suicide Intervention and Skills Training (ASIST) and SafeTALK.

The Service is offering mental health awareness training to probationary teachers during the coming session, to establish an understanding of the key issues early in their professional careers.

The service is also linking up with NHS Highland Public Health Team, to address the issues to be addressed within the proposed Scottish Government 10 year plan for mental health.

5.6ii Training with Children and Young People

Bespoke training packages are also delivered to children and young people, many contributing to the Personal and Social Education curriculum in secondary schools eg Anxiety Management, Mental Health and Wellbeing, Exam Stress, Mindfulness etc. In the 5 months between March 2016 and July 2016, 7 different courses were provided to groups of pupils in schools. Feedback from the pupils was almost always positive in each case, with pupils commenting on how much they enjoyed the interactions with the professionals delivering the interventions and also commenting on their enhanced knowledge as a result of the input. As a next step, it will be important for the service to develop a way to track any changes in feelings or behaviour as a measure of the lasting effects of the interventions provided.

6. SERVICE USER EVALUATION

During 2015/16 several evaluative processes were undertaken to provide feedback to members of the service on their work. These evaluations were undertaken by team members themselves, with colleagues from other services and with children/young people and families who use the service. All feedback informs future service delivery and provides an opportunity to shape the work of the service, which is planned and supported by the Service Improvement Plan. The Service Improvement Plan is updated quarterly and captures the improvement activity undertaken by members of the service.

6.1 Feedback from Parents and Young People

The service currently uses 2 tools to evaluate direct work with children, young people and their families.

A service evaluation form has been sent to every young person/family when a case has been discharged. This form is sent out centrally and returned to a central point, thus ensuring the objectivity of the responses. Although parents and young people are encouraged to return these evaluations, they are not always completed. However, to date (July 2016), 72 responses have been received from young people and 47 from parents. The evaluations ask for 8 different aspects of service delivery (see table 1), to be rated on a 5 point Likert Scale.

Q1.	I feel I was listened to
Q2.	It was easy to talk to the PMHW
Q3	I was helped to feel at ease
Q4.	My views and worries were taken seriously
Q5.	The PMHW knew how to help me with the problems I came with
Q6.	The time/work with the PMHW helped
Q7.	My appointments were at a convenient time.
Q8.	I liked the place we met

table 1

The collated responses from these evaluations indicate that 93% of young people and 98% of parents feel that they were listened to all or most of the time (appendix 9). 86% of young people and 95% of parents also felt that their views and worries were taken seriously all or most of the time. In addition, 78% of young people and 95% of parents felt that the time/work with the PMHW mostly or completely helped improve their situation.

These are extremely positive responses to receive and validate the work of the service. While this measure has proved useful, the team have decided that from August 2016 they will use a different but similar tool - the Paediatric Care Measure. This evaluation tool is widely used within the NHS and is currently being used by

allied health professionals within the Council and so will provide some consistency as a measure across Children's Services.

6.2 YP Core as an Outcome Measure for PMHW Service

The Child Outcomes Research Consortium (CORC) support mental health services to carry out routine outcome monitoring. They recommend a number of measures and in 2014 the PMHW team chose to use the YP Core to collect data for all referrals from the 11-17 year age group. The YP core was chosen as it was felt that it had the most comprehensive set of information to collect an evidence base for the team. It was also chosen after some discussion with the Phoenix Centre and hearing that it was a measure that they used at the time.

The YP-CORE provides data on the reasons for referrals that require direct intervention. This tool provides a measure of progress made, as indicated by client rating and therefore can be used as an evaluation of effectiveness of the interventions used. It is however most helpful as a way to feedback the direction of travel and progress with the young person and as a focus for discussion about further intervention and next steps. It does of course also provide feedback to team members to reflect on service delivery.

The YP core consists of a start of therapy assessment, a questionnaire (appendix 10), recommended to be used at assessment and end of treatment, and an end of treatment form. Improvement in the presenting difficulty is measured as a lower score at the end of treatment than was evident as the start of the assessment process.

The information has been collated by all PMHWs, although there has been a number of challenges in collecting full sets of information, especially when young people disengage before treatment is finished. Even-so, the data that has been collated is extremely helpful in supporting service planning (appendix 11).

The completed assessment questionnaires show an 85% return and an average score of **22** at assessment, for those young people assessed up to June 2016. The end of treatment questionnaires were collated for 49% of these young people and provided an average score at end of treatment of **15**. These responses indicate improvements in presenting difficulties and the positive impact from PMHW interventions.

The most commonly assessed needs relate to anxiety, low mood and behavioural/relational difficulties (appendix 12). A comparison between the assessed need and the reason for referral shows a good correlation (figure 5), indicating that referrers generally identify accurately the area of difficulty. This is very helpful in focusing the intervention from the outset. This information has also enabled the service to focus much of it's training and support for staff around these issues as they are the ones they will come across most frequently.

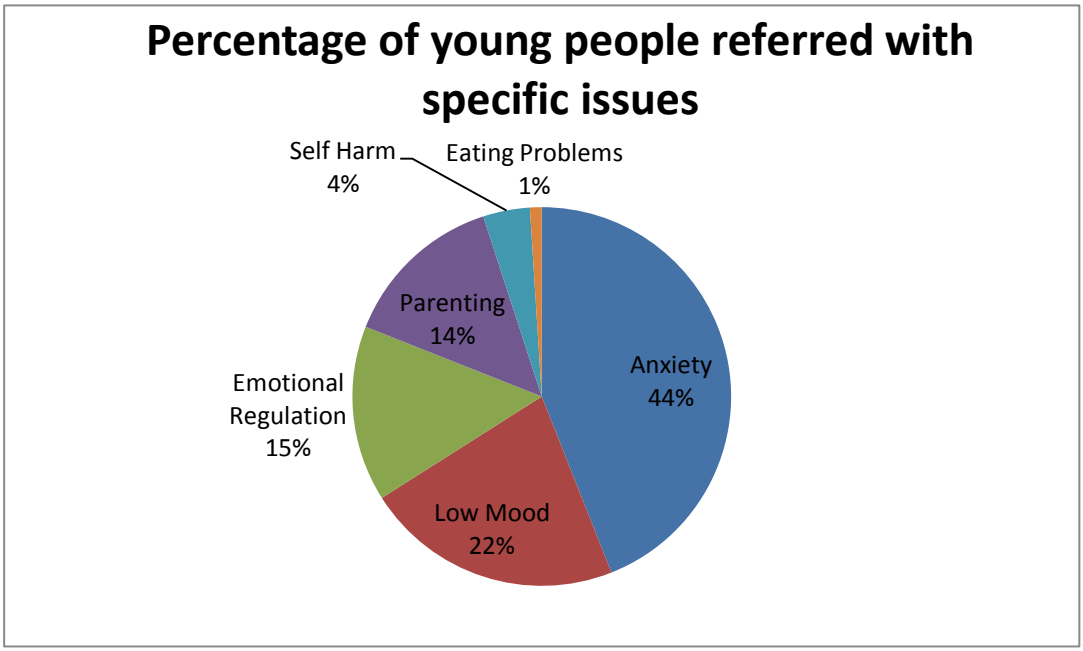


figure 5

The YP Core also gives a measure of risk of suicide and this has been used with other research evidence reported recently (Manchester University 2016), which has been considered by the PMHW team in relation to professional development for team members and also training offered to the wider children's services teams on suicide prevention. It has to be stressed however, that as an early intervention service, the majority of requests for service (69%), carry no risk of suicide (figure 6).

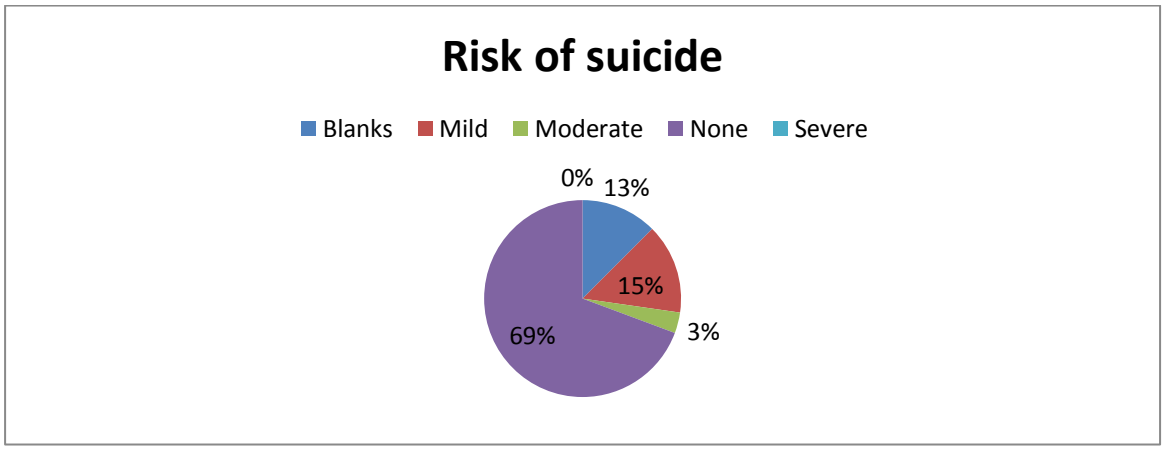
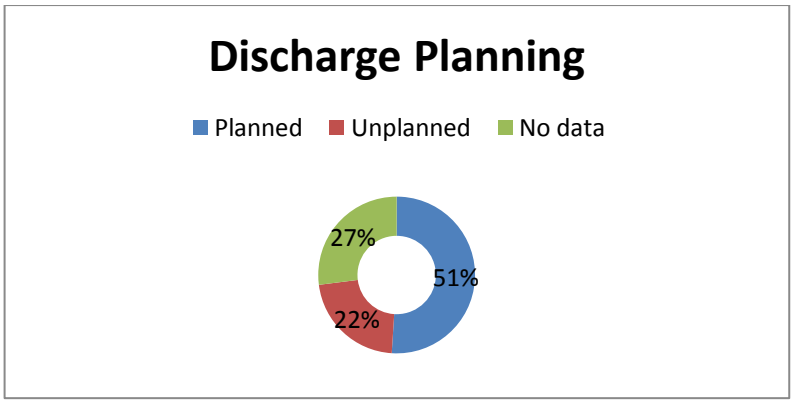


figure 6

There have been a number of challenges in collecting full sets of data for the YP-CORE, for several reasons. These have been discussed and explored in team meetings and it has been agreed to adapt the YP-CORE for the service to make it more user friendly. It will continue to be used as an ongoing outcome measure for all cases where the PMHW Service provides a direct service to young people. This will

ensure that relevant information is collected, to help evaluate the service and evidence service improvement.

The information gained from this evaluation indicates that only 51% of children and young people have a planned discharge. This data has helped the team to consider how they might better plan for discharge as soon as they start to see a child/young person, as this can support a young person who may not follow through to the end of 'treatment' (Hall et all 2013).



6.3 User Feedback

Individual team members often receive feedback directly from service users and the service manager and team lead also receive complaints and compliments about the service from time to time. In session 2015/16, the service received only two formal complaints that were logged and dealt with through the council's complaints procedure. Positive feedback relating to individual case holders is held in a 'praise book' by the service manager and includes the following quotes from parents and young people:

- *'Excellent support and strategies you're providing.'*
- *'X was a huge help to me. He listened to me and understood what was going on.'*
- *'We just wanted to say that he (our son) is completely cured of the fears and phobias he had and he and we couldn't be more pleased.'*
- *'Big thank you. I think he saved me from going mad or hurting someone.'*
- *'A seamless referral from GP to PMHW. Excellent and inclusive of carers' observations and views in a partnership style – valuable.'*
- *'Thank you for seeing X. It has been a great help in such a short time and she has settled into her new school and is so much happier.'*

Members of the team are encouraged to pass on any positive feedback they receive as it supports service improvement and provides regular evidence of service user satisfaction to the service manager and team lead.

7. PLANNING FOR 2016/17

7.1 Improvement Methodology

The Framework for Improvement, used in many NHS Boards, used as the framework for public services in Scotland and also promoted through the Scottish Government's collaborative networks, (Scottish Government 2013), forms the basis for the improvement methodology starting to be much more embedded within the team. Several self-evaluation activities have taken a solution oriented approach and more recently, driver diagrams were developed by the team to identify the priorities for the Improvement Plan. A short session was presented to all staff on the use of run charts and PDSA cycles and some members of the team are involved in completing their own PDSA cycles for pieces of work undertaken in their own patch eg a project on Remote and Rural Health (RRHEAL) using video conferencing for consultation and possible direct work; considering those pupils noted as having mental health issues, who are on part time attendance at school and the use of consultation with the PMHW to support their return.

The service manager and the team leader are both members of the Highland Improvement Network, taking an active role in supporting the role out of this methodology across Highland Council and mentoring individual members of the network.

The PMHW Service uses the Service Improvement Plan to plan and track activity undertaken by the three improvement groups within the Service: Looked After Children, Early Years and Training and Development. In reviewing the plan before the summer break, it was clear that many of the actions have been achieved and the service is now into a new phase of planning and development. New actions agreed by the team will be incorporated into the plan to ensure a strategic overview is maintained at all times. The PMHW Service Improvement Plan is monitored through the ASN Head of Service meetings, with key measures and outcomes reported to the ASN Improvement Group and the Mental Health Improvement Group, both of which sit within the planning structure for Children's Services, For Highland's Children 4.

7.2 LAAC Mental Health Project

The joint project with the Tier 3 service to support looked after children, is in its early stages. This project is funded by the Scottish Government Innovation Funding and aims to provide joint Tier 2/3 consultation and training from both services, to residential care staff working in Highland Council residential units. Budget has been

released to support an additional 0.5 fte PMHW to work alongside the two FTE workers from the Tier 3 service. Given that there are residential units in several areas in highland, it's been decided to provide additional time to staff who have already given input to children/young people in the residential units on an occasional basis, as they already have a relationship with staff. It would not be economical of time to have a centrally based post of 0.5 fte travelling across Highland.

This project has several aims which are outlined in the project and will report on a 90 day cycle to the children's health commissioner and on a quarterly basis to the Mental Health Improvement Group and the ASN Improvement Group.

7.3 Early Years Development Group

The PMHW service received additional funding from Highland Council for 2 PMHWs in 2013. Additional posts were provided to the service to support preventative work in early years. This additionality allowed several members of the team to access training in Video Interaction Guidance (VIG), with a view to using this in the early years. It is unfortunate that two members of the team who were trained initially have now left the service, however two of the current members of staff completed training and have continued to use VIG with young children and their parents/carers. VIG is an evidence based intervention which has shown to have very positive outcomes in building better relationships between children and their parents/carers.

Feedback from parents has mirrored the international evidence base for VIG and demonstrated how powerful an intervention this can be:

> *"I don't see (her daughter) like that. I see her more defiant and bolshy, whereas here (in the film) she's totally different. It's like I'm looking into my life which is good ….. it makes me more aware that I'm not a bad parent"*

> *"It (the film clip) just proves that I can do it. It's just the mental block I had in my head thinking I can't do this, I can't cope; but look at me I can do this. I can do this!*

> *" It's become a lot easier. Whenever I see him or feel his presence I feel a shift in me saying (her son) is here now. I like that.*

When asked if they would recommend Video Interactive Guidance to others, parents almost all respond positively, demonstrating how the intervention has changed their relationships with their children….

> *"Yes. I was able to see things about myself and my child I wouldn't otherwise have seen and which have helped me to modify my behaviour to be more attuned to his needs."*

…and also indicating that the process of using film of them interacting with their child is what makes the difference in this approach.

> *"Observing my child as this helped me understand the feedback he was receiving from me, both positive and negative, and vice versa actually"*

> *"Being able to discuss specifics with the guider rather than having to describe a situation before discussing it with someone. The feedback sessions are very important"*

Both members of the PMHW Service who offer this intervention have now completed Stage 2 of their training and are currently working on Stage 3. Once Stage three has been achieved, both will be able to be 'VIG Guiders' for others. Additionally, five other members of the team are also interested in investing time in this approach and they will complete their initial training during 2016/17.

7.4 Training and Development Group

The PMHW service has just started a collaboration with Stirling University to consider further research on the use and effectiveness of the consultation process. This will be progressed during the coming year, with input from all team members.

The focus on mental health awareness for this group, has also extended to the work around Suicide and Self-Harm, with a piece of work already underway to develop guidelines and pathways for the service. A driver diagram relating to the delivery of safeTALK for older pupils in schools, is being developed and this pathway is likely to be completed and trialled during the coming school session.

The Team Lead has a focus on maintaining the individuality of the interests and skills of each team member, while also developing more consistent processes to support service delivery within a quality assurance framework. The various evaluative processes will be considered by this group and will inform discussion at team meetings regarding appropriate changes in practice.

The group has recently established a Twitter account and has links to schools and professionals who use Twitter as a means of passing on information. This will hopefully raise the profile of the work of the team, with Tweets about training that has been undertaken and useful links to information about the mental health of children and young people.

7.5 Workforce Planning and Development

With new members of staff expected to join the service in the near future, work will continue on building trust and positive relationships and a sense of belonging within the team.

Ensuring the continued professional development for each team member is an essential component of the development planning within the service. Having a planned approach to both individual and group training and development ensures the continued provision of a high quality service. During the coming session training is already planned for the following topics: Supervision and Consultation, Solution Focused Approaches, Video Interaction Guidance, EMDR, Attachment and Attunement, Theraplay, Mindfulness with Children and Leading Change.

As indicated within this document, individual members of the team have particular interests and projects they have developed or participate in and all team members contribute to the service development groups. While there are many opportunities for engaging in and supporting more integrated work with other services, it is also important to retain the unique character and contribution of the PMHW role within this. To support this aim, self-evaluation has become a central feature of the management and leadership of the service and is now well embedded within the team. It will remain a core feature of the work undertaken by the service, informing and shaping future planning.

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Appendix 1

PMHW Service

RELATIONAL TRUST

Developing a culture of relational trust and disciplined performance can be difficult. Reina and Reina (1999) provide a model of reciprocal trust – you have to give it to get it - that is built up incrementally within teams. In this, they have identified three types of trust:

- Competence Trust (Trust of Capability),
- Contractual trust (Trust of Character) and
- Communication Trust (Trust of Disclosure).

All three components must be actively developed and reinforced by leaders. The subcomponents of each type of trust include:

Competence Trust - Respect people's knowledge and skills
- Involve others and seek their input
- Help people learn skills

Contractual Trust - Manage expectations
- Honour agreements
- Encourage mutual intentions

Communication Trust- Share information openly
- Maintain confidentiality
- Give and receive Constructive feedback

Where do **YOU** consider trust to be, from **YOUR** perspective, within the PMHW service?

COMPETENCE TRUST

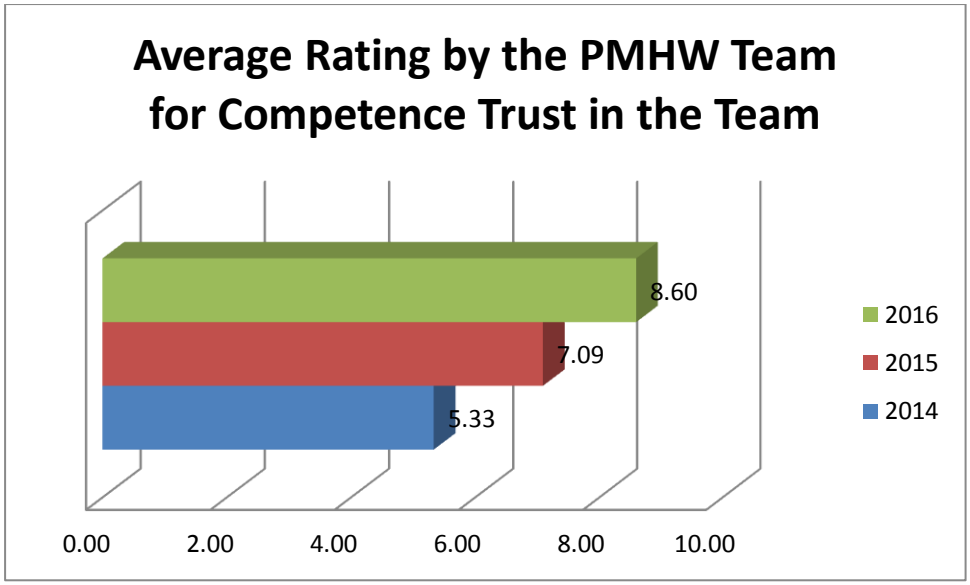
1 2 3 4 5 6 7 8 9 10

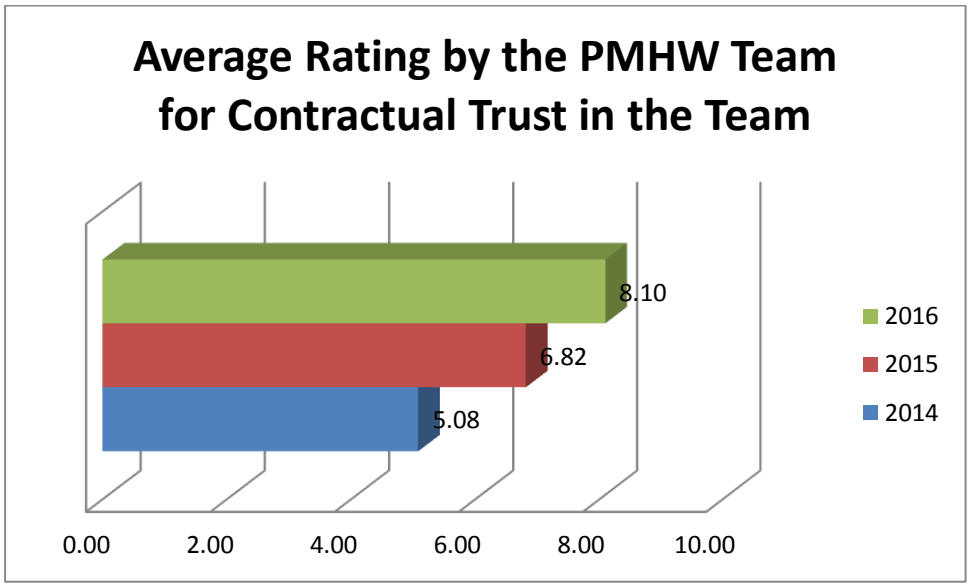
CONTRACTUAL TRUST

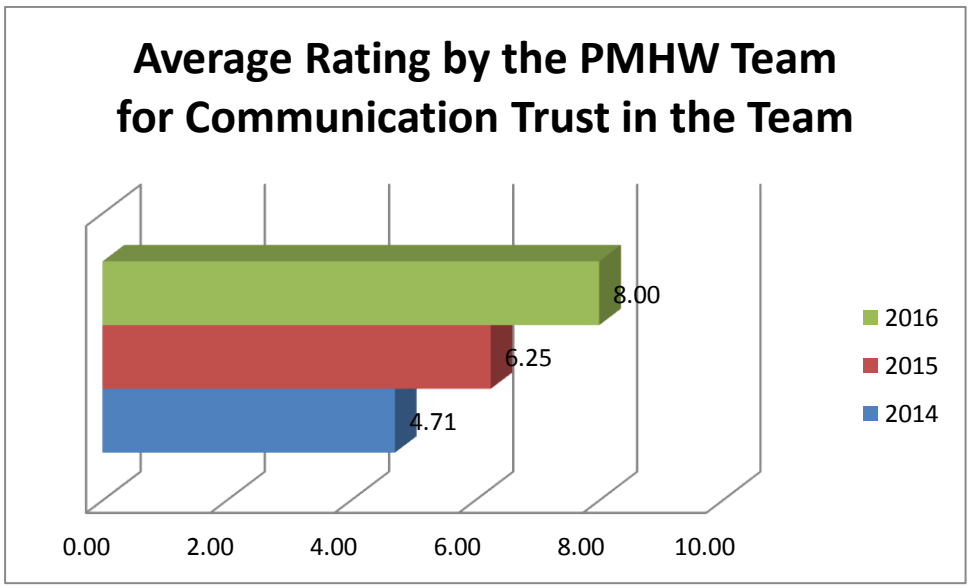
1 2 3 4 5 6 7 8 9 10

COMMUNICATION TRUST

1 2 3 4 5 6 7 8 9 10


Average Rating by the PMHW Team for Competence Trust in the Team
8.60
7.09
5.33
2016
2015
2014
0.00
2.00
4.00
6.00
8.00
10.00


Average Rating by the PMHW Team for Contractual Trust in the Team
8.10
6.82
5.08
2016
2015
2014
0.00
2.00
4.00
6.00
8.00
10.00


Average Rating by the PMHW Team for Communication Trust in the Team
8.00
6.25
4.71
2016
2015
2014
0.00
2.00
4.00
6.00
8.00
10.00

Appendix 2

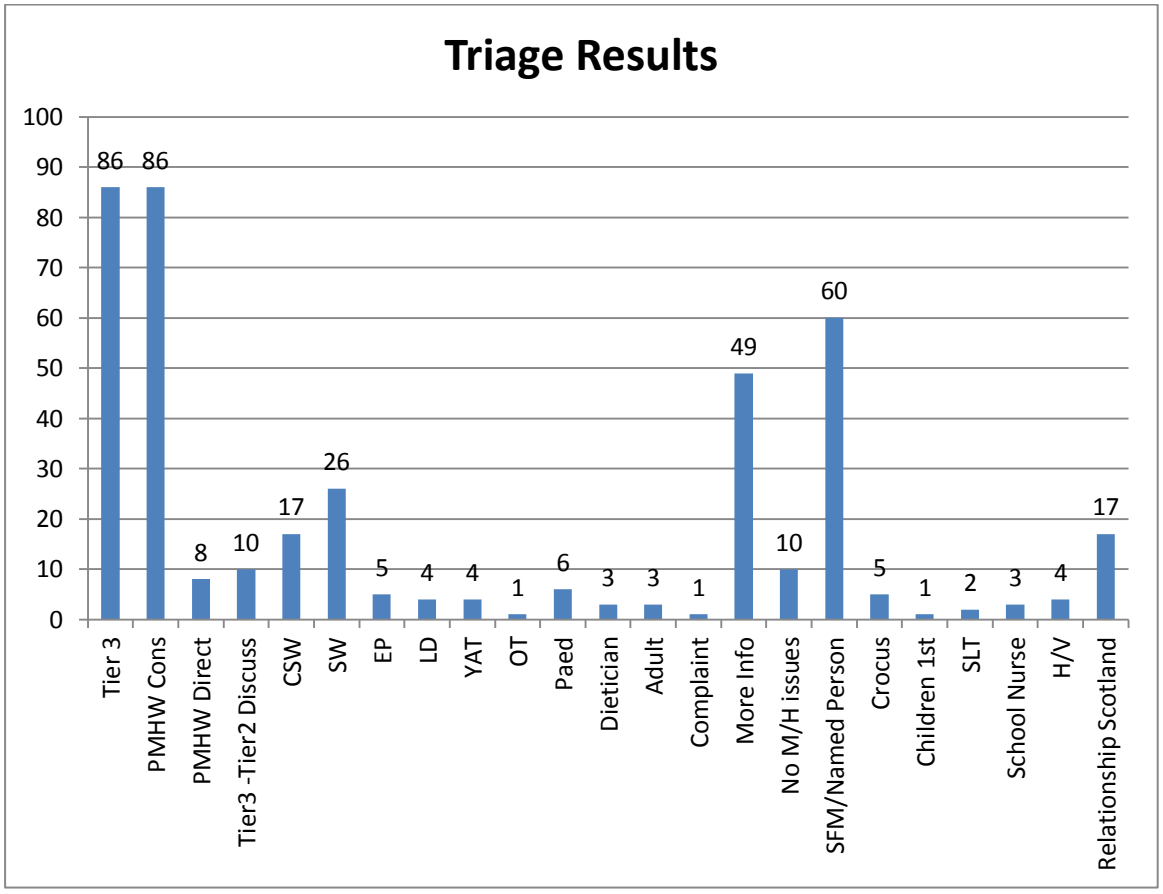
T2/3 Triage July 2015 - June 2016

Total Cases Discussed = 411

All considered Tier 2 level initially. After discussion, 94 went directly to PMHWs, 86 remained with the Tier 3 Service and 10 required further discussion between T2 and T3 services.

60 were further referred to a solution focused meeting. Some then were appropriately directed to CAMHS and some to other services.

For 49, further information was sought and as above, some were then were appropriately directed to CAMHS and some to other services.



PMHW Service – Staff List

Appendix 3

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Jill Mallison	Ardnamurchan Kinlochleven Lochaber Mallaig Kilchuimen	01397 709840	jill.mallison@highland.gov.uk	Highland Council Care and Learning Service Fulton House Fort William PH33 7AQ
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Appendix 4

Primary Mental Health Worker Service

MISSION STATEMENT

"The Primary Mental Health Worker Service builds capacity within other agencies and provides early intervention to support the mental health and emotional wellbeing of children, young people and their families, within their local communities, through consultation, direct intervention and training"

For Highlands Children 4 outcomes (with highlighted priorities for the PMHW Service)

1. Children are protected from abuse, neglect or harm at home, at school and in the community.
2. Children are well-equipped with the knowledge and skills they need to keep themselves safe.
3. Young people and families live in increasingly safer communities where anti-social and harmful behaviour is reducing.
4. Children and young people experience healthy growth and development.
5. Children and young people make well-informed choices about healthy and safe lifestyles.
6. Children and young people are equipped with the skills, confidence and self-esteem to progress successfully in their learning and development.
7. Children and young people are supported to achieve their potential in all areas of development.
8. Children and young people thrive as a result of nurturing relationships and stable environments.
9. Families receive support, advice and guidance which is well-matched to their needs and available in ways which helps them to prepare for the various developmental stages.
10. Children and young people are physically active.
11. Children and young people know their rights and are confident in exercising these. They are able to express their views and be involved meaningfully in decisions which affect them.
12. Families are valued as important contributors and work as equal partners to ensure positive outcomes for their children and young people.
13. Children, young people and their families are supported well to develop the strengths and resilience needed to overcome any inequalities they experience.
14. Improvement in service provision is determined by the participation of children, young people and families and by understanding their views, wishes, and expectations.

Key:
On time
Significantly delayed
Not yet started
A little behind time
completed

Primary Mental Health Worker Service
Improvement Plan

DATE of Plan: June 2016

FHC4 Outcome
(7) Children and young people are supported to achieve their potential in all areas of development.

Improvement priority:
1. Develop more evidence based practice through the use of research and evaluation and contribute to the evidence base locally for tools, interventions and practices where this may be limited.

Actions	Measures / evaluation	Timescale	Lead	BRAG
PMHWs will be empowered to develop a culture of research across the PMHW team and wider Integrated Services. They will develop research projects and a relevant range of evaluation tools.	Results and findings from research will be disseminated to other staff within children's services and consideration given to publishing some of this work for wider dissemination	Ongoing	Training and Development Group	GREEN
Evaluate the effectiveness of all interventions from an objective and subjective standpoint and use the evidence from evaluations to design a service for the future	Periodic reviews of the consultation process will show consultation being used to build capacity in others.	Ongoing	Training and Development Group	BLUE

Progress since last plan:
Regular reviews of the consultation process have been undertaken and demonstrate capacity building in others.
Research being undertaken on the use of VIG.

FHC4 Outcome
(14) Improvement in service provision is determined by the participation of children, young people and families and by understanding their views, wishes, and expectations.

Improvement Priority:
2. Ensure high quality engagement with and inclusion of children and young people across service and policy development

Actions	Measures / evaluation	Timescale	Lead	BRAG
Children and young people will be empowered and directly involved in their personal planning. They will be involved in consultations and engagement with the	Every individual file will include an evaluation of input and effectiveness of intervention. Feedback from file audits will provide this data.	By August 2016	PMHW Team Team Lead	**BLUE**

service, to help develop and shape policy and practice. Develop a process for evaluating the effectiveness of intervention and support from the PMHW service.	An initial evaluation project will be undertaken to assess the use of evaluation tools that might be helpful to use on a permanent basis.	Project to commence August 2014	PMHW Team	**BLUE**

Progress since last plan:
File note audit ensuring feedback on the interventions provided.
Evaluation of the User Feedback forms and the use of the YP-CORE have proved useful. The YP-CORE and Paediatric Care Measure will be used in the future.

FHC4 Outcome
(13) Children, young people and their families are supported well to develop the strengths and resilience needed to overcome any inequalities they experience.

Improvement Priority:
3. Enable PMHWs to support colleagues and families during their child's early years and to provide input into the early years agenda

Actions	Measures / evaluation	Timescale	Lead	BRAG
Sharing of PMHW skills relevant to early years across the team and increase the confidence of staff in this area of work.	Team members will feel they have the necessary skill and knowledge to provide effective consultation and interventions in early years work. This will be evidenced by an increase in the numbers of referrals /consultations from the Early Years.	By December 2015	Early Years Group	**BLUE**
	Evaluation of training will demonstrate the knowledge and understanding of other professionals.	By October 2015	Early Years Group	**BLUE**
	Team members' delivery of training at meetings and on development days to the rest of the team.	On-going	Early Years Group	**BLUE**
Identify training needs of staff and parents and with other professionals working in early years, support the delivery of training to early years workers and parents	Parents/carers and staff will have an awareness of the importance of positive relationships and how they contribute to healthy brain development and good mental health.	On-going	Early Years Group	**BLUE**
Support Development of PMHW infant mental health service to Tier 1 and 2 Provide Clinical Infant Mental Health input to Tiers 1 and 2 through targeted Interventions such as VIG, EMDR, mindfulness, parenting, attachment based relational	Evidenced through requests for direct work/consultation. Case files showing ongoing and completed work.	On-going	All team Team Lead	**BLUE**
	Other agencies are aware of interventions that promote infant mental health that are provided by PMHW service. Through the creation and sharing of a 'menu of services' and clear pathways.	By December 2015	Members of Infant Mental Health working group	**BLUE**

therapy, behavioural interventions etc	Training – Fostering and Adoption Team etc - put on CPD calendar	Series of training sessions on CPD calendar for session 2015-16	DM	**BLUE**
Develop pathways in relation to identifying need and onward referral to Tier 2 and 3 as per the Infant Mental Health guidelines.	CAMHS Pathway will be agreed for the various interventions helpful in early years appropriate to the PMHW service and wider CAMHS.	By February 2016	IMH WG Tier 2 and 3 Services	**BLUE**

Progress since last plan:

Training delivery offered around early years development and building positively attuned relationships.
There has been an increase in the number of EYs consultations taking place. This information is now gathered monthly and embedded in the monitoring process.
Training is evaluated positively.
Staff are members of the Infant Mental Health Group.
The feedback from the Fostering and Adoption Team re the training/consultation is very positive.
Referral pathway agreed by CAMHS
Information provided to Family Teams – consultations with Health Visitors offered and VIG interventions in Early Years.
Case File Audit demonstrates work undertaken in the Early Years.

FHC4 Outcome

(13) Children, young people and their families are supported well to develop the strengths and resilience needed to overcome any inequalities they experience.

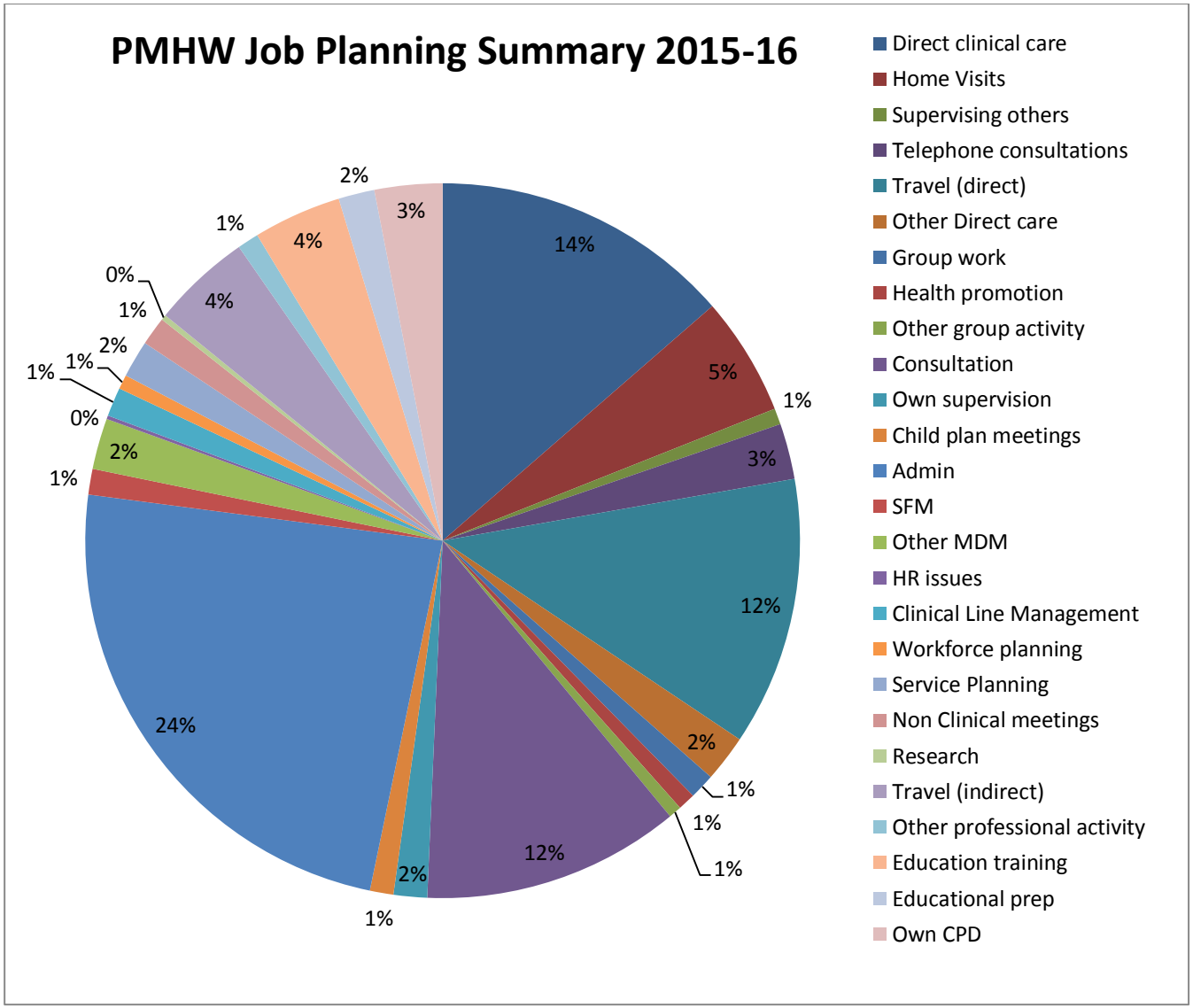
Improvement Priority:

4. PMHW's will have an improved understanding of their role/skills

Actions	Measures / evaluation	Timescale	Lead	BRAG
Agree a range of policy and guidance documents for the service that are kept under review	Policy and practice documents will be up to date and current. Annual audit of policies will ensure this.	On-going	Team Leader	**BLUE**
Team members will have an improved knowledge and understanding of the PMHW role and be confident in undertaking this role	Ensure appropriate supervision is in place to support the delivery of therapeutic interventions	By June 2016	Team Leader	**GREEN**
	Skilled practice will be evidenced by positive comments and evaluations from service users and low numbers of complaints. Evaluation project commenced August 2014. Annual review of complaints will evidence < 10	Evaluation results August 2015	Team Leader Head of Service	**BLUE**

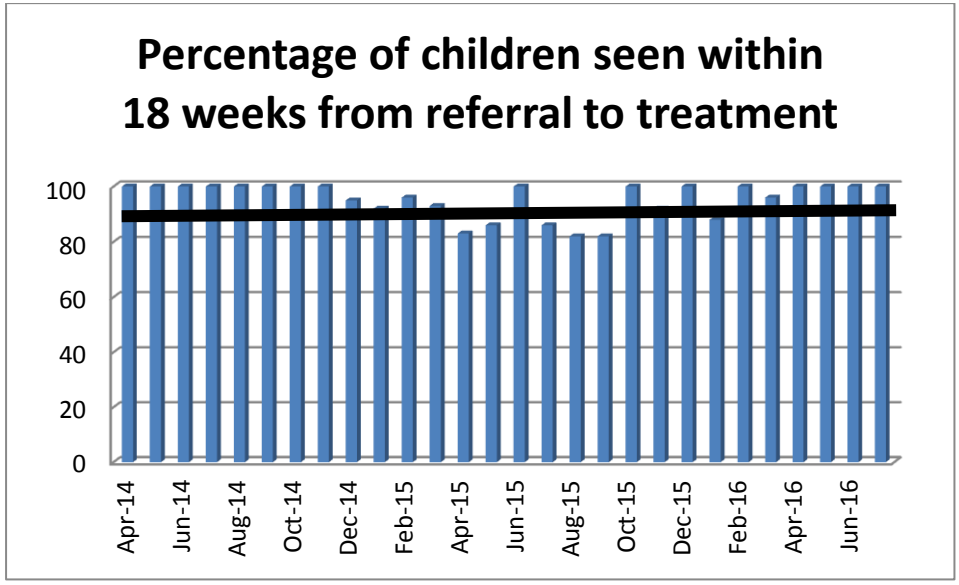
Progress since last plan:

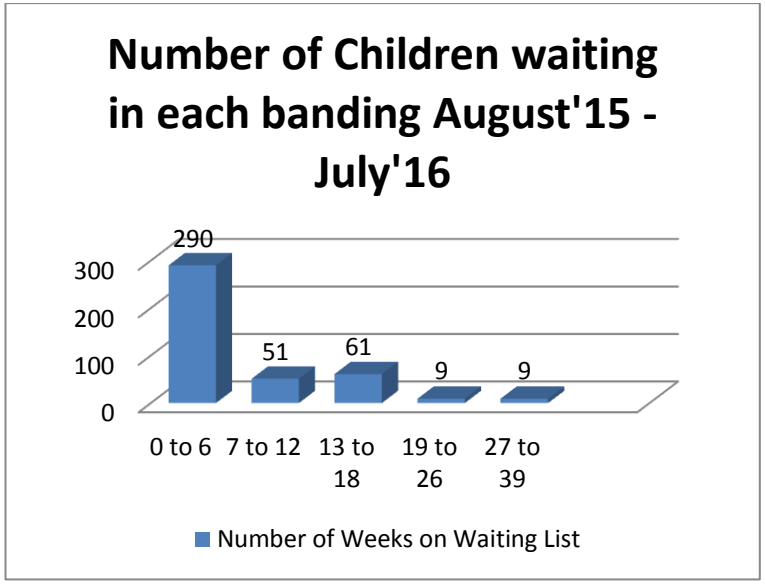
Most team members now have individual supervision and all participate in group supervision. All have 6 weekly management support.
Policy and practice documents are developed as appropriate. A suite of documents have been agreed to date.
In session 2016-17 there were only 2 complaints relation to the service.


PMHW Job Planning Summary 2015-16
14%
5%
1%
3%
12%
2%
1%
1%
1%
12%
2%
1%
24%
1%
0%
2%
1%
1%
2%
0%
1%
4%
1%
4%
2%
3%
Direct clinical care
Home Visits
Supervising others
Telephone consultations
Travel (direct)
Other Direct care
Group work
Health promotion
Other group activity
Consultation
Own supervision
Child plan meetings
Admin
SFM
Other MDM
HR issues
Clinical Line Management
Workforce planning
Service Planning
Non Clinical meetings
Research
Travel (indirect)
Other professional activity
Education training
Educational prep
Own CPD

Appendix 5

Appendix 6



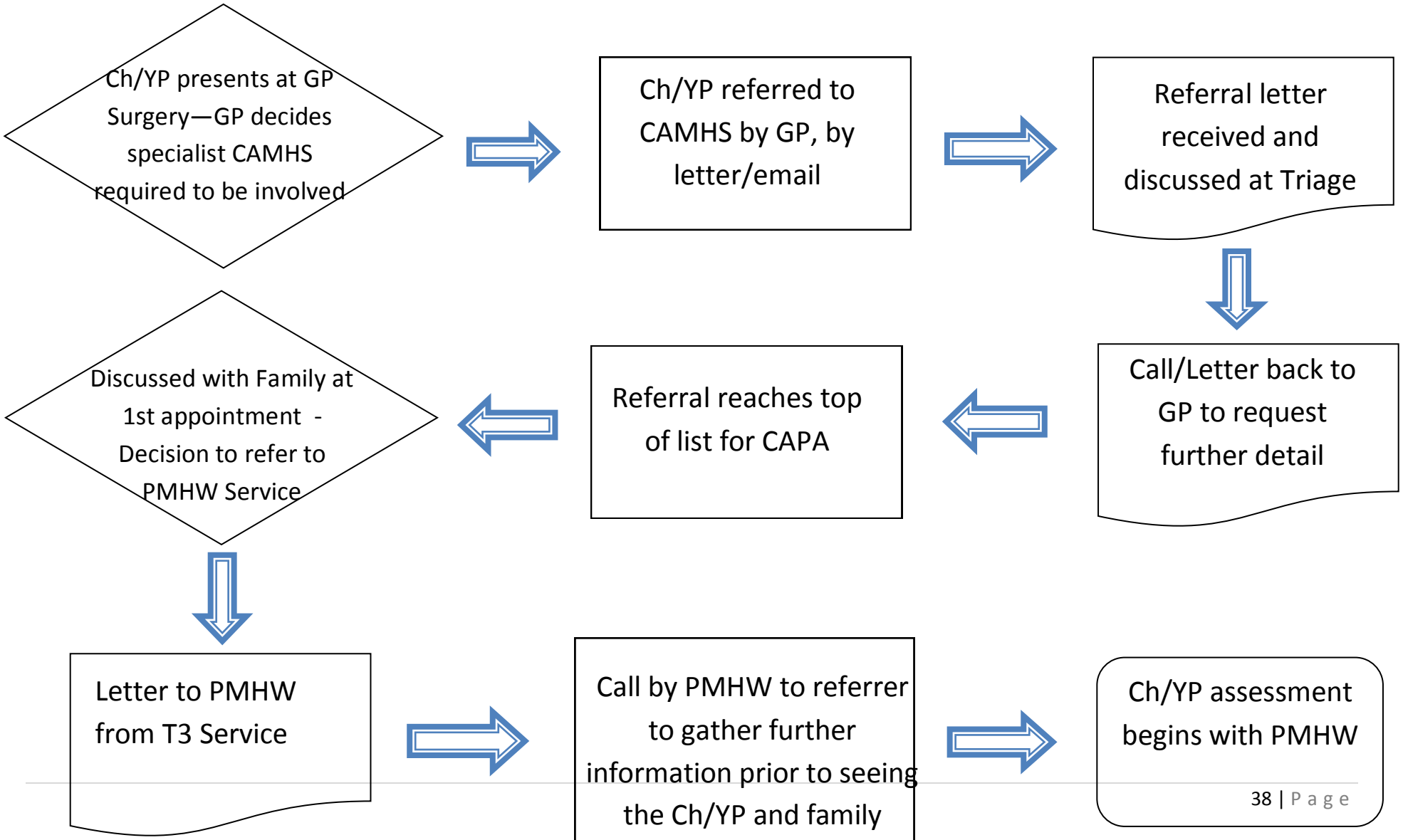


= Scottish Government Target that 90% of children and young people will be seen within the 18 week target set.

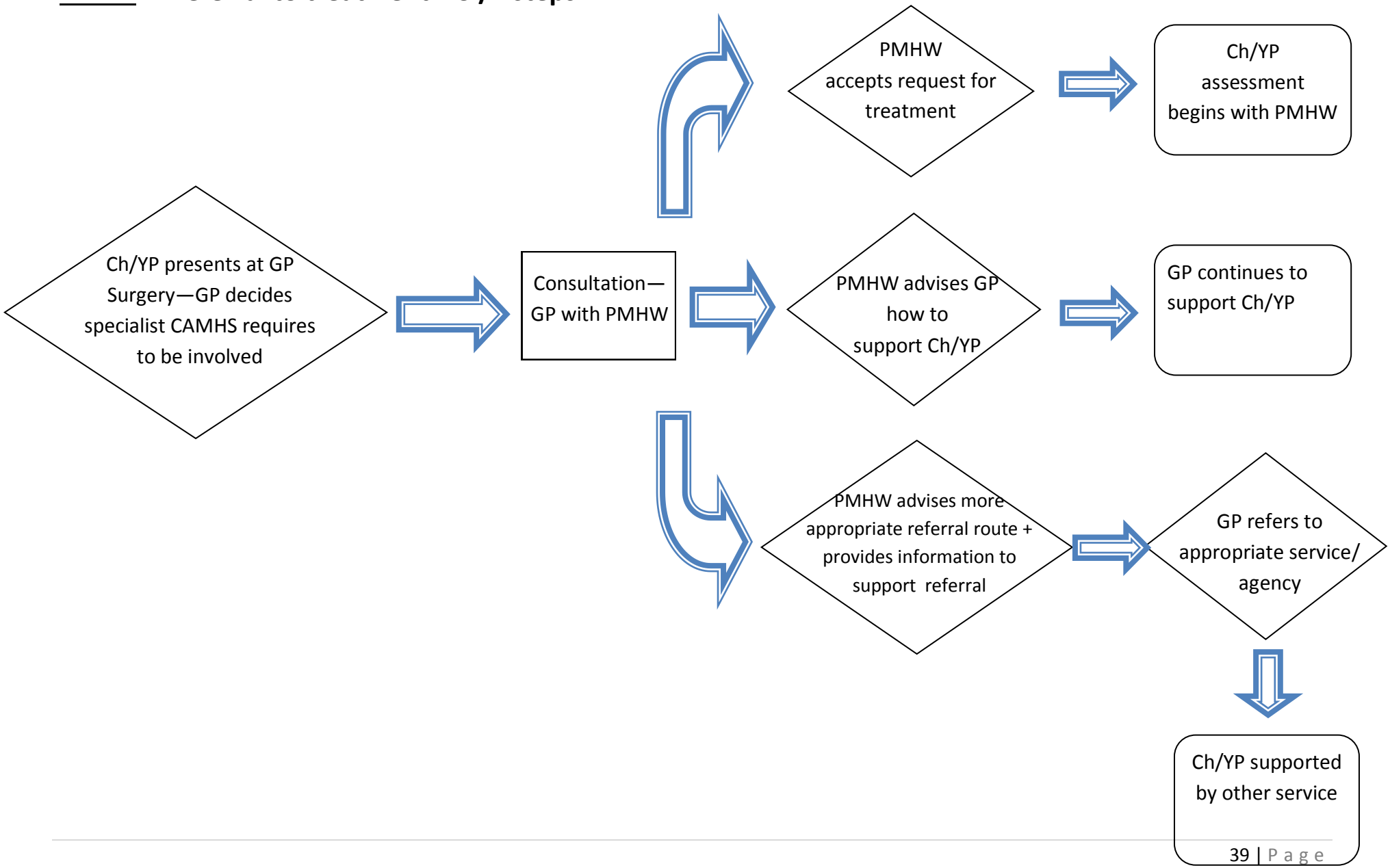
PMHW Improvement Activity—Process Map for Referral to PMHW from GP

Appendix 7

BEFORE— Referral to treatment = 8 steps



AFTER— Referral to treatment = 3 /4 steps



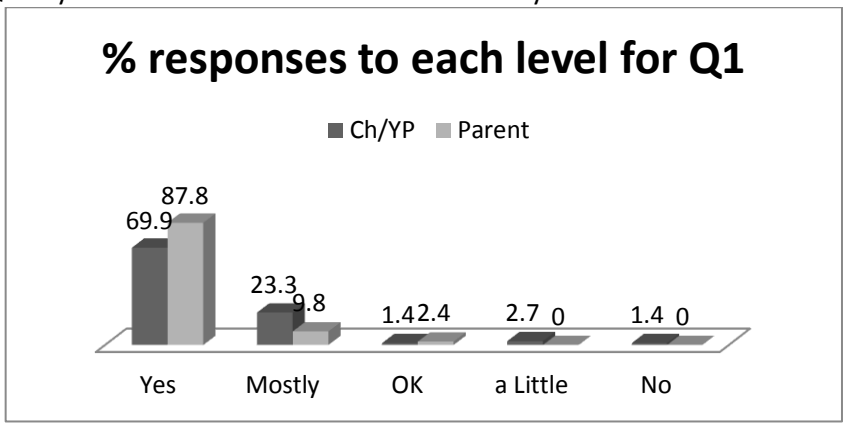
PMHW Service Training Log April-June 2016

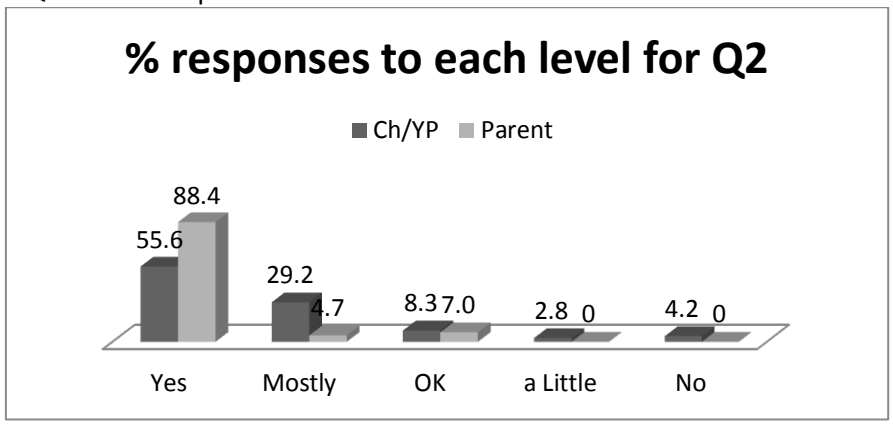
Appendix 8

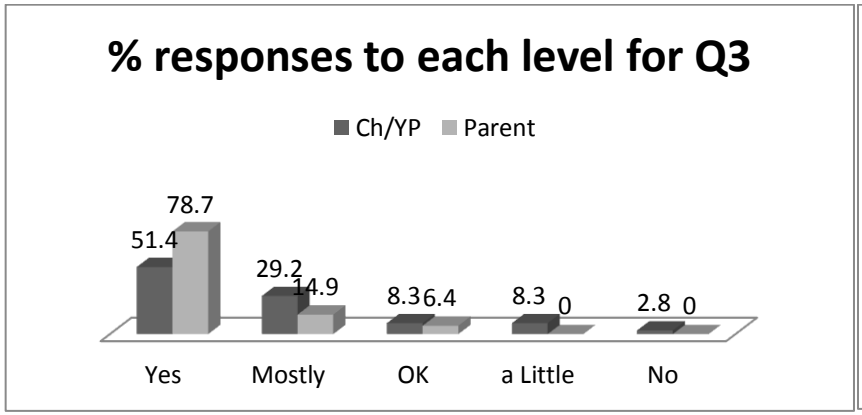
Subject	Group	Number
Understanding and Managing Exam Anxiety	Pupils	15
Understanding Self Harm	Vol Org	8
Self Harm and Suicide	School Nurses	16
Exam Stress	Pupils	24
Consultation	GPs	15
PMHW Role	GP practice	9
Emotional Regulation	GP practice	9
Sandplay	School staff	2
Managing Stress	School staff	12
Emotional Literacy	School staff	9
STORM	T2 and T3 CAMHS	14
SMHFA-YP	C+L and HLH staff	10
Exam Stress	S4 pupils	80
SMHFA-YP	Multi-Agency Group	10
Attachment/Intersubjectivity	PMHWs	5
SafeTALK	Mixed	9
Introduction to Mindfulness	Pupils	30
Introduction to Mindfulness	Pupils	150
Self Harm	Youth Action Team	6
Introduction to Mindfulness	Nursery	4
MH Promotion	Pupils	80

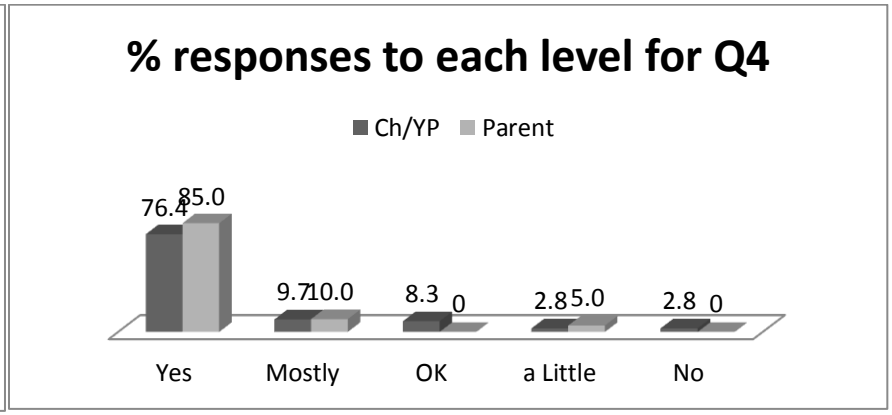
Service User Responses from Young People and Parents from the Individual evaluations.

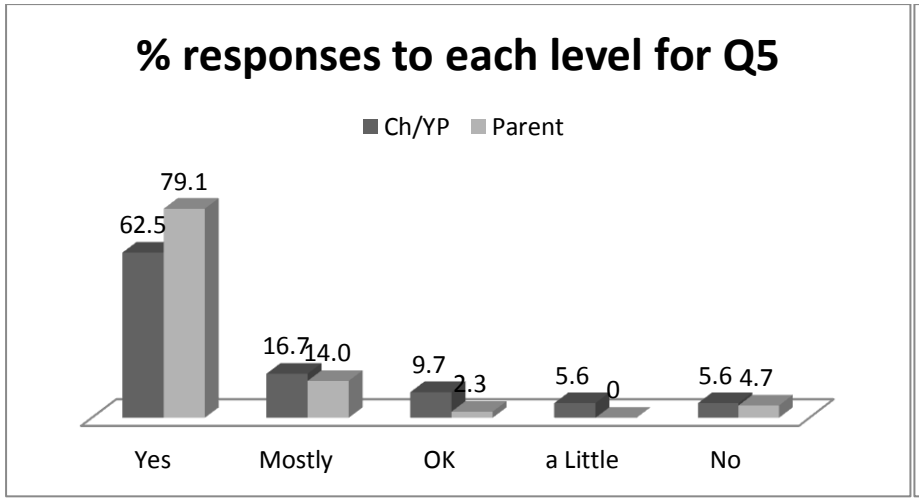
Q1. I feel I was listened to
Q2. It was easy to talk to the PMHW
Q3. I was helped to feel at ease
Q4. My views and worries were taken seriously
Q5. The PMHW knew how to help me with the problems I came with
Q6. The time/work with the PMHW helped
Q7. My appointments were at a convenient time.
Q8. I liked the place we met

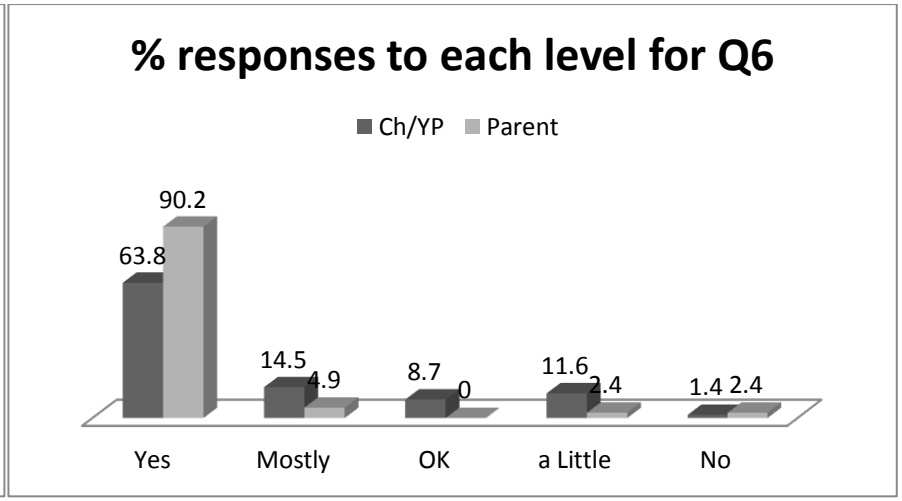


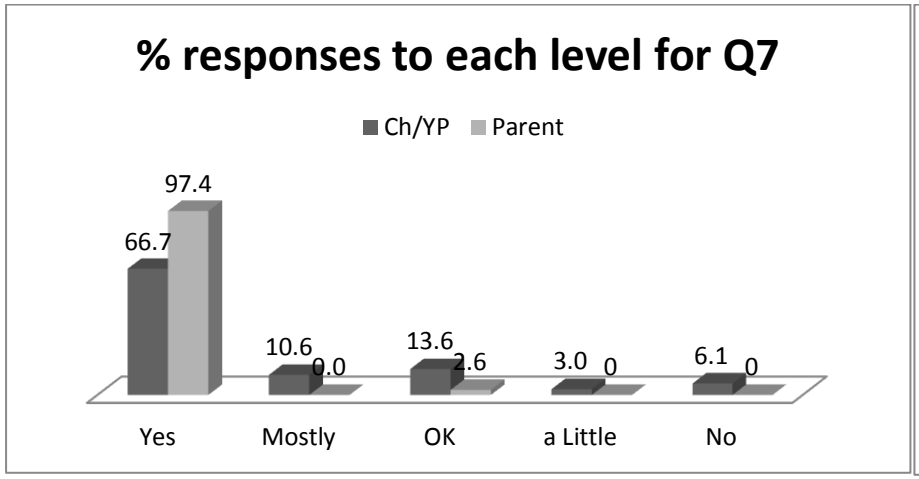


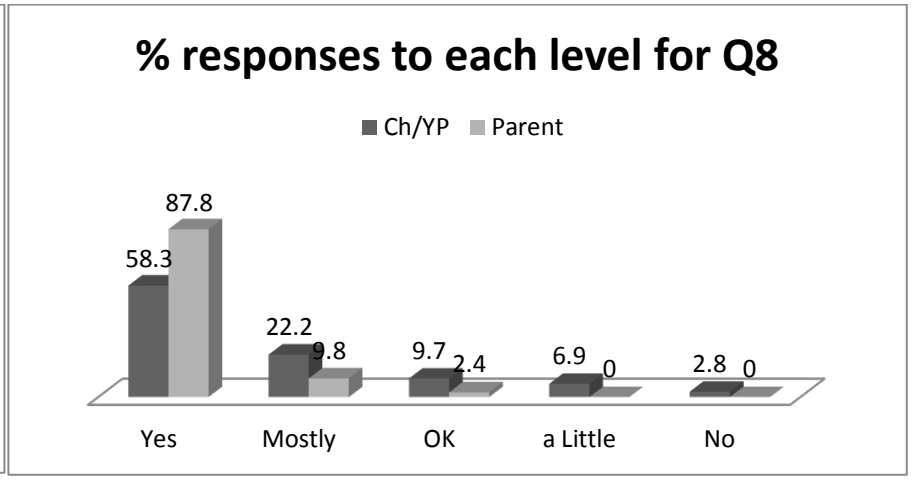












Total number of responses completed - 47 parental responses and 72 responses from young people.

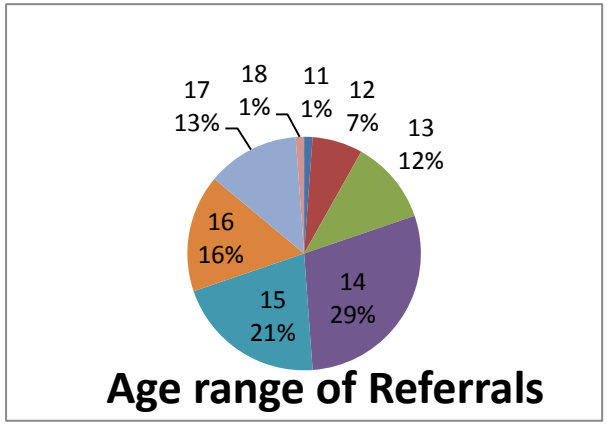
YP Questionnaire – used at Initial Assessment and End of 'Treatment'

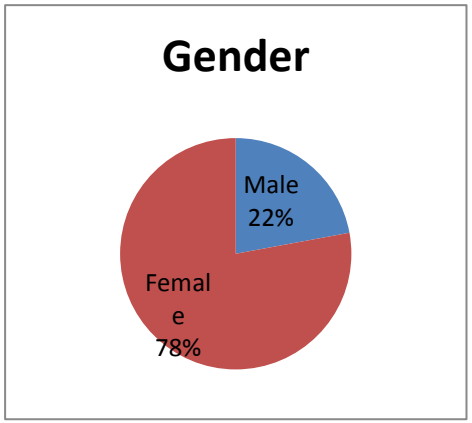
These questions are about how you have been feeling OVER THE LAST WEEK. Please read each question carefully. Think how often you have felt like that in the last week and then put a cross in the box you think fits best.
Please use a dark pen (not pencil) and mark clearly within the boxes.

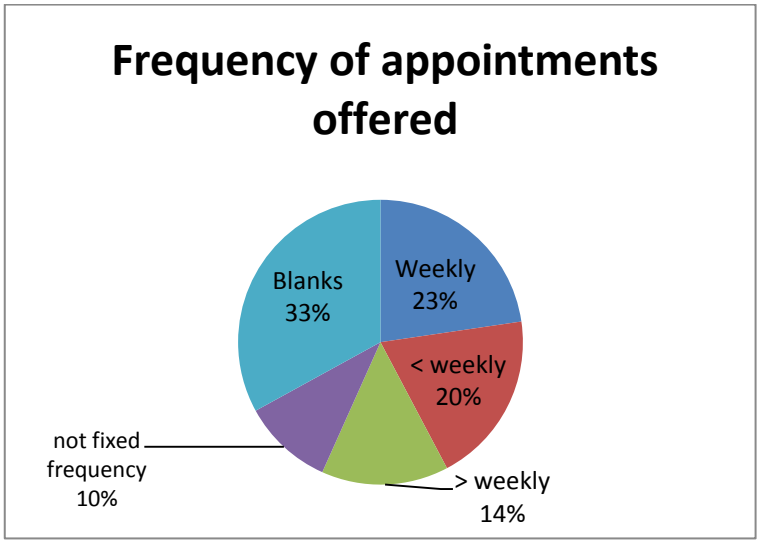
OVER THE LAST WEEK…	Not at all	Only occasionally	Sometimes	Often	Most or all of the time
1. I've felt edgy or nervous	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
2. I haven't felt like talking to anyone	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
3. I've felt able to cope when things go wrong	☐ 4	☐ 3	☐ 2	☐ 1	☐ 0
4. I've thought of hurting myself	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
5. There's been someone I felt able to ask for help	☐ 4	☐ 3	☐ 2	☐ 1	☐ 0
6. My thoughts and feelings distressed me	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
7. My problems have felt too much for me	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
8. It's been hard to go to sleep or stay asleep	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
9. I've felt unhappy	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
10. I've done all the things I wanted to	☐ 4	☐ 3	☐ 2	☐ 1	☐ 0

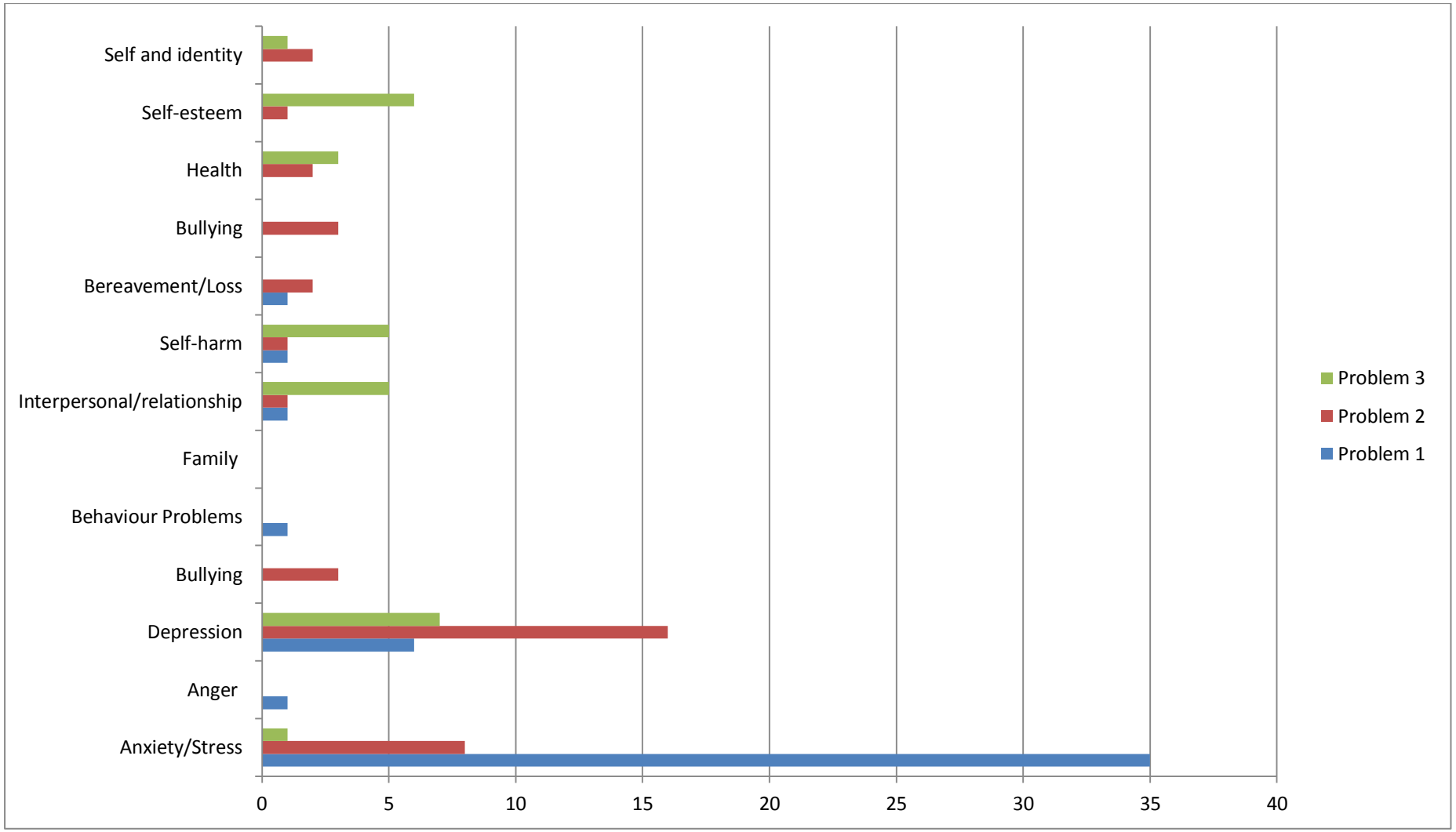
Data from YP CORE-

Age (11-18), Gender and presenting Problems, with frequency of appointments offered to support the young person









YP-CORE Main reasons for intervention as assessed by the PMHW (top 3 'problems')