Department for Education

Mental Health and Emotional Wellbeing Project evaluation

Hastings Opportunity Area Intervention Level Evaluation Report

May 2022

Authors: York Consulting

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Glossary of abbreviations

ADHD	Attention deficit hyperactivity disorder.
CAMHS	Child and Adolescent Mental Health Services.
CBT	Cognitive Behavioural Therapy.
CCG	Clinical Commissioning Group.
DfE	Department for Education.
ELSA	Emotional Literacy Support Assistant.
FTE	Full time equivalent.
MHEW	Mental health and emotional wellbeing.
NEET	Not in education, employment or training.
PMHW	Primary Mental Health Worker.
PSHE	Personal, Social, Health and Economic.
RCADS	Revised Child Anxiety and Depression Scale.
RSHE	Relationships, Sex and Health Education.
SEN	Special Educational Needs.
SEND	Special Educational Needs and Disabilities.
SENCO	Special Educational Needs Co-ordinator.
Triple P	Positive Parenting Programme.

Executive summary

Key insights for future delivery

The following key insights should be taken in consideration for future roll-out:

- **The benefits of a multi-stranded offer.** Mental health and emotional wellbeing challenges vary in their symptoms, severity and required response. An evident strength of the Mental Health and Emotional Wellbeing (MHEW) Project was how it enabled more young people to be supported with a range of different issues, rather than having a single focus.

- **Broadening the Short-term Keywork offer.** This was highly regarded by pupils and parents. Pupils expressed how the sessions had positive effects on their mental health and emotional wellbeing. Parents supported these claims, expressing that their child's behaviour and demeanour had improved. There is a clear appetite amongst the schools in Hastings that have accessed the Short-term Keywork service for that offer to be made available to pupils in years 2 to 4 with emerging mental health and emotional wellbeing issues. Staff at those schools believe that earlier intervention could help prevent the escalation of those issues and avoid the need for CAMHS support.

- **Understanding demand.** Participation in the Parenting Support offer in Hastings has been lower than anticipated, due in part to a stigma associated with participating in structured parenting programme. The likely willingness of parents in a given locality to engage in such should be researched (as far as is possible) before funding allocations are committed.

- **Blended delivery approaches.** The MHEW Project has proven that one-to-one support for young people and parents can be provided effectively via remote delivery and need not only be used in times of crisis. Some participants preferred the blended approaches and it should therefore be considered in the future. This may also result in lower delivery costs.

- **Pre- and post-intervention feedback.** Wherever possible, all strands within a project like the Hastings MHEW Project should collect pre- and post-intervention data from participants and should store it in a way that allows it to be analysed at an individual level. This will help with the assessment of outcomes and effectiveness. Likewise, the ability to identify where young people have received support through more than one strand and whether that generates a greater impact than single interventions.

Introduction

This report presents findings from the evaluation of the Mental Health and Emotional Wellbeing (MHEW) Project. The MHEW Project was an initiative developed by the Hastings Opportunity Area (OA) in 2018 to provide early intervention support to promote children's and young people's resilience, social and emotional skills and self-regulation. The MHEW Project was one of 5 OA projects evaluated as 'intervention level evaluations' by York Consulting on behalf of the Department for Education (DfE).

The MHEW Project delivered the planned activity, despite some delays and disruptions due to coronavirus (COVID-19) restrictions. There have been six different strands to the MHEW Project, together receiving total funding of £1.4m between September 2018 and July/August 2021. Four of these six strands were the main focus of this evaluation:

- **Short-term Keywork** provided support to pupils with low-level emotional wellbeing concerns. It was delivered primarily via a 12-week programme of one-to-one support sessions by trained keywork practitioners in schools. This switched to telephone/video calls when COVID-19 restrictions applied.

- **Parenting Support** offered the Positive Parenting Programme (Triple P) to parents. Triple P sought to equip parents with practical strategies to build strong relationships with their children, manage behaviours and prevent problems from escalating. [1]

- **i-Rock** is a drop-in service for 14-25 year-olds, offering advice and support on emotional and mental wellbeing, employment, education and housing. Funding through the OA enabled i-Rock to open five days a week (previously it was open three days a week) and provide in-house wellbeing interventions for young people.

- **The Whole School Approach** strand offered a bespoke package of mental health-related support and consultancy to schools in Hastings.

Evaluation aims and methodology

The evaluation aimed to assess the efficacy of the MHEW Project approach, namely early intervention and support, joint commissioning and a delivery model that involves schools, the local authority, the voluntary sector and the NHS.

[1] There are five different levels to Triple P, discussed in more detail in the main report. These are: Level 1 - communication strategy; Level 2 - one-time assistance via one-off seminars or 'Brief Primary Care' sessions (a one-off conversation with a practitioner); Level 3 - one-to-one interventions of between three and six sessions, plus discussion groups on specific parenting topics; Level 4 - known as 'Standard Triple P', this involves more intensive one-to-one support and is delivered over ten one-hour sessions; Level 5 - intensive support for families with complex needs.

The evaluation was structured into three waves. Wave 1 explored the implementation, delivery and early outcomes of the MHEW Project. Wave 2 reviewed the adaptations introduced to address COVID-19 restrictions. Wave 3 focused on levels of need and demand for mental health and emotional wellbeing support (particularly following the re-opening of schools in March 2021) and the outcomes and impacts generated by the MHEW Project. Unfortunately, due to quantitative data constraints as a result of COVID-19, and ethical concerns prohibiting the adoption of a control group, a robust impact assessment on the outcomes and impacts was not possible and therefore a qualitative approach was taken instead. Research participants included Special Educational Needs Co-ordinators (SENCOs), teachers, senior managers in schools, strand leads, practitioners, young people and parents/carers.

Key findings

Implementation and delivery

Need and demand. Prior to the COVID-19 pandemic, SENCOs and other school staff agreed that demand for mental health and emotional wellbeing support amongst pupils in Hastings was increasing. They attributed this to a range of factors including worsening levels of parental mental health, local economic and social deprivation and increasing use/prevalence of social media. Anxiety, low self-esteem, eating disorders, self-harm and problems relating to resilience and emotional intelligence were reported most frequently.

Following the re-opening of schools in March 2021, interviewees consistently spoke of large increases in the number of pupils presenting with mental health and emotional wellbeing issues and of those issues becoming more serious. They included social anxiety, attachment issues and self-harm.

Short-term Keywork. Participating schools engaged well with the Short-term Keywork service when it was introduced, welcoming the Keyworkers into the schools and providing appropriate facilities for the support sessions. Ineligible referrals (for example, pupils with more severe mental health problems) were an issue in the early stages of delivery, but as the service became more established and better understood within schools, the number of ineligible referrals reduced considerably.

Parenting Support. From the outset of the MHEW Project, it proved challenging to engage parents in structured parenting programmes. As a consequence, the Parenting Support strand did not achieve its original targets. For example, 205 parents took part in Primary Care interventions against a target of 300 (69% of target), while 401 parents took part in discussion groups against a target of 660 (61% of target). The parenting practitioners attributed this to a combination of factors for parents including: a stigma

around formal parenting programmes; limited awareness of the benefits that such programmes can offer; and having childcare issues that prevented attendance.

i-Rock expansion. The i-Rock service moved from being open three days a week to five days a week as planned. By the end of December 2019, it had exceeded its target for young people supported by 64% (787 young people compared with a target of 480 young people). i-Rock staff developed effective relationships with statutory and voluntary services in Hastings and became recognised as an important part of the mental health and emotional wellbeing landscape in the town. However, the recruitment of psychology specialists to the i-Rock team took several months longer than expected, delaying the full implementation of the i-Rock expansion and meaning that young people could not be offered in-house wellbeing interventions until early 2020.

Whole School Approach[2]. This strand has involved mental health training for school staff, consultancy for schools on organisation-wide approaches to mental health, and support for schools to develop Personal, Social, Health and Economic (PSHE) resources, lessons and learning. It was arguably the most affected by the COVID-19 pandemic as it became very difficult for school staff to commit time to training or developmental activities, especially when schools were closed to all but keyworkers' children and vulnerable pupils.

Responding to COVID-19 restrictions. Each of the strands responded quickly and flexibly to the first national COVID-19 lockdown (March to July 2020). The Short-term Keywork service continued to receive referrals from schools, expanded its offer to include year 4 pupils and moved to remote delivery. On the Parenting Support strand, group sessions were delivered via Microsoft Teams and covered the full range of Triple P. Additional sessions were run on managing anxiety and school transitions. i-Rock moved to a virtual offer via phone, email, text and video calls, and also introduced Instagram Live sessions. The Whole School Approach strand adapted by offering online training

[2] The original design of the Whole School Approach strand was in keeping with the principles promoted by Public Health England and the Department for Education in the following guidance document: Promoting children and young people's mental health and wellbeing - GOV.UK (www.gov.uk). However, the challenges and constraints subsequently faced by the Whole School Approach strand, mainly as a result of the COVID-19 pandemic, made it difficult to embody all of those principles to the extent that was originally intended. The findings of this report pre-date the DfE offer to state schools and colleges of training grants to access quality assured senior mental health lead training Senior mental health lead training - GOV.UK (www.gov.uk).

courses originally intended for face-to-face delivery, along with ‘top tips’ documents and a mental health guide for schools.

Benefits, outcomes and impacts

Short-term Keywork. Between September 2018 and April 2021, the service supported 377 young people via one-to-one sessions (94% of target). More than four-fifths (85%) of the young people reported an improvement in their anxiety and depression following those sessions. Qualitative feedback on the service was overwhelmingly positive throughout the evaluation. Pupils enjoyed the sessions and consistently spoke of the support having had positive effects on their levels of anxiety, calmness, happiness and self-belief. For some pupils, this had led to them feeling more comfortable attending school and being better able to concentrate in lessons. Parents agreed and had observed changes in their child’s behaviour, demeanour and/or wellbeing. School staff believe that the Short-term Keywork support has helped to prevent mental health and emotional wellbeing issues from escalating.

Parenting Support. Between September 2018 and August 2020, 2,445 parents took part in Triple P activities at Levels 2 to 5. Qualitative feedback gathered for the evaluation suggests that parents have typically gained a (better) range of tools and strategies to help manage the issues they faced and that their self-confidence improved. They described the parenting practitioners as well-informed, non-judgemental and helpful, and said that the support had helped to improve relationships with their children.

i-Rock expansion. Between April 2019 and August 2020, 1,229 young people received an initial triage by i-Rock staff, and 666 received a wellbeing intervention, in both cases exceeding target. More than 90% of young people reported feeling less distressed following their triage, and 99% said they would recommend i-Rock to a friend. Qualitative feedback was more limited but suggested that i-Rock provided an environment in which young people felt comfortable and safe asking for support. The qualitative feedback also indicated that it was helpful for young people to be able to access advice and support on a range of topics (e.g. housing, alcohol, drugs and wellbeing) in one place.

Whole School Approach. Quantitative survey feedback collected by the Whole School Approach practitioners, whilst limited, was very positive: 63 of 64 school staff (from across three different schools) said that they felt better able to contribute to a whole school approach to mental health and emotional wellbeing, and 12 school senior leaders all reported improvements in the promotion of mental health and resilience in their schools. The associated qualitative feedback suggests that where school staff engaged with the Whole School Approach strand, they generally found it very beneficial.

Sustainability. The four main strands of the MHEW Project have continued beyond the end of their OA funding period. From January 2022, a successor to the Short-term

Keywork service will be introduced, provided through local NHS-funded Mental Health Support Teams[3]. Funding has been secured for the Parenting Strand up to March 2022 and i-Rock remains open five days a week. Numerous outputs from the Whole School Approach strand (e.g. short films hosted on YouTube) will remain available after the OA funding comes to an end.

Conclusion

The multifocal nature of the MHEW project has been both a key feature and a key strength of its design and delivery. It provided new services, or expanded existing ones, at various points on a continuum of need, from lower-level mental health and emotional wellbeing issues (Short-term Keywork) to crisis intervention (i-Rock). It recognised the influence of parenting styles and parental stress on young people's mental health and emotional wellbeing (Parenting Support) and sought to instil organisation-wide good practice (Whole School Approach). The model adopted by the MHEW Project benefited the young people in Hastings by impacting positively on different, and very influential, areas of their day-to-day lives. While each strand has had its own priorities, targets and staff teams, the evidence gathered through this evaluation suggests the project as a whole has increased the awareness of, and has augmented the response to, mental health and emotional wellbeing challenges in Hastings.

[3] In 2018 NHS England and DfE began rolling out Mental Health Support Teams (MHSTs) in schools and colleges to offer early intervention for pupils and students with mild to moderate mental health needs. No MHSTs were operational in Hastings until 2022. https://www.england.nhs.uk/mental-health/cyp/trailblazers/

1. Introduction

This report presents findings from the evaluation of the Hastings Opportunity Area (OA) Mental Health and Emotional Wellbeing (MHEW) Project. The MHEW Project was designed to:

- Increase the awareness, understanding and skills of parents and school staff in relation to supporting the mental health and emotional wellbeing of children and young people.
- Provide early intervention support to promote children's and young people's resilience, social and emotional skills, and self-regulation.

In 2017, the Department for Education (DfE) launched a £72 million OA programme aimed at improving the life chances of young people in 12 local areas facing entrenched and widespread social, economic, and cultural challenges. The areas identified for support represented a broad spread of coastal, rural and urban settings, enabling a thorough investigation of what works best to address the needs of young people across a range of communities. Hastings was selected as one of the 12 areas. The OA programme was further expanded in 2020 with an additional £18 million investment.

The MHEW Project was one of five 'intervention level evaluations' (each in a different OA) undertaken by York Consulting on behalf of DfE. [4]

Key Terms

The following terms are used in the report:

Emotional wellbeing. The ability to produce positive emotions, moods, thoughts and feelings, and adapt when confronted with adversity and stressful situations.

Hastings OA. One of 12 areas identified as a social mobility 'cold spot' and where the DfE prioritised resources to break the link between background and destination.

i-Rock. a drop-in service in Hastings for 14-25 year-olds, offering advice and support on emotional and mental wellbeing, employment, education and housing.

Mental health. Good mental health is characterised by a person's ability to fulfil a number of key functions, including the ability to learn, the ability to manage a range of

[4] The other intervention level evaluations were undertaken in Blackpool, Bradford, the North Yorkshire Coast and Norwich.

positive and negative emotions and the ability to form and maintain good relationships with others.

MHEW Project. A multi-stranded intervention to promote children's and young people's resilience, social and emotional skills and self-regulation. There were six strands to the MHEW Project, together receiving total funding of £1.4m between September 2018 and July/August 2021.

Parenting Support. The core of the Parenting Support offer was the Positive Parenting Programme (Triple P). [5] Triple P seeks to equip parents with practical strategies to build strong relationships with their children, confidently manage their behaviour and prevent problems from developing or escalating.

Practitioners. Staff that have delivered the various activities through the different strands of the MHEW Project.

Short-term Keywork. Early intervention support for pupils with low-level emotional wellbeing concerns, delivered primarily via a 12-week programme of one-to-one support sessions.

Strands. The different components of the MHEW Project, e.g. Short-term Keywork, Parenting Support, i-Rock and the Whole School Approach.

Whole School Approach. A bespoke package of mental health-related support and consultancy available to primary and secondary schools in Hastings.

1.1. The local context

Hastings is a coastal town and borough located in East Sussex. It has a population of approximately 93,000 people and experiences significant economic and social challenges. It is the 13th most deprived of 317 local authority districts in England and the most deprived in the south-east. Sixteen of the 53 neighbourhoods in Hastings are in the most deprived decile nationally, and two of them (Baird and Tressell) are the top 1% most deprived.[6]

Almost 40% of primary school pupils and 30% of secondary school pupils in Hastings are eligible for free school meals, compared with 28% and 21% nationally.[7] Persistent school

[5] Triple P in a nutshell (TRIPLE P). Retrieved from: https://www.triplep.net/glo-en/find-out-about-triple-p/triple-p-in-a-nutshell/.
[6] English indices of deprivation 2019 (Ministry of Housing, Communities & Local Government). Retrieved from: https://www.gov.uk/government/statistics/english-indices-of-deprivation-2019
[7] Find and compare schools in England (gov.uk). Retrieved from: https://www.compare-school-performance.service.gov.uk/

absence and permanent school exclusions are also both above average in Hastings.[8] Set in this context, primary school performance is relatively strong: the proportion of pupils in Hastings meeting the expected standard when leaving key stage 2 is only marginally below the national average of 65%. However, pupils in Hastings typically make less progress between key stages 2 and 4 and achieve less well at GCSE.[9]

The average annual salary in Hastings, at £23,800, is less than three quarters of the national average and is more than 20% below the average for East Sussex.[10] Unemployment has historically been, and remains, above average.[11] Youth unemployment is a particular issue, with 11.7% of 16-24 year-olds claiming unemployment benefits in April 2021 compared with 6.7% nationally.[12] Approximately 11% of adults aged 16-64 in Hastings have no formal qualifications compared with 6% nationally, while the proportion qualified at Level 4 or higher, at 29%, is significantly below the national average of 42%.[13,14]

Hastings has above average rates of both common mental health disorders and GP-reported severe mental illness. Hospital admissions resulting from intentional self-harm and rates of suicide are also considerably above average in Hastings.[15]

As explained in subsequent chapters of this report, views towards the MHEW Project in Hastings were generally positive. However, it is also important to note that the project formed a relatively small part of schools' overall response to mental health and emotional wellbeing issues. That response has become larger (in terms of the financial and human resources involved) since the coronavirus (COVID-19) pandemic hit the UK in early 2020, with a marked increase in activity following the re-opening of schools in March 2021.

Listed below are selected examples from outside of the MHEW Project that were taking place in schools in Hastings at the time of writing. This is not intended to be an exhaustive list, nor have any of the activities been reviewed for this evaluation, but it demonstrates the wide-ranging measures that schools were taking in response to (what the evaluation evidence indicates are) unprecedented levels of need:

- Pupil wellbeing and pupil voice surveys.

[8] Same as footnote 6.
[9] Same as footnote 6.
[10] Annual Survey of Hours and Earnings (Office for National Statistics)
[11] Economically active times series data (Office for National Statistics)
[12]The local area benchmarking tool (Local Government Association). Retrieved from: https://lginform.local.gov.uk
[13] Examples of Level 4 qualifications include Higher National Certificates (HNC) and Certificates of Higher Education (CertHE).
[14] Annual Population Survey (Office for National Statistics)
[15] Opportunity Area 2017-20 – A plan to provide children and young people in Hastings with the essential foundations for success (Department for Education)

- Increases in Personal, Social, Health and Economic (PSHE) education provision.
- The Thrive Programme.[16]
- In-school counsellors.
- Wellbeing champions.
- Mental health drop-in sessions.
- Mental health first aid training.
- Nurture hubs/groups.
- Sand therapy.
- Drawing and talking therapy.
- Increasing the number of Emotional Literacy Support Assistants (ELSAs) working in schools.

1.2. The MHEW Project

1.2.1. Rationale

Research has shown that mental health and emotional wellbeing issues amongst school pupils can result in reduced school attendance, lower levels of concentration and disengagement during lessons (DfE, 2018 and Lawrence et al, 2019). Over the longer term this can impact on attainment. Research has also shown that pupils with better mental health and emotional wellbeing are likely to be higher achievers academically and have better employment and earning prospects (Gutman and Vorhaus, 2012 and Smith et al., 2019):

- A one-point increase in young people's Strengths and Difficulties Questionnaire scores (which indicates a negative change in levels of anxiety and depression) at key stage 3 is equivalent to dropping one grade at GCSE.
- Young people with poor mental health are nearly three times less likely to achieve five 'good' GCSE grades, even accounting for socio-economic background.

[16] https://www.thriveapproach.com/

- Pupils with poor mental health and emotional wellbeing at age seven are, on average, likely to be more than one term behind their peers with better/normal mental health and emotional wellbeing by the end of key stage 2.

In addition, pupils with mental health and emotional wellbeing problems are more likely than their peers to take time off school, have poor behaviour, be excluded and become known to the criminal justice system (Leyard, 2013 and Melzer et al., 2003). There is also evidence that good mental health and emotional wellbeing in childhood is the most important indicator of future life satisfaction and personal outcomes in adulthood (Leyard, 2013).

In 2017, the Hastings Youth Council surveyed 290 young people about issues affecting them. Almost 90% felt that mental health provision in Hastings was poor, 100% agreed that a mental health campaign was needed and 82% said that mental health was their biggest concern. At the time, Child and Adolescent Mental Health Services (CAMHS) caseloads in Hastings were above the East Sussex average, as was the proportion of youth offenders with a mental health disorder.[17]

1.2.2. Project strands and their funding

There have been six different strands to the MHEW Project. A logic model for the MHEW Project can be found at Appendix A. Four of these strands – Short-term Keywork, Parenting Support, i-Rock and the Whole School Approach – have been the main focus of this evaluation and are covered in this report:

- **Short-term Keywork** provided support to pupils with low-level emotional wellbeing concerns, primarily via a 12-week programme of one-to-one support sessions delivered by trained keywork practitioners in schools. This switched to telephone/video calls when coronavirus (COVID-19) restrictions applied.

- **Parenting Support** offered the Positive Parenting Programme (Triple P) which seeks to equip parents with practical strategies to build strong relationships with their children, manage behaviours and prevent problems from escalating.

- **i-Rock** was a drop-in service for 14-25 year-olds, offering advice and support on emotional and mental wellbeing, employment, education and housing. Funding through the OA enabled i-Rock to open five days a week (previously it was open three days a week) and provide in-house wellbeing interventions for young people.

[17] Hastings Opportunity Area social mobility delivery plan (Department for Education). Retrieved from: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/696829/Social_Mobility_Delivery_Plan_Hastings_v12_FINAL_WEB.PDF.pdf

- The **Whole School Approach** strand offered a bespoke package of mental health-related support and consultancy to schools in Hastings.

The Additional Keywork strand was included in Wave 2 of the evaluation (July to September 2020) and the Additional Mental Health Support strand was included in Wave 3 (May to July 2021). A summary of findings relating to these two strands can be found at Appendix B and Appendix C respectively.

Between September 2018 and July/August 2021, the Hastings OA provided funding of £1,401,654 for the six strands of the MHEW Project.[18] For the four main strands within the scope of this evaluation, total funding was £1,313,154.

Table 1.1 below provides a breakdown of funding by strand. It shows that nearly half (47%) of the funding was allocated to Short-term Keywork, influenced in part by the continuation of that strand to August 2021. Parenting Support accounted for 24%, the i-Rock expansion for 14%, the Whole School Approach for 8%, the Additional Keywork activity for just under 3% and the Additional Mental Health Support for just over 3%.

Table 1: Funding amount and period for each MHEW project strand

Strand	Funding period	Funding amount
Short-term Keywork	Sept 2018 to August 2021	£661,911
Parenting Support	Sept 2018 to July 2020	£334,866
i-Rock	Sept 2018 to August 2020	£202,000
Whole School Approach	Sept 2019 to July 2021	£114,377
Additional Keywork	May 2020 to August 2020	£40,500
Additional Mental Health Support	March 2021 to October 2021	£48,000
Totals		**£1,401,654**

Source: Hastings OA, 2021

1.2.3. Oversight and governance

Each strand submitted quarterly monitoring reports to East Sussex County Council. These reports covered delivery volumes, successes, challenges and forthcoming activity. Governance was provided by the Mental Health and Emotional Wellbeing Working Group, ensuring that learning could be shared across the different strands. The Working Group reported to the Hastings OA Board on a quarterly basis.

[18] Additional Mental Health Support activity will continue into the 2021-22 academic year, but the funding has been included in full here as it was originally committed in the previous year.

1.2.4. Project-level targets

The Mental Health and Emotional Wellbeing Working Group approved the following eight targets for the MHEW Project. The intention was that each of these would be achieved by the end of 2020-21 academic year:

1. All 26 schools in Hastings have a trained mental health lead.
2. The i-Rock service will have increased capacity by 40%, by operating five days a week instead of three. Similar provision will be put in place for younger children. This increased capacity will ensure that you all young people can access support when they need it.
3. All parents in Hastings can access support through digital and light touch seminar engagement in schools and other settings. All parents will be invited to seminars when their children start formal education and at key transition points.
4. All parents accessing evidence-based parenting programmes report improvements in their children's development and behaviour and parental wellbeing.
5. All young people have received support at school to understand the signs of being emotionally and/or mentally unwell and when they need help and how to access help. They have the confidence to ask for help from friends and staff when needed and have access to someone to talk to who has received mental health first aid training.
6. Pupils report increased personal and social wellbeing in school using the 'Stirling Children's Wellbeing Survey'. In 2017, 33% of boys and 34% of girls in Hastings aged ten recorded levels of high or maximum wellbeing for the Stirling Children's Wellbeing Scale. We will increase this to 50% by 2020.
7. School and college staff feel competent and confident in promoting children's wellbeing and report increased personal and social wellbeing in work.
8. Preventative mental health measures are in place and there is a reduction of concerns in addressing mental health issues.

1.2.5. Strand level logic models

At the outset of the MHEW Project, strand-level logic models were developed for Short-term Keywork, Parenting Support, i-Rock and the Whole School Approach. Text versions of these are provided at Appendix D.

1.3. Evaluation research questions

The overarching aim of the evaluation was to assess the efficacy of the MHEW Project approach, namely early intervention and support, joint commissioning and a delivery

model that involves schools, the local authority, the voluntary sector and the NHS. Beneath this overarching aim were four main evaluation questions, listed below.

1. To what extent is there robust evidence that the Hastings MHEW Project has contributed to:
    i. Improved emotional wellbeing for children and young people?
    ii. Increased confidence and skills of parents?
    iii. Improved knowledge and skills of school staff?
2. What are the benefits of the Hastings MHEW Project relative to the costs of the project?
3. How successful was the implementation process for each of the four strands of the Hastings mental health project? What barriers and challenges (if any) were encountered and addressed? Were there any unintended consequences?
4. Does the programme provide value for money when considering the value of all benefits created?

1.4. Evaluation methodology

Summarised in Table 2, the evaluation of the MHEW Project incorporated both quantitative and qualitative methods and was structured into three main waves of activity:

- Wave 1 focused on the implementation, delivery and early outcomes of the MHEW Project.
- Wave 2 focused on the delivery of the MHEW Project under COVID-19 restrictions (fieldwork in this wave took place in July 2020).
- Wave 3 focused on levels of need and demand for mental health and emotional wellbeing support (particularly following the re-opening of schools in March 2021) and the outcomes and impacts generated by the MHEW Project.

Due to quantitative data constraints as a result of COVID-19, and ethical concerns prohibiting the adoption of a control group, a robust impact assessment on the outcomes and impacts was not possible and therefore a qualitative approach was taken instead. Nevertheless, quantitative data has been collected and used within this report. This incorporates both national published data and local management information supplied by the project team. Examples of national published data include the average cost of supporting a young person through CAMHS, the average economic cost of a young person being not in education, employment or training, and the average cost of a local authority foster care placement. Local project data includes the number of individuals

supported by each strand, the number fully completing their programmes of support and (where applicable) pre and post-intervention anxiety and depression scores.

The local data provided by the project team covers the period from September 2018 to April 2021. The national published data is taken from a range of different sources published between 2011 and 2020, all of which are referenced in Chapter 7.

The evaluation was overseen by a steering group chaired by the DfE and with representation from the MHEW Project and other local stakeholders.

Table 2: Evaluation summary

Evaluation activity	Wave 1 (Feb 19 to Jan 20)	Wave 2 (Jul 20 to Sep 20)	Wave 3 (May 21 to July 21)
One-to-one interviews with Special Educational Needs Co-ordinators (SENCOs)	18 interviews (14 primary schools and 4 secondary)	-	16 interviews (11 primary schools and 5 secondary)
One-to-one and group interviews with strand leads and practitioners	3 strand leads and 10 practitioners	4 strand leads and 13 practitioners	4 strand leads and 8 practitioners
Focus groups with parents on a Triple P programme	5 parents	-	-
One-to-one and group interviews with members of the i-Rock Youth Advisory Group	2 young people	2 young people	-
Qualitative school case studies[19]	7 schools (4 primary and 3 secondary)	-	7 schools (4 primary and 3 secondary)[20]
One-to-one interviews with school staff focusing on response to COVID-19 restrictions	-	4 members of staff (representing 4 schools)	-
Secondary analysis of monitoring data (e.g. delivery	Yes	Yes	Yes

[19] The case studies semi-structured interviews with senior leaders, teaching and support staff and pupils that had been supported by the Short-term Keywork service
[20] These were the same schools as in Wave 1.

Evaluation activity	Wave 1 (Feb 19 to Jan 20)	Wave 2 (Jul 20 to Sep 20)	Wave 3 (May 21 to July 21)
volumes and pre- and post-intervention feedback)			

Source: York Consulting, 2021

Note: Neither i-Rock nor Parenting Support were funded through the OA in the 2020-21 academic year. As such, only limited primary research was undertaken on these strands during Wave 3 of the evaluation. Specifically, the Parenting Support and i-Rock strand leads were consulted on a one-to-one basis in Wave 3, and the interviewees in the case study schools were asked for their views on both strands, but participants of these strands (i.e. parents or young people) were not asked to take part in Wave 3.

1.5. Treatment of costs and benefits

This multi-method evaluation was designed to incorporate quantitative and qualitative methods and include a Social Cost-Benefit Analysis (SCBA). This would have involved comparing the treatment group of schools with a comparator group of schools with similar characteristics but that were not receiving similar support. Preliminary work was conducted to identify a set of comparator schools and refine the methodology. However, due to the following challenges it was decided that there would be no SCBA:

1. Ethical issues with establishing a comparator group. To identify a group of pupils in need of mental health support as a control group would not be ethically sound. Following steering group review this element of the research was dropped.
2. Disruptions to data collection due to the COVID-19 pandemic. These disruptions affected either the volume and/or the type of data collected by the Parenting Support, i-Rock and Whole School Approach strands.

1.6. Report structure

The remainder of the report is structured as follows.

- Chapters 2 explores need and demand.

Chapters 3-6 explores each of the core elements of the project covering a) implementation and delivery, including what worked well and key challenges; and b) benefits and outcomes:

- Chapter 3: Short-term Keywork.
- Chapter 4: Parenting Support.

- Chapter 5: i-Rock Expansion.
- Chapter 6: Whole School Approach.
- Chapter 7: explores unit cost analysis.
- Chapter 8 considers project-wide findings, revisits the original targets for the MHEW Project and explores its sustainability.
- Chapter 9 is conclusions and considerations for replication.

2. Need and demand

2.1. Pre COVID-19

Prior to the COVID-19 pandemic, feedback from SENCOs and other staff in schools suggested that demand for mental health and emotional wellbeing support amongst pupils in Hastings was increasing. They attributed this to a range of factors including worsening levels of parental mental health, local economic and social deprivation and increasing use/prevalence of social media.

SENCOs and other school staff reported that young people were regularly presenting with anxiety, low self-esteem, eating disorders and problems relating to resilience and emotional intelligence. They agreed that more primary school pupils were presenting with these concerns than had previously been the case.

> "There is a lot of pressure on young people these days…this can be caused by difficult home lives, social media, the press…lots of parents also struggle with mental health issues which has a big impact on pupils' need for support." - *SENCO (primary school)*

2.2. Demand during the COVID-19 pandemic

Staff from East Sussex County Council reported that, in the early stages of the first national lockdown (March to July 2020), referrals to early help services in Hastings reduced considerably. Reflecting this, referrals to the Short-term Keywork service also fell: five pupils started a programme of one-to-one support in March 2020 and two in April 2020, compared with an average of 15 pupils per month over each of the preceding six months.

On the Parenting strand, Triple P activities at Levels 3, 4 and 5 did not meet their pro rata targets between April and August 2020.[21] i-Rock supported 166 young people over the same period, but that too was some way below the pro rata target of 267.

The above could imply reduced demand for the MHEW Project offer, but the strand leads, practitioners and school staff consulted in mid-2020 all agreed that wasn't the case. Instead, they attributed it to a combination of factors, including:

- Schools operating with reduced staff teams and having less time than usual for activities or commitments beyond the safe running of their core functions (thus reducing referrals to the MHEW Project.

[21] Triple P activity levels are explained in more detail at Appendix G.

- The lead times involved in moving services online.
- Initial reticence amongst some young people to engage with mental health and emotional wellbeing services via remote delivery.

The school case studies and SENCO interviews undertaken between May and July 2021 point to a worsening situation in terms of young people's mental health and emotional wellbeing issues. For example:

- Interviewees consistently spoke of increases in the number of pupils presenting with mental health and emotional wellbeing issues following the re-opening of schools in March 2021.
- They reported increases in conditions/issues that were prevalent pre-COVID-19 (e.g. generalised anxiety), but also in social anxiety, attachment issues and self-harm.
- Primary and secondary school staff reported cases of attempted suicide and suicidal ideation amongst pupils at their schools.[22] The primary school staff had not previously experienced this, whilst for the secondary school staff, it had only ever been extremely rare.

Interviewees in the case study schools also spoke of significant increases in:

- Safeguarding concerns.
- Referrals to CAMHS.
- Contacts from Operation Encompass. [23]
- Fights between pupils.
- The number of pupils on their Special Educational Needs (SEN) registers with social, emotional and mental health as a particular area of need.

They also said that racist and homophobic language was being used more frequently and that they had observed a marked deterioration in pupils' social and interpersonal skills.

> "It feels like the problems are getting exponentially worse" - *Assistant headteacher (primary school)*

These interviewees often talked about mental health and emotional wellbeing amongst young people as "a crisis situation" and of not having seen issues on this scale or

[22] Suicidal ideation means wanting to take one's own life or thinking about suicide.
[23] Operation Encompass is a police and education early information safeguarding partnership enabling schools to offer immediate support to children and young people experiencing domestic abuse.

severity at any point during their careers in education. For some interviewees, those careers extend well beyond 20 years. The general consensus was that the situation had become considerably worse following the re-opening of schools in March 2021.

> "We currently have 30 pupils on risk reduction plans because of suicidal tendencies or significant self-harm. That's higher than ever before." - *SENCO (secondary school)*

Interviewees in the case study schools agreed that the conditions and constraints associated with the COVID-19 pandemic have been the primary cause of the worsening issues described above. In particular, they highlighted:

- A greater prevalence of parental mental health problems (in some cases influenced by substance misuse and/or domestic abuse) and the knock-on effects of that for children.
- Long periods where children have been without meaningful social interaction.
- Limited access to recreational activities and appropriate physical and mental stimulation.
- Increased and, for some young people, unsolicited access to the internet and social media.

Neither the case studies nor the SENCO interviews identified any clear trends in terms of the age(s) or gender(s) of pupils that have been most or least affected. However, there was general agreement that the transition back into the routine-driven nature of school had proven hardest for young people with special educational needs and those who face greater challenges with emotional regulation.

2.3. Mental health and emotional wellbeing as a strategic priority

Staff in the case study schools agreed that mental health and emotional wellbeing is both a strategic and an operational priority for their organisations. Applicants' awareness of mental health and emotional wellbeing is now assessed more regularly in job interviews, is discussed more frequently at all levels within the schools and features more prominently in communications issued by the schools to parents/carers.

> "We have no choice, it [mental health and emotional wellbeing] has to be a strategic priority across the school given how drastic the situation is." - *Senior leader (secondary school)*

Even so, and despite increasing levels of awareness and understanding of mental health and emotional wellbeing issues, there remains an underlying unease within the case study schools about how well placed they are to provide an appropriate response. Staff in non-SEN roles that contributed to the case studies (e.g. teachers and heads of year) often made the point that they are primarily educationalists, not mental health professionals, and do not feel fully equipped to respond to the range and volume of mental health and emotional wellbeing issues they are now observing.

3. Findings: Short-term Keywork

Overview of the service

Short-term Keywork was an early intervention emotional wellbeing service available to pupils in years 4 to 9 in 11 schools in Hastings. It provided support to pupils with lower-level mental health issues (Level 2 on the East Sussex County Council Continuum of Need).[24] Pupils were referred to the Short-term Keywork service by school staff. The main element of the offer was a 12-week programme of one-to-one support sessions, each lasting 30-45 minutes. The sessions were delivered by keywork practitioners, either face-to-face in schools, or via telephone/Teams where COVID-19 restrictions apply. Pupils completed the programme when they had attended all 12 of their one-to-one sessions.

Keyworkers also ran group sessions and drop-ins – although these became less frequent during the COVID-19 pandemic – and spoke with parents/carers by telephone to help them and their children apply appropriate strategies and techniques in the home.

The main aims of the Short-term Keywork service were to:

- Ensure that pupils have easy access to early intervention support.
- Reduce the need for referral to CAMHS and other services.
- Support pupils to improve their mental health and emotional wellbeing.
- Reduce behavioural and emotional problems amongst those pupils who have accessed support.
- Improve attendance and engagement with school and learning.

3.1. Implementation

The Short-term Keywork service was delivered by five Keyworkers, a senior Keyworker, a specialist mental health practitioner and an admin support officer. Keyworkers had to obtain parental consent before any one-to-one support sessions with pupils could take place (parental consent was not required for drop-in sessions).

Keyworkers have used a range of evidence-based tools, resources and exercises in the one-to-one sessions with pupils. These include, although are not limited to, cognitive behavioural therapy (CBT) worksheets, circle of control exercises, and anger

[24] Using the continuum of need levels and indicators (East Sussex County Council). Retrieved from: https://www.eastsussex.gov.uk/childrenandfamilies/professional-resources/continuum-of-need/levels-indicators/

management techniques. Keyworkers decided which resources to use based on the needs and emotions of each pupil.

From early 2020 onwards, the Short-term Keywork service placed an increased emphasis on maintaining a dialogue with the parents/carers of the young people receiving support. The aim of this was to help families apply and embed the strategies covered during the keywork sessions within the home, thus creating more consistency and helping to instil lasting change.

Operationally, this has varied from family to family, driven mainly by the preferences, availability and willingness of the parents to engage. In some cases, it has been quite structured (e.g. weekly calls between the parent and Keyworker), whereas in others, it has been more ad hoc.

Participating schools engaged well with the Keywork service when it was introduced. In the main, they welcomed the Keyworkers into the schools, provided appropriate rooms and facilities for them and involved them in relevant dialogue and communications. The main implementation challenge was unsuitable referrals: in the early stages of the service, school staff were prone to referring pupils who did not satisfy the main eligibility criteria. This was either because they had a higher level of need than the Short-term Keywork service was designed to address, or because they had behavioural/disruption issues rather than mental health and emotional wellbeing concerns. As the service became more established and better understood within schools, the number of ineligible referrals reduced.

Although not an implementation challenge per se for the service, the issue of unmet demand was raised by staff in each case study school. Staff consistently said they could have identified numerous other pupils that would have benefitted from the Short-term Keywork service. These pupils were unable to access the support, either because there were no spare places available or because the pupils were too young.

3.2. Delivery volumes

Between September 2018 and April 2021, the Short-term Keywork service supported 377 young people from 11 schools via one-to-one programmes of support. This was 94% of its target of 394 young people.[25]

[25] Calculated by taking the full target of 435 that applied from September 2018 to July 2021 and adjusting it down on a pro rata basis to the end of April – the latest point for which data is available at the time of writing.

Table 3 shows this data broken down into pre- and post-COVID-19 periods, i.e., from September 2018 to February 2020, and from March 2020 to April 2021. Key points relating to this data are that:

- The average number of young people starting a programme of support each month in the pre-COVID-19 period was 13.7. This reduced to 9.2 during the COVID-19 period.
- From the beginning of the first national lockdown in March 2020, the service experienced an increase in the number of families disengaging and the number of families declining support. This was primarily because some parents took the view that their child would not engage well with remote support. In early 2021, the number of families disengaging or declining support began to fall.
- March 2021 saw a large increase in the number of young people being supported. Between June 2020 and February 2021, in only one month did the number of new interventions exceed 10, but in March 2021 it was 21.

Table 3: Short-term Keywork delivery volumes

Period	New 1:1 starts	1:1 programmes completed	Families declining support	Disengaged from support	Transferred to CAMHS
September 2018 – February 2020	248	215	2	23	11
March 2020 – April 2021	129	71	30	16	6

Source: Short-term Keywork service, 2021

A month-by-month breakdown of the above data has been provided at Appendix E.

3.3. Responding to COVID-19 restrictions

During the first national lockdown (March to July 2020), the Short-term Keywork service moved to a remote delivery model, primarily via FaceTime and telephone, and suspended all group sessions. The service continued to receive referrals from schools and expanded its offer to include year 4 (due to spare capacity).

Practitioners reported some initial challenges in the transition, particularly around the need to devise new and creative tools, resources and exercises that were suitable for remote delivery. However, the practitioners quickly grew in confidence that their

new/revised resources, for example using role play and visualisations, could achieve similarly positive results to those that they used face-to-face.

Nonetheless, the engagement of pupils via remote delivery was varied. Some pupils preferred the relative anonymity of phone support and, as a result, were willing to talk in more detail about their issues than they would have done face-to-face. Others, and particularly pupils with Special Educational Needs and Disabilities (SEND) and those in primary schools, felt less comfortable sharing their worries and concerns on the phone. Short-term Keywork practitioners also delivered food parcels and learning resources to families during the first national lockdown (March to July 2020). This enabled them to see families face-to-face from a safe distance, which they report worked well as a substitute for direct engagement.

3.4. Outcomes and impact

3.4.1. Pre- and post-intervention Revised Child Anxiety and Depression Scale results

The Revised Child Anxiety and Depression Scale (RCADS) is a 47-item questionnaire for young people aged 8 to 18 which assesses levels of anxiety and depression. [26] The questionnaire produces scores which range from a lowest possible score of 26 for 'anxiety' and 25 for 'anxiety and depression' (in each case indicating low anxiety/depression), to a highest possible score of 119 for 'anxiety' and 123 for 'anxiety and depression' (indicating high anxiety/depression).

RCADS questionnaires were completed by pupils accessing Short-term Keywork service at two time-points: once at the start of their programme of one-to-one support and once at the end.

The Short-term Keywork team began using RCADS in January 2019. Between then and April 2021, 211 pupils supported by the service provided both pre- and post-intervention RCADS data, the results from which appear positive:

- 81% (171 pupils) reported a reduction in their overall anxiety following the one-to-one support. The average pre-intervention anxiety score was 55.2, reducing to 46.3 post-intervention.

[26] Revised Children's Anxiety and Depression Scale (and Subscales) (Child Outcomes Research Consortium). Retrieved from: https://www.corc.uk.net/outcome-experience-measures/revised-childrens-anxiety-and-depression-scale-rcads/

- 83% (175 pupils) reported a reduction in their combined anxiety and depression. The average pre-intervention anxiety and depression score was 56.5, reducing to 47.1 post-intervention.[27]

- The results are very similar in the pre- and post-COVID-19 periods. Between January 2019 and February 2020, 81% of pupils reported a reduction in their combined anxiety and depression. Between March 2020 and April 2021, this rose to 85%.

In the absence of a control group, it is difficult to pinpoint the extent to which the Short-term Keywork service is responsible for the changes in RCADS scores. Attribution is also made more complicated by the fact that the pupils may have been exposed to other interventions or avenues of support that have the potential to improve their mental health and/or emotional wellbeing. However, qualitative feedback on the Short-term Keywork service (outlined below) is very encouraging.

3.4.2. Qualitative insight

Throughout this evaluation, the feedback gathered on the Short-term Keywork service has been overwhelmingly positive. From the perspective of staff in the case study schools, this is for the following main reasons:

- **Addressing unmet need**: the service is targeted at a cohort of pupils who do not meet the threshold for CAMHS and for whom schools have previously found it difficult to provide bespoke or ring-fenced support. These pupils tend not to be disruptive in class and their issues may not immediately be overt, but if left unaddressed they could become more prominent and impact negatively on attendance, attainment and future prospects.

> We rely on the Keywork service very heavily…..the one-to-one support it provides for the pupils is invaluable". - *Designated Safeguarding Lead (secondary school).*

- **Skills and attributes of Keyworkers**: school staff see the Keyworkers as being skilled and effective at engaging with pupils with a wide array of different characteristics. They are confident that the keyworkers have a good understanding of the impact of mental ill health, are flexible and adaptable and can engage well with families that may be in crisis. They not only offer additional capacity that the schools did not have previously but bring skills and techniques which are grounded in a solid appreciation of good practice.

[27] Note that the early intervention nature of Short-term Keywork, and its focus on young people with lower level MHEW issues, means that the average RCADS scores were always likely to be at the lower end of the range.

> "She [the Keyworker] has worked miracles with some of our hardest to reach pupils. She is money well spent I say." - *Headteacher (primary school).*

- **An important part of the COVID-19 response**: staff in the case study schools report having become more time-stretched following the start of the COVID-19 pandemic. A significant influence on their time has been the aforementioned increases in young people's mental health and emotional wellbeing issues and the severity of those issues. There is a shared view across these staff that they would not have been able to provide tailored support for the young people that have accessed the Short-term Keywork service, had that service not been available. It has given the staff reassurance that pupils in need of this support have had their needs met during COVID-19, despite them not presenting with the same severity of issues as other young people in the schools.

> "It [Short-term Keywork] has been a godsend. It's meant that these pupils aren't having to take their negative feelings into the classroom each day." - *SENCO (primary school)*

- **Positive outcomes**: importantly, school staff believe that the Keywork service continues to deliver positive outcomes. In their view it has reduced pupils' anxiety levels, enabled them to feel calm and deal more effectively with adversity, improved their self-confidence and self-esteem and brought more stability to their friendship groups.

> "I have noticed a real difference in the children in my class who have worked with the Keyworker. They are more confident, have better relationships with other pupils and can verbalise things that they like or don't like." - *Teacher (primary school)*

The pupils consulted for the evaluation had received support for a variety of reasons, including generalised anxiety, anger issues, low self-esteem, body image issues, grief/bereavement and problems with friendships (in some cases leading to bullying). [28]

Regardless of their age, characteristics or reasons for referral, the pupils were positive about the Short-term Keywork service. They all spoke of having enjoyed the sessions and benefitted from them. They all said that they would recommend the service to other pupils facing similar challenges to themselves. In particular they liked:

[28] 42 in total (22 in primary schools and 20 in secondary schools). All 42 pupils had received one-to-one support from a Keyworker, either face-to-face or remotely via telephone or Teams. Either the Keyworker or a member of school staff was present during the evaluation interview.

- **The techniques and strategies they had learned**: for example, strategies for coping with anxiety, calming techniques to help prevent outbursts of anger and techniques for dealing with issues in friendship groups. The pupils consistently said that these strategies and techniques had benefited them both at school and at home.

> "There was a lot of bad stuff at home and [the Keyworker] really helped me. If they get bad again, I have my box of strategies to use." *- Pupil (year 5).*

- **The activities in the sessions**: they often described these as "fun" and "interesting". Examples include using clay modelling to express emotions/feelings, activities based around board games designed to improve resilience, and remote activities that focused on mindfulness, role play and visualisations.

> "I have really enjoyed my time with [the Keyworker], especially the mindfulness activities which help me to relax. I feel more confident now and don't worry as much as I used to." - *Pupil (year 9).*

- **The personalities and characteristics of the Keyworkers**: pupils regularly referred to the Keyworkers as "kind" and "caring" and said that they "trusted them".

- **Independent input**: the pupils have valued having someone to talk to, and to share issues and concerns with, that was not a teacher or a family member.

Pupils consistently spoke of the support having had positive effects on their levels of anxiety, calmness, happiness and self-belief. For some pupils, this had led to them feeling feel more comfortable attending school and being better able to concentrate in lessons (specific examples are provided in the boxes beneath the quotations below).

> "It [the one-to-one support] has made me feel more confident. I've been able to understand why I felt unhappy. *Pupil (year 6).*

> "I don't have panic attacks as often now." *Pupil (year 5).*

Pupil example: year 9

A year 9 male pupil was referred for Short-term Keywork support due to incidents of self-harm and school staff believing he would benefit from developing greater resilience. He was also experiencing bullying. Following the Short-term Keywork sessions, his self-harming reduced significantly, he reported having a greater understanding of how to manage his anxieties and said he was more positive about his future.

Pupil example: year 5

A year 5 male pupil was described by school staff and his Keyworker as a “very anxious child” who would often cry during the school day, including in lessons and assemblies. Following the Short-term Keywork sessions, the pupil and the Keyworker both agreed that he was much happier about being in school and was more confident about engaging in lessons and extra-curricular activities. The pupil said he’d benefitted from having someone to talk to who could help him improve his self-confidence. He subsequently won an award at school for his contributions in lessons.

The parents interviewed for the evaluation were similarly positive. All of them were able to provide examples of changes in their child’s behaviour, demeanour or wellbeing which they attributed to the Short-term Keywork service. That is not to suggest that their problems had been overcome or eradicated entirely (indeed, the one recommendation made consistently by parents was for a longer period of one-to-one support than the current offer of 12 weeks), but they had all observed lower levels of anxiety and increased resilience in their children. And like their children, they greatly valued the opportunity that the service had provided for issues and problems to be discussed with someone from outside the family.

> “Things had got really, really bad. Before [the Keyworker] I really wasn’t sure what to do…but she has been amazing and an absolute lifesaver…I couldn’t fault her. Things are 1,000% better now and our lives are back on track because of her for sure.” - *Parent/carer*

3.4.3. Impact and attribution

As above, attributing impact to the Short-term Keywork service is challenging in the absence of control group data.

Nonetheless, the consensus view from the young people, parents and school staff that have contributed to this evaluation is that the Short-term Keywork service is very effective at helping young people with low to moderate mental health and emotional wellbeing issues. At no point during the evaluation did any of the consultees suggest that it duplicates provision that is already available, nor that they believe it to be ineffective. It therefore appears reasonable to conclude that the service has made a contribution to the improvements in RCADS scores, i.e., that it helps to reduce anxiety and depression in a large majority of the young people it supports.

4. Findings: Parenting support

Overview of the service

The Parenting Support strand was funded through the Hastings OA between September 2018 and August 2020. It targeted parents/carers of children and young people aged 2-18 in Hastings and had two main aims:

- To enable access to parenting programmes that use evidence-based approaches to provide a progressive universal model of parenting advice and intensive support.
- To decrease the stigma associated with accessing parenting support.

The core of the Parenting Support offer was the Positive Parenting Programme (Triple P), which seeks to equip parents with practical strategies to build strong relationships with their children, confidently manage their behaviour and prevent problems from developing or escalating.

There are five different levels to Triple P. These are summarised below and explained in more detail at Appendix G:

Level 1: communication strategy designed to reach a broad cross-section of the population.

Level 2: one-time assistance to parents via one-off seminars or 'Brief Primary Care' sessions (one-off conversations between a practitioner and a parent using a Triple P tip sheet).

Level 3: one-to-one interventions of three to six sessions, plus discussion groups on specific parenting topics.

Level 4: known as 'Standard Triple P', this involves more intensive one-to-one support and is delivered over ten one-hour sessions.

Level 5: intensive support for families with complex needs (these might involve parental conflict, separation and/or mental health).

4.1. Implementation

It proved challenging for the Parenting Support strand to engage parents in Triple P activities on the scale that was originally anticipated. This was for four main reasons:

- **Stigma:** the Parenting Support team said they had observed parents in Hastings attaching a stigma to formal parenting programmes, with some assuming that such programmes are only for 'bad parents'. They can also see it as an admission of guilt or failure if they take part. The significance of this challenge is echoed in much of the existing research evidence (e.g. SCIE, 2009 and Mansell, 2013).

- **Childcare:** for parents without ready access to childcare support, it was often difficult to find the time for, and/or commit to, structured parenting activities.

- **Value:** the parenting practitioners interviewed for the evaluation shared the view that, on average, structured parenting programmes tend not to be held in especially high regard, mainly because parents do not have a particularly well-informed view on the benefits they can generate for themselves and their children.

- **Embedded norms:** parenting practitioners and school staff both reported that certain schools in Hastings have historically suffered with poor parental engagement. This was said to be influenced by negative parental attitudes towards education and the transiency of the local population in some parts of the town.

In response to these challenges, the parenting practitioners made varied and concerted efforts to engage parents in Triple P activities. These included:

- Distributing printed leaflets via a range of community and educational settings.

- Attending community-based events and local food banks.

- Attending parents' evenings and other school-based events.

It became apparent early in the delivery of the Parenting Support strand that parents were more likely to engage in activities that were not overtly focused on 'improving parenting'. In particular, parents tended to be more willing to attend sessions on online safety and bullying, prompting the practitioners to use such sessions as a 'hook' for subsequent participation in Triple P activities. This had some success, but as shown under 'Delivery volumes' below, the Parenting Support strand was unable to meet the majority of its targets. On reflection, it appears that these targets were too optimistic.

The reduction in the size of the Parenting Support team was another influencing factor on the scale of its delivery. Originally the team had 10 full-time equivalent members of staff (FTEs), but by April 2020 this had reduced to 3.5 FTEs. The strand lead for Parenting Support attributes this mainly to natural attrition, noting that all the staff that left went to permanent roles, whereas their roles in the Parenting Support were fixed term.

4.2. Delivery volumes

Between September 2018 and August 2020, 2,445 parents engaged in Triple P programmes at Levels 2 to 5 through the Parenting Support strand. Just over two thirds of these parents (67%) took part in a Brief Primary Care session – 629 parents in 2018-19 and 1,008 parents in 2019-20 (Table 4). Between September 2018 and August 2019, the service supported an average of 94 unique parents per month. Between September 2019 and August 2020, this rose to an average of 110 unique parents per month (a month-by-month delivery profile has been provided at Appendix F).

Table 4: Parenting Support strand delivery volumes

Strand	2018-19 No. parents	2019-20 No. parents
Brief Primary Care (Triple P Level 2)	629	1,008
Primary care and discussion groups (Triple P Level 3)	374	242
Group Triple P (Triple P Level 4)	113	47
Transition groups (Triple P Level 5)	14	18
Totals	**1,130**	**1,315**

Source: Parenting Support strand, 2021

Across its full period of OA funding (September 2018 to August 2020), the Parenting Support strand exceeded one of its targets but did not meet the other three:

- **Target 1: Engage 400 parents per year in Brief Primary Care interventions (Triple P Level 2).** This target was comfortably exceeded, by 57% (229 parents) in 2018-19 and then by 152% (608 parents) in 2019-20.
- **Target 2: Engage 150 parents per year in Primary Care interventions.** This target forms a subset of the Triple P Level 3 row in the above table (it is the 'primary care' part). The service engaged 205 parents in a primary care interventions against an original target of 300 (150 each year). This equates to 69% of the target.
- **Target 3: Engage 660 parents in discussion groups.** This target is also a subset of the Triple P Level 3 row in the above table. Discussion groups were attended by 401 parents (61% of the target).
- **Target 4: Engage 120 parents per year in Triple P Level 4 activities.** A total of 160 parents took part in Triple P Level 4 activities, which is 67% of target.

These figures suggest that the targets assigned to the Parenting Support strand were too high and that local demand for formal parenting interventions was over-estimated.

4.3. Responding to COVID-19 restrictions

Both the one-to-one and group elements of the Parenting Support strand moved to remote delivery via Microsoft Teams during the first national COVID-19 lockdown (March to July 2020). Additional sessions focusing on issues pertinent to COVID-19 (e.g. managing anxiety and school transitions) were also delivered. Due to school closures, practitioners relied more on social media to engage parents/carers.

Technological challenges, and the need to adapt resources to be suitable for remote delivery, caused delivery volumes to reduce in the first half of the March to July 2020 lockdown. [29] For example, in March to May 2020 inclusive, an average of 12 parents per month took part in Level 3 Triple P activities, compared with an average of 23 parents per month across the preceding three months.

However, an important finding from the evaluation is that remote delivery for parenting activities in Hastings subsequently worked very well. In July 2020, for example, 37 parents took part in a Triple P Level 3 activity, which was the highest number in a single month since November 2019 and the second highest since July 2019. Thirteen parents took part in a Triple P Level 4 activity in August 2020, which was also the highest since November 2019.

There appear to be two main reasons for this:

- Reduced stigma and anxiety when compared with receiving face-to-face support. Parents/carers said that receiving support on the phone or via video call had made them feel more "confident" and "comfortable".

> "It really worked for me [having the support delivered remotely] because it fits in well around my work and kids. Also, the thought of attending a group in real life fills me with dread, because I'm not a very confident person…I suppose it would have been nice to meet other mums but I would have been very anxious." *Parent/carer*

- Parents/carers have found it easier to attend the sessions at home, as there are fewer transport and childcare issues.

> "Engagement has been much better doing the sessions online. We have had better attendance and less drop-out…I also think it has really opened new doors to parents who wouldn't have engaged pre-COVID." *Parenting practitioner*

[29] Initially the team tried using Skype to deliver Triple P sessions but found this to be relatively ineffective for screen sharing.

Based on this evidence, the Parenting Support team subsequently took a decision that all its services would be delivered online in the future, even following the easing of COVID-19 restrictions.

4.4. Outcomes and impact

4.4.1. Pre- and post-intervention Parenting Scale results

The Parenting Scale is designed to measure parenting ability. It contains 30 statements scored on a seven-point scale, with low scores indicating good parenting and high scores indicating dysfunctional parenting.[30] There are three categories on the parenting scale: laxness, over-reactivity and hostility.

The evaluation has had access to pre- and post-intervention Parenting Scale data from 193 parents that took part in Triple P activities at Levels 3, 4 and 5. However, this data has the following limitations:

It covers the period from April 2018 to December 2019 and therefore doesn't include any feedback obtained since the onset of the COVID-19 pandemic. This is primarily because the Parenting Scale questionnaires were used with participants of group sessions at Triple 3 Levels 3 and above, and during the first national lockdown (March to July 2020), very few of these group sessions took place.

It is aggregated rather than individual-level data. It does not show how many of the 193 parents reported an improvement against the three categories in the Parenting Scale, nor to what extent. It only provides average pre- and post-interventions across the full cohort of 193 parents.

These issues notwithstanding, the results appear positive. As shown in Table 5, the average score in each category fell following the Triple P interventions. The largest improvement (both absolute and proportionate) was in over-reactivity (-1.1 / -31%). The smallest absolute improvement was in hostility (-0.5), while the smallest proportionate improvement was in laxness (-24%).

These results follow a similar pattern to those from international studies where the Parenting Scale has been used as a means of gathering pre- and post-intervention feedback on Triple P. For example, a Dutch study by Spikers et al. (2013) and a Swiss study by Bodenmann et al. (2008) both found that parental stress reduced significantly following Triple P support.

[30] The parenting scale (Cabarrus Health Alliance). Retrieved from: https://www.cabarrushealth.org/DocumentCenter/View/1011/Level-4---Standard---Parenting-Scale---English

Table 5: Pre- and post-intervention Parenting Scale results (scale 1-7)

Parenting Scale category	Pre-intervention average score (n=193 parents)	Post-intervention average score (n=193 parents)
Hostility	2.0	1.5
Laxness	3.4	2.6
Over-reactivity	3.5	2.4
Total	3.4	2.5

4.4.2. Qualitative insight

There is a consistent message from the parenting practitioners and the parents/carers consulted for the evaluation that:

- Parents/carers have typically gained a (better) range of tools and strategies that they can use to help manage the issues they are facing.
- Amongst those parents that have taken part in a Triple P intervention, views towards formal parenting programmes have typically become more positive.
- The self-esteem and self-confidence of parents/carers has improved.
- Relationships and communication between parents/carers and their children have improved.
- In the majority of cases, children's behaviour has improved and, where the support took place during a COVID-19 lockdown, they became better able to engage in home learning.

Parents/carers spoke positively of the support they had received and would recommend the service to others. They attributed the achievement of the above outcomes to two aspects of the service: the well-informed, non-judgemental and helpful practitioners, and the useful tools, strategies and resources provided during the support.

> "It was so helpful to get a fresh perspective because things were so bad, we couldn't see a way out. [Parenting practitioner] went above and beyond for us and she was so helpful, kind and re-assuring…a real gem to work with." *Parent/carer*

Parent example

A mother was referred to the Parenting Support service by her daughter's school and took part in one-to-one Triple P Level 3 sessions. She hoped the support would help her to manage her children's anxiety and aggression.

She felt that receiving the support via Microsoft Teams was *"perfect"*, because she could see the practitioner (*"which helped us build a strong relationship"*) but did not have to leave home or find childcare. She also said she had been *"more open because the computer screen is like a protective barrier."*

Mum described the outcomes of the support as *"better than expected"*, because the tools and strategies she had learnt *"really worked and were super easy to use".* She also felt that the resources (namely videos and a parenting book) were *"really easy to understand…. I can look back at them later if I need a reminder."*

Staff in the case study schools all expressed their support for the Parenting Support strand and agreed that a structured intervention to help parents/carers work through common challenges was important. However, staff at three of the schools also noted that it became more difficult to maintain a relationship with the Parenting Support practitioners, and consequently to successfully refer parents to the service, during the COVID-19 lockdown periods. In one school, for example, a parenting practitioner had previously attended parents' evenings and parents' drop-in sessions, both of which led to take-up of Triple P activities. In another school, a parenting practitioner used to visit the school on a weekly basis. According to the school SENCO, "the parents took to her brilliantly" and it too led to engagement in Triple P.

Another running theme in the case study research was that each school has parents/carers who, in the views of the staff consulted for the evaluation, have the greatest need for a Triple P intervention but who are unwilling to engage. This is an unavoidable challenge for the service as it cannot mandate parents to take part. The team has tried various approaches to overcome this, such as engaging parents in activities around online safety before moving on other parenting topics. Anecdotally these appear to have had some success. But an unwillingness to participate amongst those for whom the service could potentially deliver the greatest benefit has remained an ongoing challenge.

4.4.3. Impact and attribution

As with the other strands of the MHEW Project, the absence of a control group makes an objective assessment of impact and attribution difficult. However, parents consulted for the evaluation agreed unanimously that they would not have taken part in a different parenting programme, or indeed any parenting support activities at all, had Triple P not

been available locally. In other words, the public funding invested through the MHEW Project appears to be reaching new participants and is not impacting negatively on participation in other parenting schemes available locally.

5. Findings: i-Rock expansion

Overview of the service

i-Rock is a drop-in service for 14-25 year-olds in the centre of Hastings, offering advice and support on emotional and mental wellbeing, employment, education and housing. Age aside, there is no minimum threshold to access i-Rock.

Funding through the Hastings OA between April 2018 and August 2020 enabled i-Rock to open five days per week (Monday to Friday) from 11am to 6pm, instead of the previous three days per week. The funding also enabled the recruitment of a psychologist and assistant psychologist, both on a fixed-term basis, to develop and deliver wellbeing interventions to young people on a range of topics including coping with suicidal thoughts and anger management. The wellbeing interventions were delivered at the i-Rock premises in Hastings.

i-Rock staff have a wide range of transition pathways to which they can signpost or refer. These include community mental health services, children's services, organisations offering employment, careers and housing support and advice, and charities offering support on bereavement, sexual health and substance misuse.

i-Rock also have a Youth Advisory Group which provides input on the design and delivery of the service.

5.1. Implementation

The i-Rock service opened five days a week as planned and, between April 2019 and December 2019, had exceeded its target for young people supported by 64% (787 young people supported compared with a target of 480 young people). An important factor in this was the awareness raising work that i-Rock practitioners did with schools around the new opening times and the service more broadly. They did this by liaising directly with SENCOs and giving presentations on the service at school assemblies.

i-Rock staff also developed effective working relationships with professionals operating in a range of statutory and voluntary services in Hastings. This enabled them to quickly become recognised as an important part of the mental health and emotional wellbeing landscape in the town.

However, the recruitment of psychology specialists to the i-Rock team took several months longer than expected, due primarily to a shortage of suitable applicants. This delayed the full implementation of the i-Rock expansion and meant that young people could not be offered in-house wellbeing interventions until early 2020.

5.2. Delivery volumes

Data on usage of the i-Rock is available for the period from April 2019 to August 2020. During that time:

- 1,229 young people received an initial triage by i-Rock staff (an average of 72 young people per month). This is 44% above the target of 853 young people over the same period.

- 666 received a wellbeing intervention (an average of 39 young people per month). At 54% of the 1,229 receiving a triage over this period, this exceeds the 50% target.

In addition to the above, i-Rock introduced Instagram Live sessions during the first national lockdown (March to July 2020). These were held three times a week and covered topics such as: how to access i-Rock during COVID-19; coping with uncertainty; social media and wellbeing; self-care; and managing transitions. The sessions were typically viewed by 30-40 people when live and by up to 250 people when they were posted on Instagram TV.

5.3. Responding to COVID-19 restrictions

i-Rock responded quickly to the COVID-19 disruptions. The drop-in site in Hastings closed on 20th March 2020, and by 23rd March 2020 the team was able to offer remote provision including virtual clinics, telephone, email and text support.

i-Rock practitioners worked closely with schools throughout the first COVID-19 lockdown (March to July 2020) to raise awareness of the service's remote offer and how it could be accessed. This included leaflets being inserted in school learning packs and e-seminars with SENCOs. They also increased the service's social media presence and introduced the aforementioned Instagram Live sessions.

The number of young people accessing i-Rock during the early stages of the first COVID-19 lockdown (March to July 2020) was nonetheless lower than in the preceding months. Practitioners attribute this to a lead time during which young people were becoming aware of, and then comfortable with, the remote offer. Usage levels increased in July and August 2020 to an average of 47 young people per month, compared with an average of 34 per month across April to June 2020 inclusive. Between March and August 2020, the proportion of young men accessing the service stood at 56%. This compares with 43% pre-COVID-19 and reflects the efforts made by the i-Rock practitioners to promote the service to young men through social media and Instagram Live.

The service's Youth Advisory Group continued to meet via Skype and gave practitioners valuable information about the effectiveness of the remote delivery model. Attendance at

Youth Advisory Group meetings was higher than it was pre-COVID-19, in part because it was easier for young people to attend remotely than in person.

> "I am so grateful that i-Rock was there during COVID…really not sure what I would have done without them…I liked that I had someone to talk to and [the i-Rock practitioner] also sent me some really helpful resources and made a plan to help me get through my crisis." *Young person*

> "I think the Youth Advisory Group was really good…it was easy for me to do it because it was on Skype and I thought it was good to give my views. They have used some of the ideas I suggested." *Young person*

5.4. Outcomes and impact

5.4.1. Pre- and post-triage 'distress ratings'

Young people presenting at i-Rock are asked to provide a 'distress rating' at the start and end of their initial meeting with a member of staff. It uses a ten- point scale, with higher numbers indicating greater distress. In more than 90% of cases, young people have reported a lower level of distress following that meeting:

- Between April 2019 and August 2019, the average pre-meeting distress rating was 6.7, reducing to an average of 4.5 following the meeting.
- Between September 2019 and August 2020, the averages were 5.9 and 5.4 respectively.

In addition, information collected by the i-Rock team shows that 99% of young people accessing the service would recommend it to a friend.

The evaluation has not had access to pre- and post-intervention data relating specifically to the wellbeing interventions.

5.4.2. Qualitative insight

The qualitative evidence about i-Rock is more limited than it is for the Short-term Keywork and Parenting Support strands. This is primarily because it was not feasible for the evaluation to track young people after they were triaged by i-Rock and signposted or referred to other services.

The evidence that is available – supplied primarily via interviews with four young people that had used the service and were members of the Youth Advisory Group – is generally very positive:

- The young people all agreed that i-Rock provides an environment in which they can feel comfortable and safe asking for guidance and support.
- The immediacy of the initial support is a key feature of the offer and one that continued during the COVID-19 lockdowns: all of the young people requesting support from the service during lockdown were contacted by a member of the i-Rock team either on the same day or the next working day.
- The staff were described as "welcoming", "friendly" and "understanding".
- It is very helpful for young people – many of whom have very limited prior experience of statutory services – to be able to access advice and support on a range of topics (e.g. housing, alcohol, drugs and wellbeing) in one place.

> "Although I found it hard to come to i-Rock the first time, I am so glad that I did. I was treated with care and respect. Young people are lucky to have i-Rock in Hastings." *Young person*

Young person example

The young person – a female aged 19 – described struggling with her mental health during the first COVID-19 lockdown (March to July 2020), as she felt she had *"no purpose"* and was *"struggling to adapt to all of the world's changes"*. She was pleased that there was no waiting list for the support from i-Rock and was very grateful to have someone to talk to. She also felt that the Instagram Live sessions and the resources emailed to her by the practitioner were very useful.

The young person contrasted her experience of i-Rock during COVID-19 to previous occasions she had accessed support from them, saying that she preferred receiving support on the phone. She said it had been easier to fit around her work commitments and she *"didn't have to see anyone face-to-face."*

She said that she would recommend the service to other young people and was very grateful that the support had been available during the COVID-19 lockdown: *"it is good to have the service active during the lockdown, because I wouldn't have been able to get support from anywhere else I don't think…[the i-Rock practitioner] has really given me hope and things are finally good for me at the minute."*

Staff at the four primary schools in the case study sample were all aware of i-Rock but because of the target age group (14 to 25 years) had relatively few direct interactions

with it. Staff at the three secondary schools all said that they recommend i-Rock to young people.

5.4.3. Impact and attribution

i-Rock is the only service of its kind in Hastings and is not duplicating existing provision. The feedback gathered from young people during the evaluation suggested they were unlikely to have accessed external support (namely that from outside their immediate family) in its absence.

i-Rock also appears to be reducing the distress levels of young people following their initial meeting. However, the truer test of its impact lies in the extent to which it helped young people with their mental health and emotional wellbeing issues over the longer term, either through them being referred to other local services or receiving an in-house wellbeing intervention. Unfortunately, this evaluation was unable to draw any conclusions on either of those aspects. This was for two reasons. First, it was not possible to track young people after they were referred to, and accessed, other services. Second, i-Rock did not collect pre- and post-intervention feedback from the young people supported via an in-house wellbeing intervention.

6. Findings: Whole School Approach

Overview of the approach

The Whole School Approach strand received funding from the Hastings OA between September 2019 and July 2020. It offered a bespoke package of mental health and emotional wellbeing-related support and consultancy to schools in Hastings. This included (although was not limited to) improving staff resilience, developing ways of providing all-staff training on mental health and emotional wellbeing, developing the pupil voice and helping schools to incorporate mental health and emotional wellbeing within their Personal, Social, Health and Economic (PSHE) programmes.

The Whole School Approach strand was delivered by a team from Boingboing. [31] The main aims of it were to:

- Embed preventative mental health and emotional wellbeing strategies in schools.
- Enable staff to feel more confident when talking with pupils about mental health and emotional wellbeing issues.
- Enable students to have greater awareness, trust and confidence in where to go to ask for help.
- Improve learning outcomes for mental health and emotional wellbeing sessions delivered as part of PSHE education.

6.1. Implementation

There were three contracts within the Whole School Approach strand of the MHEW Project, each of which was delivered by Boingboing:

- Support and challenge consultancy to develop whole school approaches to mental health. [32]
- Provision of training to primary schools on mental health.
- PSHE support.

[31] Boingboing homepage (Boingboing). Retrieved from: https://www.boingboing.org.uk
[32] East Sussex County Council defines a whole school approach in this context as "mobilising the whole school to promote student and staff wellbeing and address mental health issues". See https://czone.eastsussex.gov.uk/health-safety-wellbeing/mental-health-emotional/what-is-a-whole-school-approach/what-is-a-whole-school-approach/

Contracting/commissioning delays, influenced mainly by the lead time for recruiting a project manager into the Hastings OA team, caused the start date for the Whole School Approach strand to be pushed back to September 2019. Of all the strands of the MHEW Project, the Whole School Approach was arguably the most affected by the pandemic, especially when schools were closed to all but keyworkers' children and vulnerable pupils. Boingboing had spent much of the time between September 2019 and March 2020 on initial school engagement work and planning for the delivery of training and support. Unfortunately, much of this work did not subsequently yield the results it had promised as schools channelled all available capacity toward providing education remotely and maintaining key pastoral/safeguarding functions.

As explained under 'Responding to COVID-19 restrictions' below, the Whole School Approach team responded flexibly and proactively. They developed new resources for schools and parents to help them manage challenges arising from the pandemic, and where possible moved to remote delivery.

6.2. Delivery volumes

6.2.1. Support and challenge consultancy

At the end of March 2021, Boingboing had engaged 17 schools via this contract (65% of all schools in Hastings), exceeding the target of 50%. The 65% figure reflects natural demand for the consultancy offer; in other words, the team at Boingboing did not have to turn any schools away that were keen to engage.

There have been four different types or stages of engagement:

- **Stage 1:** consultation and guidance, e.g. reviewing current policies in schools and providing guidance on mental health and emotional wellbeing strategies.
- **Stage 2:** specific interventions identified and planned, e.g. dates and time for staff training sessions have been confirmed.
- **Stage 3:** specific interventions delivered, e.g. staff training sessions or pupil voice groups.
- **Stage 4:** ongoing consultancy, advice and/or training is being provided.

As shown in Table 6 below, Stage 2 engagement was the most common at the end of March 2021, followed by Stage 1, Stage 3 and Stage 4.

Table 6: Support and challenge consultancy by stage

Stage	No. schools engaged
1: Consultancy and guidance	4
2: Specific interventions identified and planned	8
3: Specific interventions delivered	3
4: Ongoing consultancy, advice and training	2
Total	**17**

Source: Boingboing, 2021

Also under this contract, Boingboing developed:

- A series of short films on staff wellbeing.
- A mental health guide for schools with a COVID-19 supplement.
- A newsletter for parents about mental health and COVID-19.
- A directory of resources for school leaders relating to resilience in schools in response to COVID-19.

6.2.2. Mental health training for primary schools

This contract involved:

- Short films on identifying and addressing mental health needs, understanding trauma, and understanding school avoidance and anxiety.
- Tips sheets for parents covering topics such as supporting a child with low mood, helping a child manage change and supporting a child with difficult emotions and self-harm.
- Mental health training for primary school staff.

6.2.3. PHSE support

Through this contract, 13 schools were supported to develop PSHE resources, lessons and learning. This has included:

- Face-to-face advice.
- Signposting schools to East Sussex training and resources.

- Supporting PSHE leads in schools to conduct pupil voice activity regarding the new Relationships, Sex and Health Education (RSHE) curriculum. Four short films were also being developed on RSHE and made publicly available.

6.3. Responding to COVID-19 restrictions

Reflecting the challenges imposed by the COVID-19 pandemic, Boingboing's contracts were extended, firstly to March 2021 and then again to July 2021. They began offering 'twilight training' – remote sessions via Microsoft Teams delivered only in the evening and covering a range of mental health and emotional wellbeing subjects. However, attendance was modest, with school staff citing a combination of time pressures and technological issues as the reasons for non-attendance. In response, Boingboing began making the short films and tips sheets mentioned above, along with other resources accessible on demand, and promoted these to schools and parents. Boingboing's flexibility, persistence and willingness to try different approaches during a very difficult period has been admirable. Their work may not have had the reach that was originally intended but, as explained below, the feedback from those that have engaged has generally been very complimentary.

6.4. Outcomes and impact

6.4.1. Quantitative feedback from schools

It has been difficult for the Whole School Approach delivery team to obtain feedback from schools on the scale they would have liked. This is for two reasons:

- They have not had direct engagement with as many school staff as originally planned, primarily because of the COVID-19 pandemic.
- It has proven challenging to persuade school staff to complete post-intervention feedback forms via remote delivery (rather than face-to-face support).

However, where the Whole School Approach delivery team has obtained feedback from schools, it has been very positive. For example:

- 63 of 64 school staff (from across three different schools) said that they felt better able to contribute to a whole school approach to mental health and emotional wellbeing as a result of training provided by Boingboing.
- All 12 school senior leaders providing feedback reported improvements in the promotion of mental health and resilience in their schools.

- 14 staff in a secondary school – 100% of those who provided feedback – said their capacity to support pupils with mental health and emotional wellbeing through PSHE teaching had increased.
- 24 of 25 staff in a primary school said they felt more confident in promoting resilience and wellbeing with pupils.

6.4.2. Qualitative insight

Six of the seven case study schools had engaged with the 'Support and challenge consultancy' element of the Whole School Approach strand, while four had engaged with the PSHE strand.

The staff consulted at the case study schools reported varying levels of engagement. In one school, for example, the PSHE lead had worked with Boingboing to develop a new PSHE offer and was very enthusiastic about both the process and the results. In another school, staff from Boingboing had spoken about mental health and emotional wellbeing at an assembly and had undertaken a survey of pupils which had then informed PSHE delivery. A third school had used the resilience materials developed by Boingboing in dialogue with both parents and pupils, with staff speaking very highly of them.

> "Our new PSHE curriculum gives the pupils lots of opportunities to talk about mental health and emotional wellbeing." *SENCO (primary school)*

> "Boingboing delivered training with our staff on how to use the resilience framework. It was very effective; staff now use the framework as a problem-solving tool when working with pupils." *SENCO (special school for pupils aged 7-16)*

In other case study schools, memories were more vague and contact with Boingboing had been less regular and not as recent. At one of the secondary schools, for example, staff recalled having been on a mental health-related training course prior to the first national lockdown in March 2020 but couldn't recall any interaction with Boingboing since then. At another school, both the SENCO and a fellow member of the senior leadership team knew very little about Boingboing's offer and didn't recall having had any direct contact with them.

The summary view from the case study schools is therefore that where staff recall having engaged with the Whole School Approach strand, they have generally found it very beneficial. Staff at three of the schools said that they would like to undertake more of the training courses available through this strand, but that it was proving difficult to do so due to other commitments and priorities.

6.4.3. Impact and attribution

The general consensus from staff at the case study schools was that the resources and support available through this strand have helped them to better plan for, and respond to, mental health and emotional wellbeing issues amongst their pupils. In that regard, it has been a contributory factor in schools developing a broader mental health and emotional wellbeing offer.

> "Feedback from the recent pupil voice activity [delivered by Boingboing] enabled us to assess and put in place further support for our children, particular how to develop and enhance our zones of regulation support. [33]" *SENCO (primary school)*

> "We now feel more confident in supporting students that are suffering with issues around food and eating. The session gave us ideas as a school on ways to promote 'body positive campaigns'." *SENCO (secondary school)*

The quality and relevance of the resources and support was praised, and no consistent recommendations were made for improving them. The efforts that the Whole School Approach team went to during the COVID-19 lockdowns have been appreciated by school staff, even where time constraints and/or technological challenges prevented those staff from engaging to the extent that they would like.

[33] Zones of regulation is an approach based around the use of four colours to help children self-identify how they're feeling. It aims to help children better understand their emotions, sensory needs and thinking patterns.

7. Findings: Unit cost analysis

Two of the four main strands within the evaluation scope – Short-term Keywork and Parenting Support – were suitable for unit cost analysis. That was not the case for the other two:

- **i-Rock:** OA funding supported the expansion of the i-Rock service, allowing it to open five days a week. It did not fund the service in its entirety. In the absence of a control group, and particularly given the short-term impacts on service use caused by COVID-19, it is difficult to say what proportion of young people accessing the service would have done so because of the extended opening.

- **Whole School Approach:** the activities undertaken through this strand are too varied to allow the costs associated with them to be apportioned in a meaningful way. The Whole School Approach work involved the development of short films, written resources for schools and training and consultancy work, amongst other activities. Applying a unit cost approach to these would require an approximation of the time spent on every one of these activities, which would then need to be converted into a cost. In addition, any unit cost analysis of the Whole School Approach strand would be based heavily on outputs rather than outcomes. For example, whilst it might be possible to estimate the cost of developing the various short films that have been made, it is the outcomes generated by those films (in the form of better mental health and emotional wellbeing support in schools, for example) that are of greater interest from an evaluative perspective. Identifying those outcomes would require a bespoke study to obtain input from teachers across Hastings, any of whom can access the videos given that they are publicly available.

7.1. Short-term Keywork

The primary output associated with the Short-term Keywork service was the number of young people it has supported via one-to-one interventions. As at the end of April 2021, that figure was 377 young people.

Funding for the Keywork strand was £661,911 for the period from September 2018 to August 2021. Adjusting that down on a pro rata basis gives estimated funding of £588,365 to the end of April 2021.

The majority of this funding enabled the Keyworkers to provide one-to-one programmes of support. However, the Keyworkers also ran group sessions and drop-ins at various schools across the town. It is estimated that, over the period in scope (September 2018 to April 2021), these group sessions and drop-ins accounted for approximately 7.5% of

the Keyworkers' time. To reflect this, the costs have been adjusted down by 7.5%, giving a revised estimate of £544,238.

This resulted in an estimated unit cost per young person supported one-to-one of £1,444 (Table 7). Comparable data in the public domain is relatively limited, although a national charity has produced an estimated unit cost of approximately £1,200 for a 6-12 week programme of counselling for a young person with a mental or emotional health difficulty.[34]

Table 7: Short-term Keywork unit costs - September 2018 to April 2021

No. young people supported	Delivery costs (adjusted)	Cost per young person supported
377	£544,238	£1,444

Source: Short-term Keywork strand and York Consulting, 2021

The primary measurable outcome of the Short-term Keywork service was the number of young people reporting an improvement in their combined anxiety and depression score using the RCADS tool. This data was available for 211 pupils, 83% of whom reported an improvement following their one-to-one support. It was not known whether those pupils were representative of the full cohort of 377 supported over the period in scope. Therefore, Table 8 includes three indicative scenarios:

- **Scenario A** assumes that the 211 pupils for whom data was available were entirely representative of the full cohort of 377.
- **Scenario B** assumes that two thirds of the pupils for whom no RCADS data was available would have reported reduced anxiety and depression scores.
- **Scenario C** assumes that one third of the pupils for whom no RCADS data was available would have reported reduced anxiety and depression scores.

The above results in an estimated unit cost per young person supported, and whose anxiety and depression reduced, of between £1,739 and £2,366.

[34] Unit Costs of Health and Social Care 2020 (Curtis and Burns, 2020), p.58

Table 8: Short-term keywork unit cost scenarios

Scenario	No. young people with RCADS improvement	Delivery costs (adjusted)	Cost per young person with RCADS improvement
Scenario A	313	£544,238	£1,739
Scenario B	285	£544,238	£1,910
Scenario C	230	£544,238	£2,366

Source: Short-term Keywork strand and York Consulting, 2021

This evaluation cannot report on the longer-term benefits of the Short-term Keywork service, nor the adverse outcomes that it might prevent in the future. It is therefore not possible, from an evidential perspective, to say with certainty whether the benefits of the Short-term Keywork service (in the form of savings to the state) outweigh the costs of delivering it. However:

- The national average cost of supporting a young person through CAMHS via a single disciplinary team is estimated at £4,814 at 2020 prices. This rises to £5,225 for a multi-disciplinary team and £6,513 for a targeted team.[35] As such, each time the Keywork service prevents a case from being escalated to CAMHS, the saving to CAMHS alone exceeds the estimated cost of the Keywork intervention.

- It is well documented that young people with mental health problems are less likely to be in employment, education or training (NEET), more likely to be in receipt of benefits and more likely to have contact with the criminal justice system.[36] The associated costs to the state are influenced by a range of different variables, but by way of example, the average economic cost (i.e. benefit payments and foregone tax contributions) of a young person being not in education, employment or training for a year is estimated at £10,500[37] at 2020 prices. The average annual cost to the state of a youth offender is £3,800[38], also at 2020 prices. The evaluation cannot conclude that the Short-term Keywork service will necessarily prevent these costs occurring in the future. But if, as the evidence appears to suggest, it helps to reduce the severity of young people's mental health and emotional wellbeing issues, then it is reasonable to assume that, for some young people, it may do.

[35] Unit Costs of Health and Social Care 2017 (Curtis, 2017), p.190
[36] For example: https://www.gov.uk/government/publications/better-mental-health-jsna-toolkit/2-understanding-place and https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/664855/Transforming_children_and_young_people_s_mental_health_provision.pdf
[37] Youth Unemployment: the crisis we cannot afford (ACEVO Commission on Youth Unemployment, 2012)
[38] NAO Analysis, based on CIPFA, Home Office, Ministry of Justice and Youth Justice Board Data. Cited in NAO 2011 - The cost of a cohort of offenders to the criminal justice system.

In Chapter Three, it was reported that the additionality of the Short-term Keywork service was likely to be high, i.e. the service is likely to have had a significant influence on the reduction in young people's self-reported anxiety and depression. For some young people, the service may have been entirely responsible for that reduction. For other young people, it may have been one of a combination of factors. There may also be young people reporting a reduction in anxiety and depression for whom the service has actually had no benefit at all, although no evidence has been gathered over the course of the evaluation to suggest that this is anything other than extremely rare.

Where a young person's anxiety and depression has been reduced by a combination of the Short-term Keywork service and other factors, then it would be good practice to adjust the potential savings down accordingly. For example, were it possible to say that the service was one of two equally important reasons why a young person wasn't subsequently referred to CAMHS (with the other reason being, say, support from family members), then the service could justifiably claim half of the savings to CAMHS.

However, this would require far more granular data than the Short-term Keywork team has been asked to collect during the MHEW Project. Even then, it would be subject to extensive assumptions were it not possible to construct a robust control group.

7.2. Parenting Support

The outputs included in this analysis are the 808 parents supported at Triple P Levels 3 to 5 between September 2018 and August 2020.

Level 1 activities, which centred mainly on the development and distribution of promotional materials rather than direct parenting support, have been excluded. Level 2 activities, or 'light touch Triple P', which provided brief one-time assistance to parents, e.g. via seminars or one-off conversations with a practitioner, were also excluded. This was partly because of the light-touch nature of the support and partly because the Parenting Support team focused its efforts on gathering pre- and post-intervention feedback from parents at Levels 3 to 5.

Total funding for the Parenting Support strand between September 2018 and August 2020 was £334,866, although it is necessary to adjust this down to reflect the fact that only the activities at Levels 3 to 5 are included here. The Parenting Support team advised that a 25% reduction was appropriate, which gives a revised total cost of £267,893.

This results in an estimated unit cost of £332 per parent supported at Level 3, 4 or 5 (Table 9). This is in line with the cost rating assigned to Level 4 Triple P by the Early Intervention Foundation, which gave an estimated unit cost of between £100 and £499.[39]

Table 9: Parenting Support unit costs - September 2018 to August 2020

No. parents supported	Delivery costs (adjusted)	Cost per parent supported
808	£267,893	£332

Source: Short-term Keywork strand and York Consulting, 2021

Pre- and post-intervention data using the Parenting Scale is available for 193 parents, although it covers the period from April 2018 to December 2019 and therefore doesn't include any feedback obtained since the onset of COVID-19.

More significantly, and as reported in Chapter Four, the available data does not show how many of the 193 parents reported an improvement against the three categories in the Parenting Scale (hostility, laxness and over-reactivity), nor to what extent.

Individual-level data of that kind has only been available to the evaluation for ten parents. Eight of these parents reported an improvement in either two or all three of the Parenting Scale categories. Two of the parents did not report an improvement in any category.

It cannot be assumed that the ten parents for whom individual-level data is available are representative of all the parents supported at Triple P Level 3 and above. Table 10 therefore includes the following indicative scenarios:

- **Scenario A** assumes that the individual-level results reflect the cohort-wide position, i.e. 80% of the parents have reported some form of improvement on the Parenting Scale.
- **Scenario B** assumes that 66% of the parents have reported some form of improvement on the Parenting Scale. This scenario assumes that the individual-level results are more positive than the cohort-wide results.
- **Scenario C** assumes that 33% of the parents have reported some form of improvement on the Parenting Scale. This scenario also assumes that the individual-level results are more positive than the cohort-wide results (and to a greater extent than Scenario B).

[39] Level 4 Standard Triple P (Early Intervention Foundation). Retrieved from https://guidebook.eif.org.uk/programme/triple-p-standard-level-4

These scenarios result in an estimated unit cost per parent supported, and who report a positive change on the Parenting Scale, of between £415 and £1,004.

There is little research evidence from the UK on the benefits of Triple P, although international evidence has shown it to have positive effects on attention deficit hyperactivity disorder (ADHD), to reduce behavioural problems and levels of depression and anxiety in children (Bor et al., 2002), to increase parenting competence and satisfaction and to improve maternal wellbeing (Franke et al., 2016). It has also been shown to reduce hospitalisations from child abuse injuries and reduce the rate at which children are taken into care (Prinz et al., 2009).

The impact of these outcomes on the mental health and emotional wellbeing of parents and their children are potentially very important, as are the associated cost savings. A local authority foster care placement in the UK, for example, costs approximately £35,000 per year, while local authority residential care can exceed £250,000 per child per year.[40,41] As above, the average cost to CAMHS of supporting a young person can exceed £6,500.

All of these figures far exceed the unit cost of providing Triple P through the MHEW Project, although in the absence of a study which tracks the families in Hastings over the longer term (and compares them with a control group), it cannot be assumed that financial savings on that scale will necessarily occur.

[40] Unit Costs of Health & Social Care 2018 (Curtis, 2018).
[41] Unit Costs of Health & Social Care 2018 (Curtis, 2018).

8. Findings: Overarching findings, targets and sustainability

8.1. Overarching findings

From an operational delivery perspective, the MHEW Project encouraged each of its strands to operate with autonomy and deliver services that responded to the needs of their target beneficiaries. Delivery models were designed and subsequently refined at strand-level, in each case informed by the knowledge and insight of strand leads with proven track records in their areas of specialism.

That is not to say that the strands existed in isolation from one another. On the contrary, the MHEW Working Group was consistently well attended and acted as an effective platform for the sharing of information, ideas and experiences. Short-term Keywork practitioners would, where appropriate, make referrals to the Parenting Support strand, while schools' promotion of mental health and emotional wellbeing often included making pupils aware of the i-Rock service.

However, the fact that the strands had different target groups, delivery structures and engagement strategies naturally placed a limit on the amount of cross-strand learning, and cross-strand replicable practice, that was generated by the MHEW Project. The strands also encountered distinctly different challenges. The Short-term Keywork service, for example, faced (at times) excess demand, whereas the opposite was true of Parenting Support. The Whole School Approach strand was only just beginning its delivery when the COVID-19 pandemic hit the UK, whereas the other three strands were already well established and enjoyed strong relationships with schools.

Project-level learning applicable across all strands may therefore be limited, but the project has nonetheless generated a rich repository of learning about the design and delivery of targeted mental health and emotional wellbeing interventions. The quarterly progress reports produced by each strand were typically detailed, explanatory and reflective. They documented what had worked well, what had not, and repeatedly demonstrated the commitment of practitioners and strand leads to providing high quality services, often in trying circumstances.

In terms of legacy, it is of note that the case study schools did not necessarily recognise the term "MHEW Project", instead identifying more readily with the individual strand names or referring to those strands as being "part of the Hastings OA". There is no evidence from this evaluation that this hindered the delivery or effectiveness of the MHEW Project, although it may mean that its legacy in Hastings exists more at a strand or OA level, rather than as a distinct project.

The flexibility of the MHEW Project – in terms of how and on what scale schools and other beneficiaries could engage with it – is a contributory factory in the potential absence of a project-level legacy. But that flexibility was also an evident strength of the project's design. Schools and other beneficiaries could engage in the parts of the project that best met their needs, but were under no obligation to engage in the parts that did not. The fact that project-level delivery structures were not imposed allowed each strand to tailor its delivery model and to respond quickly when those delivery models had to be adjusted during the first national lockdown (March to July 2020).

8.2. Targets for the MHEW Project

The MHEW Working Group set eight targets for the MHEW Project. These are listed below, together with a summative assessment of the progress made against them.

Target 1: All 26 schools in Hastings have a trained mental health lead.

At June 2021, only two of the 26 schools in Hastings had not taken part in mental health first aid training funded through the Hastings OA.

Target 2: The i-Rock service will have increased capacity by 40%, by operating five days a week instead of three. This increased capacity will ensure that you all young people can access support when they need it.

This has been achieved, with funding confirmed that will enable i-Rock to continue opening five days a week.

Target 3: All parents in Hastings can access support through digital and light touch seminar engagement in schools and other settings. All parents will be invited to seminars when their children start formal education and at key transition points.

This has been achieved, with seminars (face-to-face and virtual) covering a variety of topics including anxiety, raising resilient children and raising competent and confident children.

Target 4: All parents accessing evidence-based parenting programmes report improvements in their children's development and behaviour and parental wellbeing.

Due to data availability issues, it is difficult for the evaluation to accurately assess performance against this target. Evidence from late 2019 was encouraging, but more recent data is not available. In addition, setting a target of "all parents" was very ambitious, even for a well-established intervention such as Triple P.

Target 5: All young people have received support at school to understand the signs of being emotionally and/or mentally unwell and when they need help and how to access

help. They have the confidence to ask for help from friends and staff when needed and have access to someone to talk to who has received mental health first aid training.

The universal nature of this target ("all young people") means it is unlikely to have been achieved in its entirety. It is also difficult to measure without a large and statistically representative sample of pupils. However, the case studies and SENCO consultations undertaken for the evaluation clearly indicate that schools have put in place the conditions for this target to be met for many of their pupils. Schools have done this via a combination of mental health and emotional wellbeing awareness raising activities and a broad support offer, of which the MHEW Project is an important part.

Target 6: Pupils report increased personal and social wellbeing in school using the 'Stirling Children's Wellbeing Survey'. In 2017, 33% of boys and 34% of girls in Hastings aged ten recorded levels of high or maximum wellbeing for the Stirling Children's Wellbeing Scale. We will increase this to 50% by 2020.

A Hastings-wide survey of pupils using the Stirling scale has not been repeated[42] and this target cannot therefore be assessed.

Target 7: School and college staff feel competent and confident in promoting children's wellbeing and report increased personal and social wellbeing in work.

This target relates primarily to the Whole School Approach strand, for which quantitative evidence, in the form of teacher feedback on competence and confidence, is limited but nonetheless encouraging. It is also supported by feedback from the case study schools, in which staff reported being more aware of mental health and emotional wellbeing issues and of having a good understanding of their school's full support offer. The indications are therefore that good progress has been made against this target, although accurately assessing the scale of that progress is difficult.

Target 8: Preventative mental health measures are in place and there is a reduction of concerns in addressing mental health issues.

In terms of a quantitative assessment of this target, it is similar to the one above, i.e. the Whole School Approach work appears to have been beneficial, but the data (i.e. feedback from school staff) is limited by its volume. The qualitative feedback is nonetheless quite compelling, with the case studies and SENCO interviews clearly pointing to an array of preventative mental health measures in schools. However, because of the increased prevalence of mental health and emotional wellbeing issues amongst pupils, and the increased severity of those issues, it is not the case that there

[42] Discussions took place about including it within the evaluation, but concerns over timing and survey fatigue in schools, plus the subsequent onset of the COVID-19 pandemic, placed it out of scope.

has been a reduction in concerns in addressing them. The opposite is true, although that is not a shortcoming of the MHEW Project.

8.3. Sustainability

It is a very positive finding that the four main strands of the MHEW Project within the scope of this evaluation – Short-term Keywork, Parenting Support, i-Rock and the Whole School Approach – have continued beyond the end of their OA funding period:

- **Short-term Keywork** has funding committed from the OA until the end of 2021-22 academic year. From January 2022, a successor service will be introduced, provided through local NHS-funded Mental Health Support Teams and offered to the same group of 11 schools that currently engage with Short-term Keywork. The current Keywork team will work with the new team to help them establish relationships with those schools. Between April 2022 and the end of the 2021-22 academic year, the intention is that the current Short-term Keywork team will focus on working with young people that need additional support with their transition from primary to secondary school.

- OA funding for the **Parenting Support strand** came to an end in August 2020. The service has continued in the 2020-21 academic year, funded through the local NHS Clinical Commissioning Group (CCG). Funding is currently secured until March 2022.

- Also, with funding from the CCG, **i-Rock** remains available to young people five days per week. The fixed-term clinical psychologist post funded through the OA has come to an end, with wellbeing interventions now delivered by members of the core i-Rock team following a period of upskilling and capacity building.

- Numerous outputs from the **Whole School Approach** strand will remain available after the OA funding ends in July 2021. These include the various short films hosted on YouTube and the tips sheets that have been circulated to schools and parents.

Given the unforeseen and challenging circumstances within which each of the strands has operated, it is an endorsement of all of them that, in some capacity, they will continue into the future. This is especially true of those strands that have attracted new or additional funding. Local stakeholders evidently concur with the findings in this report that each strand, in its own way, has added value to the local mental health and emotional wellbeing offer.

9. Conclusions and considerations for replication

9.1. Conclusions

The Hastings Opportunity Area has successfully implemented a multi-stranded project to help children and young people, parents/carers and school staff identify and address mental health and emotional wellbeing issues.

The project was introduced to meet local need as conveyed in the Hastings Opportunity delivery plan. Its multifocal nature has been both a key feature and a key strength of its design and delivery. It has provided new services, or expanded existing ones, at various points on a continuum of need, from lower -level mental health and emotional wellbeing issues (Short-term Keywork) to crisis intervention (i-Rock). It has recognised the influence of parenting styles and parental stress on young people's mental health and emotional wellbeing (Parenting Support) and has sought to instil organisation-wide good practice (Whole School Approach).

The model adopted by the MHEW Project is to the benefit of young people in Hastings as it has the potential to impact positively on different, and very influential, areas of their day-to-day lives. While each strand has had its own priorities, targets and staff teams, the feedback gathered through this evaluation suggests that the project as a whole has increased the awareness of, and has augmented the response to, mental health and emotional wellbeing challenges in Hastings.

All four strands worked hard to engage effectively with schools and clearly articulated their offer. In the main, schools understood what each strand could provide and did not consider them to be directly duplicating existing provision. A clear theme in the feedback from school staff is that the MHEW Project has been an important and effective addition to the mental health and emotional wellbeing support landscape in Hastings.

Each of the four main strands of the MHEW Project moved to a remote delivery model in response to the first COVID-19 national lockdown (March to July 2020). Doing so was not straightforward, but on each strand there was evidence of excellent teamworking, innovation and an unwavering desire to help the young people and adults of Hastings in the best way they could. It seems likely that that had the project not been available during those national lockdowns, and across the period of the pandemic as a whole, a range of mental health and emotional wellbeing issues may have gone unresolved and could potentially have become worse.

Pre- and post-intervention data from the Short-term Keywork strand shows reduced levels of anxiety and depression amongst a large majority of the young people it has supported. Data from the Parenting Support and Whole School Approach strands is more limited, but it too indicates that positive outcomes have been experienced by the majority

of participants for whom information is available. i-Rock appears to be reducing young people's levels of distress via the initial triaging process. Qualitative feedback from suggested it provided an environment in which young people felt comfortable and safe asking for support. It also indicated that it was helpful for young people to be able to access advice and support on a range of topics (e.g. housing, alcohol, drugs and wellbeing) in one place. For the Whole School Approach, qualitative feedback was very positive: 63 of 64 school staff (from across three different schools) said that they felt better able to contribute to a whole school approach to mental health and emotional wellbeing, and 12 school senior leaders all reported improvements in the promotion of mental health and resilience in their schools.

The overall view on the outcomes generated by the MHEW Project is largely positive. Evidence from the qualitative research conducted for this evaluation supports this. Views on the Short-term Keywork service are overwhelmingly positive, while views towards the other strands indicate that each has become recognised as a value-adding part of the mental health and emotional wellbeing offer in Hastings.

Attribution (and therefore impact) is difficult to prove conclusively in the absence of control groups, but the available evidence makes it reasonable to assume that some causality exists, particularly on Short-term Keywork, Parenting Support and the Whole School Approach. Less can be said about i-Rock because the pre- and post-intervention data only covers the initial triage.

With hindsight, demand for the Short-term Keywork service was underestimated, while initial expectations about parents' willingness to participate in structured parenting programmes in Hastings were too high. The increase in the number of young people using the i-Rock service suggests that its expansion was justified, while the provision of in-house wellbeing interventions has given young people prompt access to professionally delivered mental health and emotional wellbeing support. Assessing demand for the Whole School Approach strand is more difficult, given the significant disruptions to its delivery caused by COVID-19.

9.2. Considerations for replication

The following considerations should be taken into account if an intervention similar to the MHEW Project (or specific strands within it) is being implemented in another locality.

- **The benefits of a multi-stranded offer:** mental health and emotional wellbeing challenges vary in their symptoms, severity and required response. An evident strength of the MHEW Project in Hastings is how it enabled more young people to be supported with a range of different issues, rather than having a single focus. Other

areas considering an area-based mental health project for young people would be advised to employ a similar model, resources and demand permitting.

- **Broadening the Short-term Keywork offer:** there is a clear appetite amongst the schools in Hastings that have accessed the Short-term Keywork service for that offer to be made available to pupils in years 2 to 4 with emerging mental health and emotional wellbeing issues. Staff at those schools believe it could help prevent the escalation of those issues and avoid the need for CAMHS support. Other areas introducing a keywork service would therefore be advised to assess the feasibility, including likely levels of demand and associated costs, of an expanded service that incorporates these younger pupils.

- **Understanding demand:** participation in the Parenting Support offer in Hastings has been lower than anticipated. The likely willingness of parents in a given locality to engage in structured parenting programmes should be researched (as far as is possible) before funding allocations are committed.

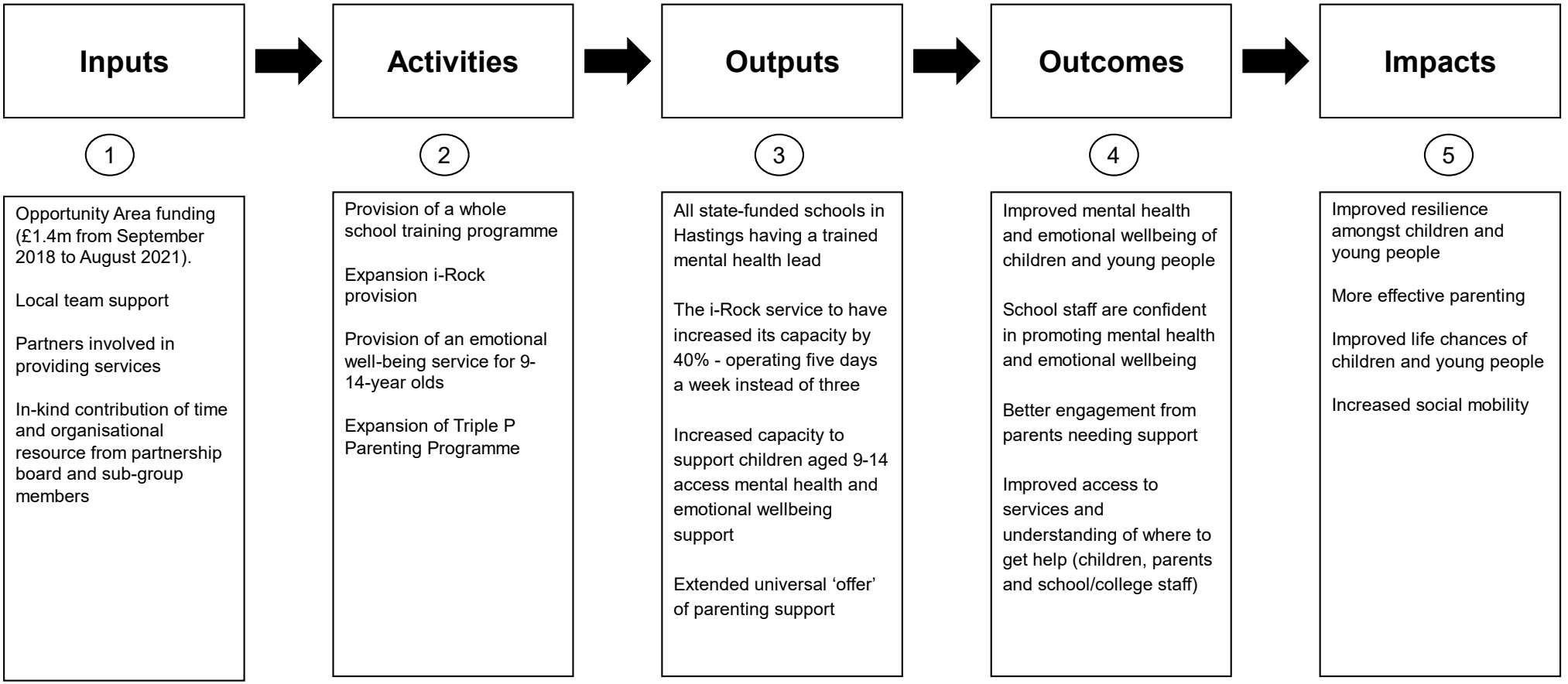
- **Blended approaches:** the MHEW Project has proven that one-to-one support for young people and parents can be provided effectively via remote delivery and need not only be used in times of crisis. It is actually preferred by some participants and blended approaches should therefore be considered in the future. This may also result in lower delivery costs.

- **Pre- and post-intervention feedback:** wherever possible, all strands within a project like the Hastings MHEW Project should collect pre- and post-intervention data from participants and should store it in a way that allows it to be analysed at individual level. This will help with the assessment of outcomes and effectiveness. The feasibility of control groups should be explored (recognising it is not straightforward) if stakeholders consider a robust assessment of impact to be important. Likewise, the ability to identify where young people have received support through more than one strand and whether that generates a greater impact than single interventions.

Appendix A: MHEW Project logic model

This logic model shows how the inputs of the project feed into the planned project activities, outputs, outcomes and impacts (see figure 1).

Figure 1: MHEW Project logic model



Source: York Consulting, 2020

MHEW Project logic model as text:

1. Inputs

The inputs were:

- Opportunity Area funding (£1.4m from September 2018 to August 2021)
- Local team support.
- Partners involved in providing services.
- In-kind contribution of time and organisational resource from partnership board and sub-group members.

2. Activities

The planned activities were:

- Provision of a whole school training programme.
- Expansion i-Rock provision.
- Provision of an emotional well-being service for 9 to 14 year olds.
- Expansion of Triple P Parenting Programme.

3. Outputs

The outputs were:

- All state-funded schools in Hastings having a trained mental health lead.
- The i-Rock service to have increased its capacity by 40% - operating five days a week instead of three.
- Increased capacity to support children aged 9 to 14 access mental health and emotional wellbeing support.
- Extend universal "offer" of parenting support.

4. Outcomes

The expected outcomes included:

- Improved mental health and emotional wellbeing of children and young people.

- School staff are confident in promoting mental health and emotional wellbeing.
- Better engagement from parents needing support.
- Improved access to services and understanding of where to get help (children, parents and school/ college staff).

5. Impacts

The desired impacts were:

- Improved resilience amongst children and young people.
- More effective parenting.
- Improved life chances of children and young people.
- Increased social mobility.

Appendix B: Additional Keywork – headline findings

Overview of the strand

Strand name: Additional Keywork

OA funding: £40,500 from May 2020 to August 2020

Summary:

Between May and August 2020, the OA funded the Education Futures Trust to provide three keyworkers to offer additional emotional wellbeing and practical support for vulnerable families in Hastings. Funding and staff resource were reallocated from the school attendance strand of the Hastings OA programme.

The main aims of the Additional Keywork strand were to identify and provide tailored support to vulnerable families during the first COVID-19 lockdown (March to July 2020), including:

- Daily checks on their welfare.
- Emotional wellbeing support and parenting advice.
- Practical support such as food parcels.
- Helping children and young people to access home learning, including creating and delivering learning packs.
- Co-ordinating help from specialist partner agencies (e.g. benefits and housing) as required.

Findings

The Additional Keyworkers quickly implemented a service providing flexible, holistic support tailored to the needs of individual parents/carers. Despite some initial concerns from the practitioners, remote delivery of the support worked well. Using a range of communication methods (namely text, email, phone and Zoom calls) alongside practical tasks such as supplying food packages and learning resources, they supported disadvantaged and harder to reach parents/carers across Hastings.

School engagement with the Additional Keywork service was very positive. The service worked with nine schools between May and August – one more than was the original

intention. Only one school approached by the service declined the invitation to take part, citing staff capacity issues as the reason.

Parental engagement with the support was also positive: the service supported 78 families, which is significantly more than the anticipated figure of 45.

Practitioners were very pleased with how the service enabled parents/carers to access practical support and advice on a range of topics, including debt, housing and mental health. The practitioners also reported having observed improvements in parents' and carers' emotional wellbeing and felt there were clear educational benefits from the provision of learning resources to young people.

Appendix C: Additional Mental Health Support – early findings

Overview of the strand

Strand name: Additional Mental Health Support

OA funding: £48,000 [43] from March 2021 to October 2021.

Summary:

In late 2020, it was confirmed that the three state-funded secondary schools in Hastings would each funding to provide additional short-term mental health support for identified cohorts of pupils during the remainder of the 2020-21 academic year (subsequently extended to October 2021). This funding was to be used for a combination of new provision (e.g. group-based mental health work with pupils and one-to-one counselling on specific topics such as suicidal ideation) and the continuation of existing inclusion work, such as the employment of staff members to support pupils most at risk of exclusion.

Findings

Delivery activity

Activities taking place through the Additional Mental Health Support strand include:

- Mental health group support delivered by Believe In You Teens
- One-to-one mental health counselling (with accompanying parental support) delivered by Eggtooth.
- Suicidal ideation small group work delivered by Eggtooth.
- Group art therapy delivered by Eggtooth.

Quantitative feedback

Reflecting the early stage of delivery through this strand, relatively little quantitative data is available at the time of writing:

[43] Includes £28,000 that was repurposed from other OA activities that had underspend. Total additional or new funding was therefore £20,000.

- In one secondary school, 11 group sessions have been run by Believe In You Teens. In eight of those, all students reported that they felt less anxious following the session. In the other three, 75% of students said they felt less anxious.

- All of the pupils that have taken part in Art Therapy have reported an improvement in their mental health and self-esteem.

Qualitative feedback

Staff at both the secondary schools in which Additional Mental Health Support activity was taking place at the time of the case studies spoke highly of it. Both have targeted it at pupils that aren't being supported by Short-term Keywork. At the school where groupwork is focusing on suicidal ideations, staff reported a strong sense of relief and reassurance that bespoke, specialist support had been made available to address what is potentially an extremely serious issue.

Staff at both schools were in agreement that it remains rather early to talk with any certainty about outcomes and impacts.

Appendix D: Text versions of strand level logic models

Short-term Keywork logic model

Inputs

The inputs were:

5 Keyworkers appointed to work in Hastings plus a 0.5 FTE senior and 0.6 FTE coordinator. £250k to establish a Keywork team.

Target (Who is the intervention for?)

The targets were:

- Children in years 5 and 6 of primary school.
- Young people in years 7, 8 and 9 at secondary school.
- Parents carers.
- School pastoral team.
- Families identified through Optivo Housing

Activities/ intervention (What is the intervention?)

The activities were:

- 1:1 short term keywork interventions.
- Short term group work to focus on identified needs.
- 48 families supported via Optivo per academic year.
- Drop in's (for years 7 to 9).
- Support and signposting for parents/ carers.
- Delivery of mindfulness sessions in schools.

Outputs/ change mechanisms (How and why does your intervention work?)

The outputs were:

- 2 x 70 CYP access 1:1 interventions per academic year.

- Access to short term interventions, reduce need for referral to CAMHs and other services.
- Staff in schools and other settings can refer CYP for really intensive support.
- Staff in schools and other settings can access training and support re: school based models of interventions.

Outcomes (What difference will it make?)

The outcomes were:

- Improvements in emotional wellbeing for CYP who access early intervention support.
- School staff can refer CYP for early intervention support when required.
- CYP identified as in-need will have greater resilience around EWB.
- Parents feel more confident as CYP access support.

Moderators (What factors will influence the change?)

The listed moderators were:

- Capacity to recruit staff with the appropriate skills.
- School and family's engagement.
- School and vol sector staff capacity to engage.
- Effectiveness of short term interventions for CYP with multiple needs.
- Ability to work in new ways across settings.
- Staff turnover.
- Willingness of CYP with emerging problems to engage and wider systems to support them.
- Capacity to join up delivery across community based settings, schools and voluntary organisations.

Impacts

- The impacts listed were:
- Normalising asking for help around emotional wellbeing.

- Greater range of support offered in schools around EWB.
- CYP are better able to access support around EWB through school networks.

Parenting Support logic model

Inputs

The inputs were:

- Expansion of Triple P (Positive Parenting Programme) - £181k investment per annum.

Target (Who is the intervention for?)

The targets were:

- All parents and carers living in Hastings CoN – 1-4.
- Parents/ carers who would benefit from parenting support.
- Parents/ carers with specific issues whose children have identified needs:
    - Parental conflict
    - ASC
    - Mental health
- School staff, multi-agency workforce.

Activities/ intervention (What is the intervention?)

The activities were:

- Progressive universal evidence based parenting interventions.
- Enhance and embed the skills of a multi-agency workforce to:
    - Embed a town-wide approach;
    - Improve signposting and referral skills;
    - Access training and private/ clinical supervisions;
    - Improve connectivity.
- Embed in schools a minimum offer for parents and the school workforce.
- Social marketing campaign.

Outputs/ change mechanisms (How and why does your intervention work?)

The outputs were:

- Progressive universal model normalising parenting based on minimal sufficiency and self-regulation.
- Early access – reducing need for more specialist interventions.
- Enhanced skills for school staff around child behaviours and parental engagement.
- Multi-agency approach – using evidence based model and maintain delivery fidelity.
- Access to specialist support – for those families with more complex/ specific needs.

Outcomes (What difference will it make ?)

The outcomes were:

- Reduction in poor child/ adolescent outcomes: risky behaviours, youth offending, conduct problems and hyperactivity.
- Improvements in emotional wellbeing for children and young people.
- Improve quality of parent-child relationship and attachment.
- Improved parental emotional wellbeing and mental health, and greater confidence in parenting ability.

Moderators (What factors will influence the change?)

The listed moderators were:

- Effective engagement of families who would most benefit from support.
- Effective engagement of statutory and voluntary partners.
- Culture change in schools/ commitment of schools to embed offer.
- Recruit staff with the appropriate skills.
- School parental engagement levels and strategy.
- Effective connectivity with other HOA strands.
- Commitment of funding beyond 2020 – alignment of funding streams.

- Effective social marketing campaign.

Impacts

The impacts listed were:

- Improved personal resilience and self-regulation (of adults and children).
- Town -wide progressive universal approach to earlier engagement and support for families.
- Effective transitions between educational settings: for children, parents and schools. With improved school attendance and readiness.
- Significant cost saving on public services.

i-Rock expansion logic model

Inputs

The inputs were:

- Upscaling i-Rock provision - £100k per annum investment.

Target (Who is the intervention for?)

The targets were:

- Young people (14 to 25) who are experiencing distress including:
    - Bullying;
    - Anger management;
    - Domestic violence;
    - Sexual violence;
    - Suicidal thoughts;
    - Fear of failure.
- Universal/ primary care professionals working with YP.
- Parents/ carers who may want to refer YP.

Activities/ intervention (What is the intervention?)

The activities were:

- Evidence based interventions to support CYP's emotional wellbeing and mental health.
- 1 to 4 early intervention session for YP for whom this would benefit.
- Brief interventions delivered in the Hub and in community locations.
- Brief intervention guidance, clinical supervision, and governance for core staff. Offered by psychologist.

Outputs/ change mechanisms (How and why does your intervention work?)

The outputs were:

- Access to short term interventions for those YP who require this.
- Better access to early support for YP with identified needs.
- Staff in schools and other settings can refer YP for early intervention support – reducing their stress.
- Providing support and clinical supervision from psychologist to skill up wider cohort of staff.

Outcomes (What difference will it make?)

The outcomes were:

- Improvements in emotional wellbeing for young people with identified needs.
- School staff can sign post to i-Rock for those who require this.
- Parents can signpost to i-Rock for thos YP who require this.
- Increase in staff in schools and staff in i-Rock – skills, satisfaction and resilience.
- Improved practice – use of outcome tools and models of collaborative practice.

Moderators (What factors will influence the change?)

The listed moderators were:

- Capacity to recruit staff with appropriate skills.
- Young people's engagement.
- School and vol sector staff capacity to engage.

- Effectiveness of short term interventions for YP with multiple needs.
- Ability to work in new ways across settings.
- Delivery of EBP in community based settings.
- Willingness of YP with emerging problems to engage and wider systems to support them.
- Capacity to join up delivery across community based settings, schools and vol orgs.

Impacts

The impacts were:

- Improved attendance, engagement and reduction in escalation of needs.
- Increase in staff emotional resilience and capacity to support YP.

Whole School Approach logic model

Inputs

The inputs were:

All schools receive 4 days backfill funding 6 days consultancy to support schools complete self-assessment. £150k to deliver training and support for schools.

Target (Who is the intervention for?)

The targets were:

- Children and young people in school and college.
- Parents/ carers.
- Teachers and non-teaching staff.
- School leaders – SLT and Mental Health Lead in schools.

Activities/ intervention (What is the intervention?)

The activities were:

- All schools to carry out self-assessment against the 8 principles of a whole school approach to promoting MH.
- Funding and support for schools to free up staff time to deliver the Audit.
- Schools to deliver MH and resilience and awareness work and “sign-posting” of support via PHSE and wider pastoral support.
- Schools to identify MH lead to coordinate whole school approach.
- Delivery of programme of training and support for schools and colleges.

Outputs/ change mechanisms (How and why does your intervention work?)

The outputs were:

- Audit itself – results in increased focus on MH provision and whole school approach.
- Greater focus on MH and resilience within curriculum and wider pastoral support.
- Funding for schools to free up staff time.
- School buy in and support for wider training and support programme.
- Better trained and supported staff – more skilled and more resilient.

Outcomes (What difference will it make ?)

The outcomes were:

- Improved CYP personal and emotional wellbeing in school.
- CYP access support re: promoting EWB and resilience.
- CYP understand how and where to go for help re: their MH.
- Improvements in EWB for CYP with identified needs.
- School staff confident in promoting CYP wellbeing.

Moderators (What factors will influence the change?)

The listed moderators were:

- Staff turnover.
- Parental engagement.

- School/ college staff capacity to engage – particularly MH lead.
- Senior leadership buy-in – and support for whole school/ college approach and MH lead.
- Schools/ colleges access to expert advice and support re: supporting CYP with MH problems.
- Capacity of schools to engage in training programme.
- Capacity and expertise of external providers to deliver what's required.
- Capacity to join up delivery across community based settings, schools and vol orgs.

Impacts

The impacts were:

- More partnership working between leadership and SENCOs across schools.
- Improved mental health literacy and reduced stigma re: mental health.
- Improved engagement at school, including improved attendance.

Appendix E: Short-term Keywork delivery volumes

Table 10: Short-term Keywork delivery volumes

Month	New 1:1 starts	1:1 completes	Families declining support	Disengaged from support	Stepped up to CAMHS
September 2018	10	8	0	1	1
October 2018	30	26	0	1	3
November 2018	14	13	0	1	0
December 2018	16	13	0	2	1
January 2019	18	18	0	0	0
February 2019	5	4	0	1	0
March 2019	12	12	0	0	0
April 2019	14	13	0	1	0
May 2019	12	9	0	2	1
June 2019	14	12	0	2	0
July 2019	8	7	0	1	0
August 2019	3	2	0	1	0
September 2019	22	20	0	0	2
October 2019	13	11	0	1	1
November 2019	19	17	1	1	1
December 2019	2	2	0	0	0
January 2020	25	19	0	5	1
February 2020	11	8	1	3	0
March 2020	5	5	0	0	0

Month	New 1:1 starts	1:1 completes	Families declining support	Disengaged from support	Stepped up to CAMHS
April 2020	2	1	1	1	0
May 2020	13	8	0	5	0
June 2020	9	7	1	2	0
July 2020	9	5	6	3	1
August 2020	0	0	1	0	0
September 2020	3	3	2	0	0
October 2020	17	16	6	1	0
November 2020	9	6	2	2	1
December 2020	10	8	5	1	1
January 2021	8	8	0	0	0
February 2021	9	0	3	1	1
March 2021	26	4	3	0	1
April 2021	9	0	0	0	1
TOTAL	**377**	**285**	**32**	**39**	**17**

Source: Short-term Keywork service

Appendix F: Parenting Support delivery volumes

Table 11: Number of parents reached by parenting support (split by level of support)

Month	Level 1	Level 2	Level 3	Level 4	Level 5
September 2018	203	7	23	2	0
October 2018	2,801	31	22	3	0
November 2018	5,515	64	52	17	0
December 2018	3,389	34	38	20	14
January 2019	7,081	42	35	0	0
February 2019	4,979	26	60	5	0
March 2019	6,830	45	69	32	0
April 2019	12,429	30	16	0	0
May 2019	8,119	69	3	8	0
June 2019	7,949	117	3	12	0
July 2019	6,487	102	47	14	0
August 2019	411	62	6	0	0
September 2019	4,589	19	3	0	0
October 2019	4,862	83	18	0	0
November 2019	2,985	66	43	15	4
December 2019	9,226	66	29	0	14
January 2020	7,560	74	29	0	0
February 2020	7,238	73	24	8	0
March 2020	5,733	93	16	11	0

Month	Level 1	Level 2	Level 3	Level 4	Level 5
April 2020	7,676	44	9	0	0
May 2020	4,320	74	15	0	0
June 2020	8,878	195	12	0	0
July 2020	5,056	151	37	0	0
August 2020	494	70	7	13	0

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