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Evaluation of the Child and Adolescent Mental Health Service (CAMHs) In-Reach to Schools Pilot Programme: Final Report

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Views expressed in this report are those of the researcher and not necessarily those of the Welsh Government.

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Glossary

Acronym

Definition

A&E	Accident and Emergency
ABUHB	Aneurin Bevan University Health Board
ACE	Adverse Childhood Experiences
ADHD	Attention Deficit Hyperactivity Disorder
ALN	Additional Learning Needs
ALNCos	Additional Learning Needs Co-ordinators
AMHFA	Adult Mental Health First Aid
AoLE	Area of Learning Experience
ASD	Autism Spectrum Disorder
BAME	Black, Asian and Minority Ethnic
BBC	British Broadcasting Corporation
BCUHB	Betsi Cadwaladr University Health Board
CAMHS	Child and Adolescent Mental Health Service
CATT	Crisis Assessment and Treatment Team
CBT	Cognitive Behavioural Therapy
CCG	Clinical Commissioning Group
CEL	CAMHS Education Link
CYP	Children and Young People
CYPE	Children, Young People and Education
DAWBA	Development and Well-being Assessment
DECIPHer	The Centre for the Development and Evaluation of Complex Interventions for Public Health Improvement
DfE	Department for Education
EEF	Education Endowment Foundation
EP	Educational Psychology
ESF	European Social Fund
EWC	Education Workforce Council
EWO	Education Welfare Officer
EWS	Education Welfare Service
GP	General Practitioner

GwE	The School Effectiveness and Improvement Service for North Wales
HBSC	Health Behaviour of School age Children
HDUHB	Hywel Dda University Health Board
INSET	In-Service (Teacher) Training
ISCAN Needs	Gwent Integrated Services for Children with Additional Needs
IT	Information Technology
LA	Local Authority
LAC	Looked After Children
LHB	Local Health Board
MH	Mental Health
MS	Microsoft
ND	Neurodevelopment Differences
NHS	National Health Service
PHW	Public Health Wales
PMHCSS	Primary Care Mental Health Support Services
PMHSS	Primary Mental Health Support Services
PRU	Pupil Referral Unit
PTHB	Powys Teaching Health Board
RAG	Red/Amber/Green
RPB	Regional Partnership Board
sCAMHS	Specialist Child and Adolescent Mental Health Services
SEAL	Social and Emotional Aspects of Learning
SENCos	Special Educational Needs Co-ordinators
SEN	Special Educational Needs
SEQ	School Environment Questionnaire
SHRN	Schools Health Research Network
SHWS	Student Health and Well-being Survey
SIR	Schools In-Reach
SLT	Senior Leadership Team

SPACE – Well-being	Single Point of Access for Children’s Emotional Well-being and Mental Health
SPoC	Single Point of Contact
TA	Teaching Assistant
TAF	Team Around the Family
T4CYP	Together for Children and Young People Programme
WG	Welsh Government
WNHSS	Welsh Network of Healthy School Schemes
YMHFA	Youth Mental Health First Aid

1. Introduction

The policy context and need for the research

- 1.1 Most pupils in Wales have good mental health and well-being. However, almost 1 in 5 (19 per cent) young people in years 7-11 reported 'very high' mental health symptoms (measured using the Strengths and Difficulties Questionnaire¹, where a higher score indicates poorer mental health) in the last Schools Health Research Network (SHRN) Student Health and Wellbeing Survey (Page et al., 2021).
- 1.2 The proportion of pupils with mental health difficulties or poor well-being is higher amongst older age groups, females and pupils from more socio-economically disadvantaged backgrounds (Page et al., 2021).
- 1.3 There was evidence before the Child and Adolescent Mental Health Services (CAMHS) In-Reach to Schools Pilot programme that mental health difficulties, such as feeling low, had increased in Wales, for example:
- the proportion of 15 year old boys reporting feeling low more than once a week increased from less than 10 per cent in 2009 to 15 per cent in 2014; and
 - the proportion of 15 year old girls reporting feeling low more than once a week increased from less than 22 per cent in 2009 to 30 per cent in 2014 (PHW, 2016).
- 1.4 There was also some evidence from across the UK that more severe mental health disorders² have also increased, albeit at a slower rate than the rise in mental health difficulties. For example:

¹ The Strengths and Difficulties Questionnaire is a screening tool used to measure psychological problems and strengths. In order to help interpretation of the scores, they are often categorised into four classes: "close to average", 'slightly raised', 'high', and 'very high'", with the cut-points based upon the responses to a large UK community sample, which represent 80%, 10%, 5% and 5% of the population, respectively (Page, et al, 2021).

² 'Mental disorders were identified according to International Classification of Diseases (ICD-10) standardised diagnostic criteria, using the Development and Well-Being Assessment (DAWBA). To count as a disorder, symptoms had to cause significant distress to the child or impair their functioning' (p.7). The most common problems are: conduct disorders, attention deficit hyperactivity disorder (ADHD), emotional disorders (i.e. anxiety and depression) and autism spectrum disorders.

- the proportion of 5-15 year olds in England experiencing any mental disorder rose slightly from 9.7 per cent in 1999 to 11.2 per cent in 2017 with data for the 2020 survey (conducted during the COVID -19 pandemic, which affected administration of the survey and which is also likely to have affected children’s mental health) indicating a further increase to around 16 per cent of children having a probable mental disorder in July 2020 (NHS Digital, 2018, 2020).

1.5 Finally, while mental health difficulties have increased, there is also some evidence from analysis of the Schools Health Research Network (SHRN) Student Health and Well-being Survey that pupils’ perceptions of levels of school support for students who feel unhappy, worried or unable to cope, has declined. Between 2017 and 2019, both year 8 and year 11 statistical models, developed by the Centre for the Development and Evaluation of Complex Interventions for Public Health Improvement (DECIPHer), suggest a decline in the perceived level of school support for students who feel unhappy, worried or unable to cope.

Staff mental health and well-being

1.6 Although they have had a lower profile than concerns about pupils’ well-being, there have also been concerns about school staff well-being and stress. School staff, and in particular teachers, experience an elevated risk of stress, depression and anxiety compared to the general working population (Harding et al., 2019). Surveys of education professionals in the UK consistently identify high stress levels, with high workload a key concern. For example, the latest National Education Workforce Survey, carried out by the Education Workforce Council (EWC, 2017) identified that less than 6 per cent of respondents agreed or strongly agreed when asked: ‘Are [you] able to effectively manage your existing workload within your agreed working hours?’

1.7 As well as being a concern in its own right, there is evidence of the damaging effects of teacher stress and low levels of well-being upon pupils; for example, a research report exploring the association of teachers’ mental

health and well-being alongside students' mental health and well-being (Harding et al., 2019), with data taken from 25 secondary schools in England and Wales, found that better teacher well-being was associated with better student well-being and lower student psychological distress. Higher levels of teacher depressive symptoms were associated with poorer student well-being and psychological distress. These findings are consistent with those of a qualitative research report undertaken in primary schools (Glazzard and Rose, 2019). In this study, most teachers agreed that their well-being affected their performance as an education professional, especially their ability to teach in the classroom. Children were attuned to their teacher's mood and could pick up when they were feeling happy or stressed, even when teachers tried to hide it. Children learned more when their teacher was happy and performing well.

Welsh Government and regional policy

1.8 Widespread concerns that pupil mental health and well-being is worsening and that schools and services like Specialist Child and Adolescent Mental Health Services (sCAMHS) have struggled to meet rising demands, have been highlighted by a number of reports in Wales, including:

- the Children, Young People and Education (CYPE) Committee inquiry into Child and Adolescent Mental Health Services (CAMHS) in 2014;
- the Children's Commissioner for Wales, who reported in 2016 that mental health was the issue most commonly raised by children, young people, their parents and carers. More recently, the Children's Commissioner for Wales raised concerns about the complexities of mental health services, which can lead to people being 'bounced' between services (Children's Commissioner for Wales, 2020); and
- the Mind Over Matter report into emotional and mental well-being of children and young people in Wales, published by the Children and Young People (CYP) Committee in April 2018 (NAfW, 2018).

1.9 This has led some people to conclude that there is a crisis in young people's mental health (BBC, 2019), and in response to the challenge of improving children's and young people's emotional health and well-being, several initiatives have been launched, including:

- the Together for Children and Young People Programme (T4CYP)³ begun in February 2015, in part as a response to the CYPE inquiry into CAMHS;
- the ACE informed school movement⁴, fuelled by Public Health Wales's (PHW's) first Adverse Childhood Experiences (ACE) Study for Wales in 2015 (PHW, 2015);
- Successful Futures, the review of school curriculum and assessment arrangements in Wales, published in 2015, which recommended a stronger focus upon health and well-being and which is being taken forward as part of the health and well-being Area of Learning Experience (AoLE)⁵ (WG, 2015a), under the duties within the Curriculum and Assessment (Wales) Act 2021;
- the third sector Mental Health Grant Scheme, to help prevent mental health problems developing by improving the information available to pupils. The scheme is funding a range of initiatives delivered by organisations such as Action for Children;
- the CAMHS In-Reach to Schools Pilot Programme announced in 2017, in part in response to the 2014 and 2018 CYP Committee inquiries into the emotional and mental health of children and young people; and
- the Joint Ministerial Task Force on a Whole-School Approach to Mental Health and Well-being, announced in September 2018 to bring together

³ The T4CYP programme aims to improve the emotional and mental health services for children and young people in Wales and includes a focus upon supporting early years' development, promoting well-being and resilience and early identification and intervention and investment in specialist services (NHS Wales, 2015).

⁴ For example, The ACE Support Hub has developed a range of learning materials to support primary schools to develop an ACE-informed approach (Hwb, 2021).

⁵ 'What matters' - the 'key elements that all learners should experience' as part of Health and Well-being AoLE are currently being developed (WG, 2015a).

all the different activities focused upon improving the mental health and well-being of children and young people (WG, 2019a).

- 1.10 These build upon earlier initiatives, such as the Welsh Network of Healthy School Schemes (WNHSS)⁶ launched in 1999 ‘to encourage the development of local healthy school schemes within a national framework’ (Public Health Network Cymru, 2021).

A whole-school approach to emotional and mental well-being

- 1.11 Mental health is one of the Welsh Government’s six cross-cutting priorities and, as an interviewee from the Welsh Government outlined, a total of £9m is planned to support projects linked to the Welsh Government’s whole-school approach to mental health in 2021-22. This includes £5m to expand the CAMHS school in-reach programme across all Wales, in line with the recommendations and findings of the evaluation; £2.75m to support local authorities to deliver interventions in schools, support teacher training on well-being and improve and extend the school counselling service; £350,000 to support teacher well-being; and £750,000 to support implementation of the Whole-School Approach Framework and undertake related research and evaluation activity. The number of approaches, though each is important, has contributed to what is an increasingly ‘crowded’ policy landscape.

The Framework on embedding a whole-school approach to mental health and well-being

- 1.12 In March 2021, the Welsh Government published the Framework on embedding a whole-school approach to mental health and well-being (WG, 2021). The guidance stresses the importance of ‘relationships’ (e.g. with staff and other learners) in promoting a ‘positive cultural environment in schools’. It stresses the ways in which well-being must be an integral part of all aspects of school life, including teaching, the curriculum, strategic planning and staff valuing their own well-being. It also identifies how action in schools

⁶ A ‘healthy school’ is defined as one ‘which takes responsibility for maintaining and promoting the health of all who “learn, work, play and live” within it, not only by formally teaching pupils about how to lead healthy lives but by enabling pupils and staff to take control over aspects of the school environment which influence their health’.

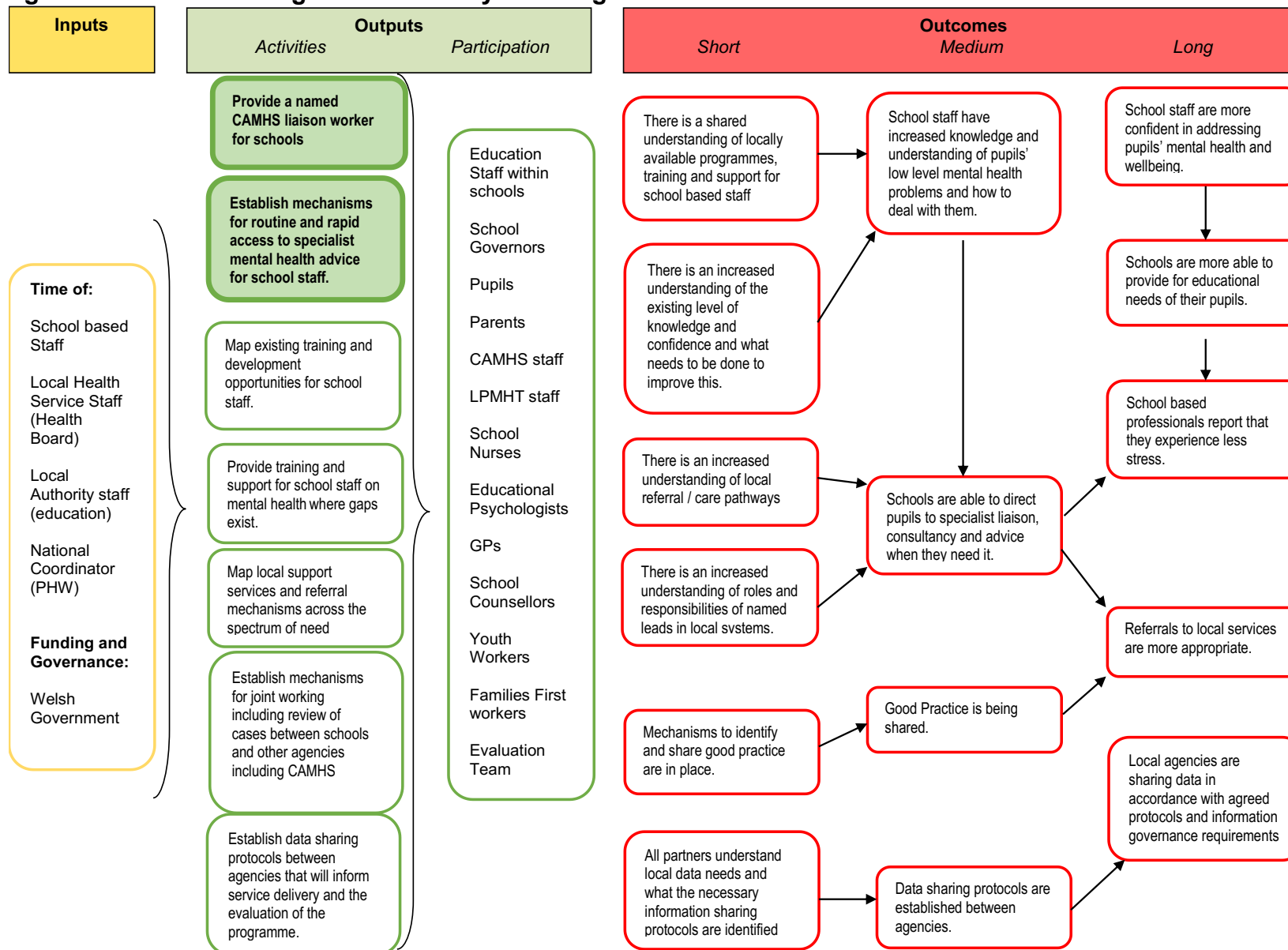
needs to be 'part of a much wider whole-system approach to the well-being needs of children and young people'. This means that whole school approaches are 'integral and codependent on the work of the NHS-led Together for Children and Young People (T4CYP) (2) [programme, which aims] to improve the emotional well-being and mental health services/support for children and young people'; much of which will be taken forward by Regional Partnership Boards (RPBs) (WG, 2021, p. 9)

The CAMHS In-Reach to Schools Pilot Programme

- 1.13 The CAMHS In-Reach to Schools Pilot Programme is part of the Welsh Government's response to concerns that pupil mental health and well-being has been worsening and that schools and services like sCAMHS (specialist CAMHS) have struggled to meet rising demand. The pilot programme aims to build capacity (including skills, knowledge and confidence) in schools to support pupil mental health and well-being and improve schools' access to specialist liaison, consultancy and advice when needed. These medium-term outcomes are intended to contribute to long-term outcomes, such as enabling schools to meet the educational needs of their pupils and reducing school staff stress.
- 1.14 The pilot programme operates in three areas:
- South Wales, covering Blaenau Gwent and Torfaen / Aneurin Bevan University Health Board (ABUHB) and South Powys / Powys Teaching Health Board (PTHB);
 - West Wales, covering Ceredigion / Hywel Dda University Health Board (H DUHB); and
 - North Wales, covering Wrexham and Denbighshire / Betsi Cadwaladr University Health Board (BCUHB).
- 1.15 The pilot programme aimed to work with all primary, all-age and secondary schools and in each pilot area and also, in North Wales, pupil referral units and special schools,. Although it worked with primary schools, the advice, liaison or consultation role was limited to supporting pupils in year 6.

1.16 The pilot programme's national co-coordinator's role was advisory and focused, for example, upon sharing good practice, giving each pilot area some flexibility about how to develop the pilot. Each pilot area has developed its own approach to addressing the programme's outcomes (expressed in the programme's theory of change, outlined in figure 1.1): increasing skills and confidence amongst school staff around mental health; providing schools with timely access to specialist advice, liaison and consultation (from mental health professionals); and, by doing so, improving school pupil and staff mental health and well-being. Given the differences in context for each pilot area, choices were made about which elements of the pilot (such as training or access to specialist advice, liaison and consultancy) to prioritise and the most effective approaches to address them. This created opportunities for comparative evaluation of different pilot approaches including, for example, the content and delivery of training and providing access to specialist advice, liaison and consultancy.

Figure 1.1. The Pilot Programme's theory of change



1.17 Initially conceived as a two-year pilot programme running from 2018 to the summer of 2020, in 2019 the pilot programme was first extended to coincide with the final evaluation (originally due to conclude in December 2020) and then extended again to July 2021, given the impact of COVID-19. In addition, the funding available for the pilot programme in the 2020/21 academic year was substantially increased. This did not change the programme's model or theory of change, but did enable an increase in delivery of training, support, advice and consultancy for schools, through the recruitment of more staff and the purchase of new training packages.

The Mental Health Services and Schools Link Project in England

1.18 The aims and objectives of the CAMHS In-Reach Pilot Programme are in many ways similar to the Mental Health Services and Schools Link Project in England (see example of practice 1). However, there are important differences in terms of:

- scale, as the CAMHS In-Reach pilot programme focuses upon six LA areas, compared to the 22 English Clinical Commissioning Group (CCG) areas, which tend to be larger than Welsh LAs; and
- focus, with the Mental Health Services and Schools Link Project having both a narrower focus around providing a lead contact in or for each school to improve access to sCAMHS, but also a broader scope, given the aim of transforming systems and services.

Example of practice 1. The Mental Health Services and Schools Link Project in England

Concerns in England about pupil mental health and difficulties in accessing services like sCAMHS, led to the establishment, in 2015-2016, of the Mental Health Services and Schools Link Project. This provided funding to establish named lead contacts within NHS/sCAMHS and in schools in 22 pilot areas. Three main models were developed, a:

- sCAMHS 'lead with contact time in schools on a regular basis, delivering services and support directly to both staff and young people';
- sCAMHS 'named lead offering dedicated training and support time to school-based professionals' (but with little or no direct work with children or young people); and

- sCAMHS 'named lead or duty team with designated responsibilities for the pilot, offering a single point of access [to sCAMHS]' with advice and guidance often delivered by phone or email and a greater emphasis placed upon improving understanding of referral pathways (DfE, 2017, p.43).

In addition, training, such as mental health awareness, was provided to schools in all areas.

The evaluation of the project identified that it improved communication and joint working arrangements between schools and sCAMHS and that there was increased understanding of referral pathways and knowledge and awareness of pupil mental health amongst school lead contacts. Qualitative evidence also indicated that: 'The programme contributed towards improvements in the timeliness of referrals and helped to prevent inappropriate referrals within many areas' (DfE, 2017, p.12.) and that: 'The reassurance and additional support provided ... often helped to alleviate anxiety that had built up, where school staff had been operating beyond the margins of their expertise' (p. 70).

The COVID-19 pandemic

- 1.19 On the 31st December 2019, the first cases of COVID-19 were identified. The virus spread rapidly and the first (confirmed) case in Wales was on 28th February 2020. On the 3rd March 2020, the UK's action plan was launched, aiming to first contain and then delay the spread of the virus. This was followed by emergency legislation giving each of the UK nations powers to respond 'quickly and effectively' to the outbreak. By 12th March, the UK moved to the delay phase and on the 16th March the UK Government advised that all non-essential contact and unnecessary travel should stop and people should start to work from home where possible. On the 20th March, hospitality and leisure business were advised to close (Senedd Research, 2021).
- 1.20 On March 23rd the first national lockdown started. People were required to stay at home except for very limited purposes and schools were closed for all bar the children of key workers and vulnerable learners. The restrictions were eased in the summer and schools re-opened on the 29th June 2020. In the autumn term, local restrictions were re-imposed in some parts of Wales in September and October

2020 (including the pilot areas of Denbighshire, Wrexham, Blaenau Gwent and Torfaen), and there were also local closures of classes and/or schools following positive cases of COVID-19 within schools across Wales. New national restrictions were announced in December 2020, with all secondary schools and colleges in Wales moving to online learning from 14th December 2020. On the 4th January 2021, it was announced that all schools should move to online learning. As before, schools were open only for children of key workers, vulnerable learners, and learners who needed to complete essential exams or assessments. The phased return of foundation phase pupils began from 22 February 2021. On the 15th March 2021, primary school pupils in key stage 2 began returning to schools and all secondary school settings were given the flexibility to provide face-to-face learning for year 10 and 12 pupils and to offer learners in years 7, 8 and 9 the 'opportunity of a check-in with teachers, focused on support' (Senedd Research, 2021).

- 1.21 There are concerns that pupil and staff mental health and well-being will have worsened during, and as a result of, the COVID-19 pandemic (Holmes et al., 2020; [WG, 2020a](#)) but the impact upon schools, students and staff is not yet understood.

The evaluation of the CAMHS In-Reach to Schools Pilot Programme

- 1.22 The aim of the evaluation was to understand how the CAMHS In-Reach Pilot Programme worked, whether the objectives of the pilot programme were being met and how the pilot programme was understood by stakeholders across the pilot regions.
- 1.23 The objectives of the evaluation were to:
- assess and evaluate the confidence and skills of teachers and schools in responding to emotional and mental health concerns of pupils, including early recognition and support;
 - assess and evaluate the effectiveness of the pilots in responding to pupils with more serious issues and facilitating access to specialist support;
 - review the process of implementing the pilots and whether the activity has been delivered effectively;

- examine how each of the pilot areas is supporting pre-critical point referrals to sCAMHS ⁷;
- identify good practice and support the work of multi-agency/co-working;
- provide recommendations for future multi-agency working, good practice, research and policy and whether further evaluations are required to inform Welsh Government, Local Health Board (LHB) and Local Authority (LA) decisions on the potential of a future roll-out of the CAMHS In-Reach to Schools Pilot Programme.

1.24 The research questions for the evaluation are included in an appendix.

⁷ Timely referrals to CAMHS before mental health difficulties escalate and become critical.

2. Methodology

Introduction

2.1 In line with HM Treasury guidance on policy evaluation (HM Treasury, 2020) a theory-based approach to evaluation, focused upon testing the CAMHS In-Reach to Schools Pilot Programme's theory of change (see figure 1.1) was used. In order to generate data to test the theory of change, and establish if, for example, activities and outputs were delivered, and outcomes generated as expected, a mixed methods approach was deployed, including:

- desk-based research;
- a baseline and end-line survey of school staff;
- qualitative case-study research, including visits to schools and interviews with LA, LHB and voluntary sector services, such as Educational Psychology (EP), sCAMHS and school counselling services;
- engagement as a critical friend to pilot programme; and
- analysis of SHRN Data.

The impact of COVID-19

2.2 COVID-19 disrupted the planned evaluation activity and also radically changed the context for the pilot programme, in terms of needs (which may have changed), the feasibility of operations (such as the move to deliver online) and policy responses (with significant additional investment and activity in this area⁸). Understanding its impact upon the pilots and schools became an essential part of the evaluation.

Desk-based research

2.3 Desk-based research focused upon reviewing:

- pilot data and documentation, including the pilot programme's theory of change (figure 1.1, outlined in section 1) project plans and self-evaluation data, such as

⁸ The new policy context includes, for example, the additional investment in support for children and young people's mental health and well-being including the expansion of school counselling services, a new Welsh Government project which aims to provide an overview of the digital resources to support mental health and well-being available locally and nationally; and the development of training and resources by support services such as EP services.

each pilots' Red/Amber/Green (RAG) rating of schools' engagement with the pilot and feedback on training and engagement collected by each pilot⁹;

- research into pupil mental health and well-being, including that undertaken by PHW (most notably PHW, 2016), SHRN (such as Page et al., 2021; Hewitt et al., 2019); the NHS (such as NHS Collaborative, 2021; NHS Digital, 2018; Murphy and Fonagy, 2012); academic research focused upon the impacts of COVID-19 (e.g. Allwood and Bell, 2020; Holmes et al., 2020); and the literature around a whole-school approach to mental health and well-being (e.g. Weare, 2015);
- research into school staff and their well-being, including that commissioned by the Welsh Government and carried out by the EWC (2017); and
- research and evaluations of comparable projects, most notably the Mental Health Services and Schools Link Project in England (DfE, 2017).

Strengths and limitations of the desk-based research

- 2.4 Pilot data provided important additional information on delivery in each pilot area (e.g. on the type and take up of training and schools' engagement with the project) and also participant self-evaluation data.
- 2.5 The desk-based review of research provided important contextual data about the pilots and included all the key sources highlighted by stakeholders who contributed to the study. However, it was not based upon a systematic or comprehensive review of sources, and therefore risks being biased and/or incomplete.

Base and end-line survey of education staff

- 2.6 School staff in pilot areas were surveyed in order to measure:
- the base and end-line position in relation to school staff knowledge and skills, access to specialist services and experiences of stress when dealing with pupil mental health difficulties (which are all key outcomes for the pilot programme); and

⁹ Each pilot area developed its own approach to data collection. Although the evaluation team was invited to comment on proposals (and provided advice to each pilot area) it was not feasible to develop a uniform pilot wide approach to self-evaluation. This reflected factors such as the differences in approaches to both delivery of the pilot programme and also to self-evaluation in each area, and the time already invested in each areas' own approach to self-evaluation, by the time the evaluation started.

- school staff engagement with, and early experiences of, the pilot programme, such as their contact with CAMHS In-Reach practitioners and their participation in, and views on, the effectiveness of training delivered by the pilot programme.

2.7 The planned mid-line survey of education staff was abandoned due to the impact of COVID-19 and closure of schools, and the end-line survey was disrupted ([WG, 2020b](#)).

The questionnaire

2.8 The base and end-line surveys used an online self-completion questionnaire. The main areas covered by the questionnaire were:

- staff confidence in:
 - identifying pupil mental health and well-being needs;
 - discussing mental health and well-being needs of pupils with pupils and their parents or carers;
 - identifying when they (i.e. staff) need advice and support.
- schools' effectiveness in promoting:
 - pupil mental health and well-being; and
 - staff mental health and well-being.
- knowledge of, and access to, support within the school (e.g. from Special Educational Needs Co-ordinators (SENCOs) or Additional Learning Needs Co-ordinators (ALNCOs) and external services (e.g. sCAMHS).
- stakeholders' views on, and experiences of, the pilot including:
 - awareness of, and support from, the pilot; and
 - the impact of the pilot training upon staff knowledge and understanding.

2.9 In addition, given the pressure upon schools at the time the end-line questionnaire was deployed (given the impact of COVID-19) and at the request of schools, a whole-school questionnaire was developed. This covered the same areas as the main questionnaire, but could be answered by a single staff member, such as a school leader, on behalf of the school; for example, rather than asking if an individual staff member was confident that they could identify if a pupil might have a mental health difficulty, it asked the respondent if they were confident that staff in their school could identify that a pupil might have a mental health difficulty. The results of this are reported separately to the results from individual staff members.

Administration of the survey

- 2.10 The baseline survey was open for approximately three months from the end of March 2019 to the end of June 2019 and the end-line survey was open for approximately six weeks in January and February 2021. As a census survey, all schools, and all school staff (school leaders, SENCos/ALNCos, teachers and support staff) in those schools within the pilot areas of Ceredigion, Denbighshire and Wrexham, Blaenau Gwent, South Powys and Torfaen were invited to participate. An email invitation, which included a link to the online survey was sent by the evaluation team to all the schools. For the baseline survey, this was followed by two reminders sent to schools that had not responded, and around 40 schools which had not responded, were telephoned by the evaluation team in areas where the response rate was very low. This was supported by the Welsh Government's promotion of the survey on Hwb (the digital platform for learning and teaching in Wales) and contact with schools by pilot staff and partners, and by the evaluation team, during visits to schools. However, for the end-line survey, while one email reminder was sent and the survey was promoted by pilots, given the pressures upon schools, which were closed at the time of the survey, no further follow up was made.

Response rates

- 2.11 Table 2.1 shows that staff from around a third of primary schools and almost 60 per cent of secondary schools in the pilot area responded to the baseline survey. With the exception of South Powys, which is smaller than the other areas with just 11 primary schools, the response rates from primary schools were broadly similar for each LA. However, the response rates from secondary schools varied considerably between LAs. In total 352 staff completed baseline surveys.

Table 2.1. The number of pilot schools that responded to the baseline survey in each pilot area.

Area	Primary schools		Secondary / Middle schools	
	No. of schools Invited	No. of schools where staff responded	No. of schools invited	No. of schools where staff responded
North Wales	101	35	17	10
Mid and South Wales	55	19	13	9
West Wales	37	10	7	2
Total	193	64	37	21

Source: *People and Work, CAMHS In-Reach baseline survey, 2019*

2.12 The end-line survey was also opened to Pupil Referral Units (PRUs) and Special Schools in North Wales that had been engaged by the pilot. Table 2.2 shows that staff from around a quarter of primary schools and just less than half of secondary schools in the pilot area responded to the end-line survey. Response rates varied considerably between LAs and were low overall in Ceredigion.

Table 2.2. The number of staff in pilot schools and PRUs that responded to the end-line survey in each pilot area

	Primary schools		Secondary / middle schools		Special schools		PRU	
	Schools invited (No.)	Schools where staff responded (No.)	Schools invited (No.)	Schools where staff responded (No.)	Schools invited (No.)	Schools where staff responded (No.)	PRUs invited (No.)	PRUs where staff responded (No.)
North Wales	107	26	18	4	2	2	3	0
Mid and South Wales	55	20	12	11	0	0	0	0
West Wales	36	6	7	2	0	0	0	0
Total	198	52	37	17	2	2	3	0

Source: People and Work, CAMHS In-Reach end-line survey, 2020 (n=218)

2.13 In addition, as outlined in paragraph 2.9, 16 school leaders completed a whole-school questionnaire. This covered the same areas as the main questionnaire, but could be answered by a single staff member, such as a school leader, on behalf of the school.

Table 2.3. The number of staff in pilot schools that completed a whole-school end-line questionnaire in each pilot area

Area	Primary schools	Secondary schools	Special School
	No. of schools where staff responded	No. of schools where staff responded	No. of schools where staff responded
North Wales	9	2	1
Mid and South Wales	2	0	0
West Wales	1	1	0
Total	12	3	1

Source: *People and Work, CAMHS In-Reach end-line survey, 2021*

2.14 As table 2.4. illustrates, responses to both the individual and whole-school survey questionnaires were higher in North and South Wales. The differences in the pilot design in North Wales, discussed in section 4, most notably the decision not to pilot CAMHS In-Reach practitioners in schools until 2021, meant that, where relevant, results for Mid, South and West Wales were analysed separately. The weaker responses from West Wales limits the conclusions that can be drawn about the pilot in that area.

Table 2.4. Respondents to the end-line survey by pilot area – percentage of all respondents and/or number.

Area	Individual school staff		Whole-school responses
	(No.)	(%)	(No.)
North Wales	98	45	12
Mid and South Wales	105	48	2
West Wales	15	7	2
Total	218	100	16

Source: *People and Work, CAMHS In-Reach end-line survey 2020 (n=218)*

2.15 As table 2.5. illustrates, the response rate to the end-line survey from primary school staff was higher than that from secondary school staff. In part this reflects the larger number of primary schools in the pilot. However, it is also a weakness as there was less pilot activity in primary schools compared to secondary schools.

Table 2.5. The number and percentage of staff who responded to the end-line survey from primary, secondary and all age schools.

Schools	No.	%
Primary schools	171	78
Secondary / middle schools	40	17
Special schools or provision within primary	7	3
Total (all staff in the sample)	218	100

Source: *People and Work, CAMHS In-Reach end-line survey, 2020 (n=218)*

2.16 Table 2.6. shows that almost half of the staff who responded to the end-line survey had a role as a teacher and around a fifth had a school leader or support staff role. Around 10 per cent were part of the pastoral teams or were SENCo/ALNCo.

Table 2.6. The number and percentage of staff who responded to the end-line survey, according to their role

Because respondents could choose more than one option, totals add up to more than 100 per cent.

Staff role	No.	%
Support staff	89	41
Teacher	68	31
School leader	58	27
SENCo/ALNCo	28	13
Pastoral lead/team	23	11
Other	5	2

Source: *People and Work, CAMHS In-Reach end-line survey, 2020 (n=218)*

2.17 The total number of staff who responded to both the base (352 responses) and end-line surveys (218 individual responses; 16 whole-school responses) is only a very small fraction of the total education workforce in the pilot area; for example, approximately 3 per cent of the school workforce in Wrexham and Denbighshire and approximately 1 per cent of the workforce in Ceredigion completed the end-line questionnaire¹⁰.

¹⁰ There are 1,991 teachers and 2,350 support staff in Wrexham and Denbighshire and 585 teachers and 627 support staff in Ceredigion. Source: StatsWales (2019): [Teachers by local authority, region and category](#), and

Analysis of survey data

- 2.18 As well as responses to closed questions (such as: 'I know who to go to in the school if I need support for my own well-being' with pre-defined answer choices, in this case, yes / no / not sure) additional written comments were made by 63 staff members in the baseline survey and by 40 staff completing the individual and whole-school end-line surveys. The comments were categorised into themes¹¹ and were (i) used to help interpret the quantitative data (i.e. the responses to the closed questions) from the base and end-line questionnaires (by providing insight into why respondents chose particular responses to closed questions); and (ii) triangulated with the data generated through the qualitative research with schools, enabling data collected through different methods (i.e. questionnaires and interviews) to be compared.

Strengths and limitations of the surveys

- 2.19 Validity of responses to the survey appear good with, for example, consistency in responses to closed and open questions and, as outlined in sections 5 to 7, findings from the survey were consistent with findings from qualitative research with school staff. So, for example, staff responses about the value they placed upon support from CAMHS In-reach practitioners in the end-line questionnaire, were mirrored in staff responses to this in interviews. The scope to triangulate responses to the same issue by using data collected through different methods (i.e. a self-completion questionnaire and interviews) increases confidence in the credibility (or trustworthiness) and validity of findings (Bryman, 2012).
- 2.20 Responses were received from staff in around a third of schools in the baseline survey and a quarter of schools in the end-line survey, representing an acceptable rate, given the challenges associated with securing responses from school staff to self-completion questionnaires (for example, reliance upon schools to distribute links to individual staff) and the additional challenges created by disruption associated with COVID-19 (such as closure of schools). However, the rate of responses from all staff within schools (at between one to three per cent) was extremely low. Results from the sample in each school cannot be generalised with

[Support staff by local authority, region and category](#), Data for Mid and South Wales is not reported because the numbers of school staff in South Powys was difficult to identify.

¹¹ Themes were identified inductively (i.e. they emerged from the data), although inevitably the construction and identification of themes was informed by researchers' perspectives, conceptual frameworks and the research questions (so there was a degree of deduction).

confidence to the whole population of school staff. The modest total number of responses also means that the size of some sub-groups is small, and it is therefore not possible to make comparisons between responses from different groups (such as teachers and pastoral staff) with confidence, unless data from the survey is triangulated with other data.

- 2.21 The disruption caused by COVID-19 coupled with the decision to anonymise the survey and make it open to all staff groups, and the difficulties respondents had recalling if they had completed the baseline survey or not when completing the end-line survey, meant that it was not possible to directly compare responses from the base and end-line surveys as planned. This meant it was not possible to measure change over time.
- 2.22 A technical problem¹² with the architecture of the end-line questionnaire also meant that the number of staff completing a question on the value and impact of staff training on staff mental health and well-being (n=35), was lower than the numbers completing the questionnaire, who had received this training (estimated to be up to around 60 respondents).

Qualitative case study research

- 2.23 Qualitative case studies (referred to as 'qualitative research' in the report) focused upon exploring the baseline position and early engagement with, and experiences of, the pilots, with case study 'sites' a sample of schools and LA, LHB and voluntary sector services working with those schools to support pupil mental health and well-being. The first round of case study research was undertaken in summer and early autumn 2019, and it was planned that they would be updated by two return visits in 2020, enabling change over time to be explored. Following the extension of the pilot in 2020, the final end-line visits were rescheduled to 2021.

Site selection

- 2.24 The criteria for selecting case studies aimed to ensure the sample of case study schools covered different types of schools across the three pilot areas, and also

¹² Those making additional written comments about training in the English language questionnaire were misdirected, and only asked about the views of the impact of training focused upon pupils' mental health and well-being, rather than being asked about their views of the impact of training focused upon pupils' mental health and well-being *and* the impact of training focused upon staff mental health and well-being.

enabled a focus upon school clusters (and a focus upon primary and secondary or all age schools). The criteria for selecting sites were:

- at least one school cluster in each LA (i.e. Blaenau Gwent, Ceredigion, Denbighshire, Powys, Torfaen and Wrexham);
- a mix of school clusters in rural and urban areas across the three pilot areas;
- a mix of English and Welsh medium schools across the three pilot areas;
- a mix of school clusters serving areas of high and low socio-economic deprivation within each pilot area; and
- willingness of the secondary school and a sample of its cluster primary schools to commit to the longitudinal study.

2.25 The first criterion (willingness to take part) introduced a degree of selection bias toward schools that are likely to be more interested and engaged in the pilot, but this was regarded as unavoidable, as participation in the case studies element of the evaluation is voluntary. The selection criteria were shared and discussed with each pilot area, who then helped identified potential schools that might fit the criteria. Schools were then approached by the evaluation team who explained the evaluation and invited schools to take part (as noted above, participation was voluntary).

2.26 Schools were visited for the baseline fieldwork and semi-structured interviews were undertaken with individual staff or, in some cases, small groups of staff identified by schools which had agreed to take part in the evaluation. The interviews focused upon a number of key areas, including:

- the school's engagement with the CAMHS In-Reach pilot programme (including the support taken up by the school and the school's motivations for engaging with the pilot programme);
- the mental health and well-being of pupils and staff in the school (including the factors felt to contribute to pupil and staff mental health and well-being and change in this over time, which became particularly relevant during the COVID-19 pandemic);
- the interviewee's judgments on levels of staff skill and confidence in relation to pupil mental health and well-being; the school's access to specialist advice, liaison and consultancy; and support for staff mental health and well-being

(including the factors felt to contribute to these, such as the difference the support offered by the pilot programme was felt to have made); and

- the interviewee's judgments on the implementation of the pilot programme; how well it complemented other initiatives and services focused upon pupil and/or staff mental health and well-being; and suggestions on how the pilot programme could be developed or improved.

2.27 Given the restrictions on social contact (due to COVID-19) some of the interviews for the mid-line research and all of the interviews for the end-line fieldwork were done via Microsoft Teams or telephone. During the first (baseline) round of fieldwork, the 21 schools were asked if they would be willing to be re-contacted to discuss a second visit in early 2020. All the schools agreed to this. Unfortunately, as outlined below, the second (mid-line) and third (end-line) rounds of fieldwork were disrupted by the impact of the COVID-19 pandemic, reducing both the numbers of schools and numbers of staff within schools able to take part in the evaluation. In total, 42 school staff (including school leaders, schoolteachers and pastoral staff) were interviewed during the baseline research; 15 school staff were interviewed during the mid-line research; and 17 school staff were interviewed during the end-line research.

Mid-line research

2.28 The fieldwork in North Wales was largely completed before the closure of schools in response to the COVID-19 pandemic in March 2020, with only one school unable to take part. However, the closures seriously disrupted fieldwork in West, Mid and South Wales. Contact was made with staff involved in the first round of fieldwork, where possible, before schools closed, but planned visits were either cancelled or put indefinitely on hold. In order to minimise pressure upon schools during a very difficult period, and at the request of the Welsh Government, fieldwork was put on hold in mid-March. Once schools had time to adjust, with the agreement of the Welsh Government, school staff in West, Mid and South Wales were re-contacted by email and/or phone in April to ask if they would be willing to be re-interviewed by phone. Not all responded, and in several cases, interviews that had been rearranged were called off.

2.29 As the impact of COVID-19 was judged unprecedented and uncertain, when fieldwork restarted in late April and May, the opportunity was taken to ask schools

and services in West, Mid and South Wales additional questions about the impact of COVID-19. The questions focused upon three key areas: the impact of COVID-19 upon the school and its pupils, on the CAMHS In-Reach programme, and on other services. This included exploring the extent to which the programme meant schools were better prepared for the impact of COVID-19 and the implications for the programme when schools increased their operations.

End-line research

2.30 An expansion of the qualitative research with schools and services was planned for the end-line research by adding a school cluster, comprising one secondary school and one primary school in:

- North Wales, where the consultation model was being trialled;
- Mid and South Wales, an area hard hit by COVID-19; and
- Ceredigion, where the pilot planned to extend its work with primary schools.

2.31 However, the lockdown in winter 2020/2021 disrupted the final round of fieldwork with schools (including plans to increase the number of schools). Table 2.7 provides a breakdown of school by type and by pilot area in each of the three rounds of research.

Table 2.7. Case study schools by pilot area and LA.

Local Authority	Primary schools	Primary schools	Primary schools	Secondary / all age schools	Secondary / all age schools	Secondary / all age schools
	Baseline	Mid-line	End-line	Baseline	Mid-line	End-line
Ceredigion	2	0	1	2	1	1
South Powys	2	1	1	2	0	1
Blaenau Gwent	1	1	2	1	1	1
Torfaen	2	1	2	2	1	1
Denbighshire	2	2	2	2	2	1
Wrexham	1	2	1	2	1	1
	10	7	9	11	6	6

Interviews with services

2.32 Key services working with schools to support pupil mental health were identified through interviews with schools and, as table 2.8. outlines, interviews were

conducted with 15 staff from a range of services across the three pilot areas in the baseline work, with the intention that the research team would talk to them again in the mid and end-line phases of research. The interviews focused upon a number of key areas including:

- how children and young people accessed the service, the type of mental health difficulties children and young people accessing the service presented and any change in the numbers and/or needs of children and young people accessing their service;
- the factors felt to contribute to pupil and staff mental health and well-being, such as changes in society and/or in policy and practice, and how (and why) pupil and staff mental health and well-being was changing over time;
- the interviewee's judgments on levels of school staff's skills and confidence in relation to pupil mental health and well-being; schools' access to specialist advice, liaison and consultancy, and support for staff mental health and well-being (including the factors felt to contribute to these, such as the difference the support offered by the pilot programme was felt to have made); and
- the interviewee's judgments on the implementation of the pilot programme; how well it complemented other initiatives and services focused upon pupils' and/or staff mental health and well-being; and suggestions on how the pilot programme could be developed or improved.

2.33 As with schools, the mid-line interviews with services in North Wales were largely completed before the lockdown and disruption caused by COVID-19, but the crisis seriously disrupted the mid-line fieldwork in Mid and South Wales. As with schools, all fieldwork with services was put on hold in March 2020. Once services had time to adjust, and with the agreement of the Welsh Government, services in West and Mid and South Wales were contacted in April and May to ask if they would be willing to be re-interviewed by telephone or Microsoft Teams. As table 2.8 outlines, interviews were conducted with six staff from six services in North and West Wales, but no services in Mid and South Wales responded or chose to take part.

2.34 The end-line research was less disrupted by COVID-19 and additional interviews were conducted by telephone or Microsoft Teams, with services such as sCAMHS, Education Welfare Services (EWS) and EP services in the pilot areas. In total, 21 staff from services were interviewed during the end-line fieldwork.

Table 2.8. Services interviewed by pilot area.

Pilot area	Services included in the study	Base	Mid	End-line
West Wales	The Educational Psychology Service	✓	✓	✓
	The School Counselling Service (Area 43)	✓	✓	✓
	The Youth Service	✓		
Mid & South Wales	The Educational Psychology Service	✓		✓
	The Education Welfare Service	✓		✓
	Primary Mental Health Service	✓		✓
	The School Nursing Service	✓		✓
	Specialist CAMHS	✓		✓
	The Youth Service.	✓		✓
North Wales	Action for Children	✓		
	The CAMHS Early Intervention Service	✓	✓	✓
	The Education Service			✓
	The Educational Psychology Service	✓	✓	✓
	The School Counselling Service.	✓	✓	✓
	Specialist Youth Work Service	✓	✓	✓
	Specialist CAMHS			✓
	Child Psychology			✓
WNHSS			✓	

Strengths and weakness of the qualitative case studies

2.35 The qualitative research with schools and services provided important opportunities to explore questions in depth, enriching the evaluation teams' understanding of issues, and enabled triangulation of survey data. In particular, it enabled the interplay between the changing context for the pilot programme, the pilot intervention and the response of school staff to this, and the observed outcomes, such as changes in staff skills and confidence, to be explored. However, the sample was relatively small, and while intended to be as representative as possible (including, for example, a mix of different types of schools in rural and urban areas from across the pilot LAs) is likely to be biased toward schools that were more

engaged with the pilot programme. Engagement with schools in West Wales also declined during the mid and end-line phases.

Engagement with the pilot programme as a critical friend

- 2.36 Throughout the evaluation, the evaluation team worked with the pilot programme's National Co-ordinator and each of the pilots as critical friend, for example, attending and contributing to national and local pilot steering group meetings, and discussing emerging issues and themes in more informal meetings with individual pilot staff. This aided the pilots' engagement with the evaluation; enriched the evaluation team's understanding of the pilot programme (e.g. by providing opportunities to observe which issues each pilot's steering group focused upon); and helped enable emerging findings to be fed back and discussed with the national team (at PHW) and each of the pilots. These more informal discussions have been complemented by interviews during the base, mid and end-line fieldwork with the CAMHS In-Reach Practitioners; the National Co-ordinator; and other stakeholders in the Welsh Government, including staff within the Mental Health Policy Team.
- 2.37 In late 2020, a series of three cross-pilot workshops was organised. This created opportunities for the pilots to share practice and explore commonalities and differences, and also the perceived strengths and limitations in the approaches taken to training and to the advice and consultancy models developed by each pilot area. Sessions within the workshops were led by the evaluation team. This provided opportunities to test and develop the evaluation' team's emerging thinking about the different models' strengths and weakness and also to further explore questions of interest to the evaluation with pilot staff.

Analysis of SHRN data

- 2.38 The research undertaken by People and Work was complemented by a statistical analysis of SHRN data undertaken by DECIPHer. This aimed to identify if there was any impact upon the responses of pupils (in the Student Health and Well-being Survey (SHWS)) and schools (in the School Environment Questionnaire (SEQ)) to questions around their perception of support, comparing pupils and staff in pilot and non-pilot schools.

The Student Health and Well-being Survey

- 2.39 The SHWS is an online self-completion survey. Undertaken every two years it provides a snapshot of 11 to 16 year olds' health behaviours. It measures self-reported health behaviours and well-being outcomes among young people aged 11-16 years and incorporates the Welsh Health Behaviour of School Age Children (HBSC) survey (SHRN, 2019).
- 2.40 The survey includes questions about students' feelings about their schools' support and understanding, which are relevant to the pilot outcomes. In particular, the 2017/18 and 2019/2020 survey rounds included the following.:
- 'Here are some statements about your teachers. Please show how much you agree or disagree with each one:
- ... There is at least one teacher or other member of staff at this school who I can talk to about things that worry me'.
- and
- 'How much do you agree with the following statements?
- ... There is support at my school for students who feel unhappy, worried or unable to cope'.
- 2.41 Each question offered the following responses: Strongly agree, Agree, Neither agree nor disagree, Disagree, Strongly disagree and I do not want to answer.
- 2.42 In order to estimate the extent to which any observed changes in these outcomes could be attributed to the pilot, a 'difference in difference' design, comparing changes between the 2017/18 and the 2019/20 survey in pilots (treatment) and non-pilot (comparison group) schools was developed. This design is based upon the assumption that in the absence of the intervention (i.e. the pilot), any differences in outcomes between the two groups, such as changes in the proportion of pupils who felt unhappy, worried or unable to cope, and changes in the proportion of pupils reporting their perceptions of access to support, would be constant over time. Therefore, any differences in the changes observed over time in the outcome variables, between the treatment and the comparison group, could be attributed to the intervention (i.e. the pilot).

The School Environment Questionnaire

2.43 The student questionnaire is accompanied by the School Environment Questionnaire (SEQ), which focuses upon the relationships between school policies and practices and student health (SHRN, 2021). There is one questionnaire for each school in the SHRN and the questionnaire is either completed by a member of the senior management team or reviewed by a member of the senior management team before the questionnaire is submitted. The SEQ includes a number of questions about access to sCAMHS and also other specialist services, such as EP services. Questions of interest include:

‘Do you have a named person within your local Child and Adolescent Mental Health Service (CAMHS) who you can contact for help and support?’

‘In the last two years, approximately how often has your school been in communication with your local CAMHS?’

‘How is communication achieved?’

‘If you made any referrals, did the student(s) get access to treatment?’

‘To what extent do you feel supported by your local CAMHS?’

2.44 A cross-sectional rather than longitudinal analysis was judged more appropriate for the SEQ, as it relied upon subjective data provided by one staff member in each school. The analysis compared responses to these questions from pilot and non-pilot schools in the 2019/20 survey.

Strengths and weakness of the analysis of SHRN data

2.45 The analysis of SHWS and SEQ data provided a valuable opportunity to explore if the pilot had made a measurable impact upon pupils’ and schools’ perceptions of support. It was therefore a potentially valuable complement to the process evaluation data outlined above. However, the scope to measure impact was constrained by:

- the available outcome measures (i.e. pupils’ perceptions of support and schools’ perception of support from sCAMHS). The chosen measures (outlined above) could be expected to change if the pilot was having an impact, but were neither comprehensive measures of the range of outcomes anticipated, nor particularly precise measures of the type of outcomes anticipated, were the pilot programme effective (illustrated by the pilot’s theory of change – figure 1.1); and

- concerns that the effect of the pilot programme might not be sufficiently large to be distinguished from expected 'noise' in the data, created by, for example, the number of different policy interventions active during the period studied (and highlighted in section 1).

3. Pupil and staff mental health and well-being

Schools (pre-pandemic) perceptions of pupil mental health and well-being

- 3.1 As part of the qualitative research, schools were asked to describe the types of mental health difficulties that their pupils experienced. Before the pandemic, staff in both primary and secondary schools described increasing rates of mental health difficulties. This was attributed to:
- increasing awareness and understanding of mental health difficulties; for example, as a deputy head in one secondary school described it: ‘It feels that there is a lot more talk about mental health now’ and that pupils have ‘the terminology to talk about anxiety’ and that ‘there probably was anxiety before, but it wasn’t talked about’;
 - social changes, including:
 - the perceived negative impacts of social media and the internet; for example, as one school described it: ‘Social networks and platforms can be a real problem with a lot of sites around self-harm, suicide, sex and grooming’;
 - increased awareness of the impacts of Adverse Childhood Experiences (ACEs), such as family breakdown, domestic abuse, drug or alcohol misuse and/or parents’ own poor mental health; and
 - to a lesser extent, increased recognition of neurodevelopmental disorders such as Autism Spectrum Disorder (ASD) or Attention Deficit Hyperactivity Disorder (ADHD); for example, as one service described it: ‘ASD linked to anxiety is very common’.
- 3.2 The rise was therefore thought to reflect both an increase in mental ill health (and, to lesser extent, neurodevelopmental disorders) and greater recognition of previously hidden or misunderstood difficulties¹³; as one interviewee summed it up: ‘It is both that we talk more about mental health these days - we give sadness another name - and there are more problems’.
- 3.3 Some interviewees were unclear about what was driving the increase: ‘Is it because kids are more comfortable talking about it or because there is an increase in these problems?’

¹³ Similarly, the increase in neurodevelopmental disorders is believed to have been driven by both an increase in such disorders and increasing awareness and recognition of disorders.

- 3.4 This touches upon a wider concern amongst some interviewees that normal childhood experiences, such as sadness and stress, were being medicalised. As a school welfare officer described it: 'Children say that they have mental health difficulties, but they don't know what they are saying, they say that they have mental health issues when actually they are sad'.
- 3.5 Both primary and secondary schools reported that they were struggling to meet increasing need because resources had been cut and that the focus upon other priorities, like raising standards, had drawn time and attention away from well-being. The emphasis upon well-being provided by the pilot programme and the new curriculum, and the (then) forthcoming guidance on a Whole-School Approach to Mental Health and Well-being was therefore welcomed.

Primary school pupils

- 3.6 Before the COVID-19 pandemic, primary school staff described the earlier onset, and also increasing severity, of pupil mental health difficulties. As one teacher described it: 'Ten years ago, working in primary, we weren't used to dealing with these sorts of issues' and, as a head teacher explained: 'We see self-harm, eating disorders, several boys have issues with their weight, don't take their jumper off when it's warm. Anxiety, presenting with depression, but not clinically diagnosed yet'.
- 3.7 Anxiety was a key concern. As one head teacher described it (expressing a commonly held view): 'We see that it is anxiety that is the biggest issue for our pupils and often they are anxious because their parents are anxious. We see pupils here who often know too much about what's going on at home'.
- 3.8 The emphasis upon the impact of ACEs, like family break up, neglect, domestic abuse or drug abuse, was also a common theme. This may reflect both increasing awareness of ACEs (increasing awareness was widely reported by schools) and the greater knowledge that primary school staff may have of children's home lives, compared to secondary schools.
- 3.9 A number of schools linked ACEs to attachment (as ACEs could undermine emotional bonds between children and their parents), and as one SENCo explained: 'Attachment issues are the biggest area of concern in the school'. More broadly, as one pastoral staff member (in a secondary school) commented: 'Often it

is just lack of emotional support – children who go home and there is no one there...parents who are doing their best but they cannot do everything’.

Secondary school pupils

- 3.10 Before the COVID-19 pandemic, as in primary schools, secondary school staff described the increasing severity of pupils’ mental health difficulties. As staff in one school reported: ‘Anxiety, depression, self-harm, suicidal thoughts/actions, eating disorders are on the rise’ for both boys and girls. As in primary schools, anxiety was a key concern as a pastoral lead explained: ‘Anxiety is a massive issue in the school’. Self-harm was also frequently mentioned, and in one school and by one service, described as feeling like an ‘epidemic’. This was a much greater concern for secondary schools than it was for primary schools. Several secondary schools also discussed the impact of suicides upon the school whilst others (which had not experienced it themselves) described their fears and concerns about the risk of suicide.
- 3.11 Some schools described, as one primary school deputy head put it: ‘Trying to help pupils and families understand what is normal’, describing how it is normal to worry about exams, but also to understand and recognise what goes beyond normal. This was linked to pupils’ resilience (pupils’ ability to cope with adversity) and concerns that pupils’ resilience was declining and normal childhood experiences, such as sadness, were being medicalised.
- 3.12 The perceived negative impact of social media upon pupil mental health and well-being was a much greater concern for secondary schools than it was for primary schools, presumably partly because social media use increases with age. It is worth noting that the research evidence of the impact of social media upon mental health is somewhat equivocal; for example, Welsh Government research examining the findings of the Millennium Cohort Study found that: ‘Children who were very heavy social media users did have higher depressive symptoms and lower life satisfaction’. However, it also noted that: ‘Directions of causality are unclear; for example, depressed children may turn to social media. Very heavy social media use may indeed harm children and young people, but it is much less clear that moderate use has ill-effects and it may also have benefits’ (WG, 2019b, p.5, p.26).
- 3.13 Some schools highlighted pressure to succeed, particularly for ‘high-flyer’ young people who put themselves under pressure to succeed, and the period around

exam time was described by some schools as particularly worrying. Secondary schools also talked about the impact of ACEs, such as family breakdown, although to a lesser extent than primary schools.

Services' experiences

- 3.14 Services' descriptions of pupil mental health difficulties during the first round of fieldwork (pre-pandemic) were similar. As an educational psychologist described it: 'We see different manifestations of anxiety at the core. We're also seeing an increase in the number of young people who self-harm and at a younger age'. As expected, more specialist services (with higher thresholds of need before children and young people could access them), described seeing children and young people with more severe and complex mental health difficulties than schools. Services and, in one or two cases schools, also identified mental health difficulties linked to pupil gender identities.

Evidence from school counselling services

- 3.15 Data collected by school counselling services supports this. As table 3.1. illustrates, the most common presenting issues have consistently related to family, anxiety and stress ([WG, 2020a, p.14](#)).

Table 3.1. Independent counselling services data for Wales: the main presenting issues upon referral for the academic year 2018-19 (the number of referrals where this is the main presenting issue and each main presenting issue as a percentage of all presenting issues)

Main presenting issue	No. of referrals where this is the main presenting issue*	Rate at which this the main presenting issue (%)
Family	3,630	18
Anxiety	3,429	17
Anger	1,821	9
Stress	1,413	7
Self-worth	1,203	6
Relationships other	1,113	5
Behaviour related	1,107	5
Depression	1,095	5
Bereavement	1,038	5
Self-harm	861	4
Bullying	696	3
Academic	549	3
Suicide	378	2
Sexual (including orientation)	285	1
Abuse (including sexual)	258	1
Relationship with boyfriend/girlfriend	219	1
Illness	216	1
Relationships with teachers	189	1
Domestic abuse	126	1
Eating disorders	123	1
Substance misuse	117	1
Caring responsibility	99	0
Not Known	96	0
Transgender issues	78	0
Cyber safety (including cyber-bullying and sexting)	36	0
Financial concerns/poverty	27	0
Offending	9	0
Other	288	1

* Local authorities can record up to three presenting issues per child or young person.

Source: WG, 2020a, p.14

Research to assess the impact of the COVID-19 pandemic upon children and young people

3.16 The impact of COVID-19 upon schools, services and pupils was unprecedented and is not yet fully understood. As a position paper outlining priorities for research during the first lockdown identified, the pandemic and policy responses like lockdown, social distancing and school closures, are likely to be associated with ‘worries and uncertainties’, an increased exposure to loneliness and isolation and ‘a sense of loss’, including the loss of face-to-face social contact, people’s livelihoods, freedoms, educational and leisure opportunities and support (Holmes et al., 2020, p.551). The paper concludes with the forecast that:

‘A rise in symptoms of anxiety and coping responses to stress are expected [and] during these extraordinary circumstances, there is a risk that prevalence of clinically relevant numbers of people with anxiety, depression, and engaging in harmful behaviours (such as suicide and self-harm) will increase’ (p. 548).

3.17 Looking specifically at children and young people, the review notes that:

‘The pandemic intersects with rising mental health issues in childhood and adolescence.... Ascertaining and mitigating the effects of school closures for youth seeking care is urgent and essential, given that school is often the first place children and adolescents seek help’.

It identifies that:

‘Children, young people, and families will be affected by school closures. They might also be affected by exposure to substance misuse, gambling, domestic violence and child maltreatment, absence of free school meals, accommodation issues and overcrowding, parental employment, and change and disruption of social networks’.

3.18 It also identifies that those people (including pupils) with ‘existing mental health issues’, may experience a ‘loss of access to mental health support, alongside loss of positive activities [which] might increase [their] vulnerability during COVID-19 lockdown’. Similar concerns are raised about other groups of pupils, such as those with neurodevelopmental disorders like autism, who ‘might be affected by changes and disruption to support and routines, isolation, and loneliness’.

3.19 Research conducted in the UK during the pandemic concludes that the impact of the pandemic’s disruption of education and restrictions on social interaction on

children and young people is not yet clear. However, the available evidence suggests an uneven or unequal impact with much greater, typically negative, impact upon some groups of children and young people, such as those with pre-existing conditions and those living in more socio-economically disadvantaged households (Holmes et al., 2020; NHS Benchmarking, 2020). Having reviewed the evidence, Allwood and Bell (2020) conclude that:

‘The Covid-19 crisis intensifies the level of risk, the precariousness of maintaining good mental health, and the difficulties accessing the right support at the right time’.

and that:

‘Unmet mental health needs in childhood can cast long shadows for years to come, and COVID-19 may widen inequalities for the most deprived and most vulnerable’.

- 3.20 This negative, but also uneven, impact upon children and young people’s mental health is also identified by the Co-Space study (Skripkauskaite et al., 2021). Based upon a UK sample of 8,225 participants¹⁴, albeit a non-representative self-selecting sample, the study identified increases in school aged (4-16) children’s mental health difficulties¹⁵ associated with each lockdown..
- 3.21 The study also identifies that: ‘Children with SEN [special educational needs] /ND [neuro development differences] and those from low-income or single adult households have continued to show elevated mental health symptoms throughout the pandemic, with higher levels of behavioural, emotional, and restless/attentional difficulties’ (Skripkauskaite et al., 2021, p.6).

¹⁴ The study draws upon data provided by parents/carers who completed the baseline and follow-up questionnaires. The sample is not representative, both because participants are self-selecting, and because those that completed the follow-up are different in some important ways to those that did not. Parents/carers and their children were typically from high-income, white British households, and parents/carers were typically working full- or part-time.

¹⁵ Behavioural difficulties (conduct problems subscale): items relate to the child doing what they are asked, having tantrums, fighting, lying or stealing things (e.g. whether the child ‘often lies, or cheats’, or is ‘generally obedient, usually does what adults request’); • Emotional difficulties(emotional symptoms subscale): items relate to the child being worried, afraid, unhappy, clingy and having physical symptoms of anxiety (e.g. whether the child is ‘often unhappy, down-hearted or tearful’, or has ‘many worries, often seems worried’); • restless/attentional difficulties (hyperactivity/inattention subscale): items relate to the child being restless, fidgety, distractible, impulsive and having a good attention span (e.g. whether the child ‘sees tasks through to the end, good attention span’, or is ‘restless, overactive, cannot stay still for long’).

Schools' perceptions of the impact of the pandemic upon pupil mental health and wellbeing

- 3.22 The picture schools provided of pupil mental health and well-being during the first and second lockdowns was mixed. A number of secondary schools, primary schools and services (such as school counselling services, sCAMHS and EP services) across all three pilot areas reported that mental health difficulties, particularly more severe problems like self-harming, were increasing and anxiety was a key concern. As one primary school head teacher put it: 'Anxiety is still the biggest issue. Pupils are often anxious because their parents are anxious'. Others, interviewed early in the lockdown, were unsure what the impact would be.
- 3.23 Keeping in touch with vulnerable pupils was a key concern for schools and staff during the first lockdown, with only a small proportion of vulnerable pupils¹⁶ attending schools during the first lockdown (WG, 2020b)¹⁷. Schools described strategies to contact vulnerable pupils regularly but also the frustration of sometimes not being able to talk to the pupil (for example because a parent answers the phone) or see a pupil when they visit a house. One education welfare officer described being turned away by a parent saying they had COVID-19 and being unable to challenge this.
- 3.24 The picture schools provided of children and young people's mental health and well-being during the third round of fieldwork (conducted in the second national lockdown) was somewhat clearer. School staff reported many pupils coped better than expected with the first lockdown as being at home took away the stresses associated with school. However, most were described as happy to see friends if/when they briefly returned to school in the summer of 2020 and autumn of 2020. However, other pupils struggled; these included:
- those pupils for whom school offered a 'safe' space and respite from difficult home lives – as one primary school teacher put it: 'School's their safe space, they can talk to teachers, to their peers, for them it's been really difficult and has had an impact on their mental health'; and

¹⁶ Vulnerable pupils are defined as 'children with a social worker or with Statements of special educational need' (WG, 2020c).

¹⁷ Although the numbers have been steadily increasing since March 2020, during the week of 8 June to 12 June, on average, only around 6 per cent of vulnerable pupils attended educational settings (WG, 2020c).

- those who had struggled with the constraints on movement and social isolation and/or whose anxiety increased during the pandemic.

- 3.25 As one pastoral lead in a secondary school summed it up: 'I would say that a lot of the kids, say 50 percent are quite enjoying the current situation as the pressure is off and they are comfortable at home. But other kids are having a pretty tough time'.
- 3.26 The concern for schools and services was what would happen when those pupils who found lockdown a welcome respite from school returned (as expected) to school in spring 2021. Particularly as they would be returning to a very different school environment (after being out of school for so long and the ways schools had changed to be 'COVID safe'), as a primary school leader put it: 'Those who are okay now at home may really struggle when they return to school'.
- 3.27 Schools also reported concerns about how pupil mental health difficulties would manifest themselves; for example, one primary school teacher said: 'Some kids have not got the language to express their feelings' so they express it 'through their behaviour'. As noted, the Co-Space study identified an increase in behavioural difficulties, such as tantrums, fighting or lying, and also restlessness and attentional difficulties, which could cause problems and disruption in classrooms. Similarly, CAMHS In-Reach practitioners reported anecdotal evidence from schools of an increase in behavioural concerns amongst some foundation phase pupils who returned to school in late February 2021. This was creating concerns about what would happen when older pupils returned.
- 3.28 As in the first lockdown, increases in anxiety were a key concern for both schools and specialist services like sCAMHS; for example, as a secondary school leader put it:
- 'Definitely since COVID-19, anxiety amongst pupils has increased. There's anxiety about the COVID itself, anxiety on the impact on school and schoolwork and their individual progress, anxiety about the impact of COVID on their lives outside, their family, their friends. No doubt, there's an increase in emotional issues amongst pupils generally'.
- 3.29 As well as increases in anxiety, specialist services also reported seeing increases in depression and eating disorders; for example, as an educational psychologist put it:

‘We don’t have all the data yet. There is an increase in anxiety-related behaviour, the physical reactions to anxiety such as hair loss. There appears to be more eating disorders amongst girls, bright, high-achieving girls. When things are out of control, controlling eating is one way we can maintain a sense of control when we have lost our routines, our safety, the regularity of our lives. We will find out more about this when we talk to staff’.

3.30 This is consistent with evidence reviewed by the NHS Benchmarking (2020) which concludes that: ‘A 30-60% increase in CAMHS demand seems sensible [to plan for] based on the limited evidence available’.

3.31 There were also concerns amongst schools and services interviewed for the study that there might be long term effects, with some pupils might have suffered ‘trauma’ as a result of, for example, bereavement or difficulties in the family; as one interviewee from an education service put it:

‘We know the mental health needs of young people are increasing/changing as a result of COVID. Anxiety, parental separation, issues around COVID compliance, going on-line increases screen time and can exacerbate other behaviours such as gambling, bullying, issues around social media, child sexual exploitation, adding to it all. We won’t know the full impact of COVID for years to come, how it impacts on long-term behaviour and mental health’.

Staff mental health and well-being

3.32 Poor staff mental health and well-being was a significant concern in each round of the fieldwork. A number of schools described steps taken to address staff well-being, often focused upon showing care and kindness to each other. One primary school head teacher described how: ‘We were quite good at looking after each other– Friday Fairy, bringing in treats, staff evening discussion session, exercising together, a social once a month, just holding someone in your thoughts, eating together, laughing together’.

3.33 However, others said that staff well-being had not been a priority for schools before the pilot and the pandemic.

3.34 The qualitative research with schools illustrated how the effects of both the pandemic and the pilot have shone a spotlight on the problem of poor staff mental health and well-being; as one pastoral leader in a secondary described it: ‘Staff

definitely have more awareness of mental health and this is definitely having a positive impact allowing people to talk about it more, to smile more’.

3.35 Before the pandemic, the key factors reported by schools to have a negative impact upon staff wellbeing were:

- workload, and as one school leader expressed it: ‘I would say workload is the main cause of stress’ and as a secondary school teacher commented: ‘The demands of the teaching profession are great, there’s a lot to do in little time’;
- inspection and accountability regimes, sometimes seen as an unfair ‘shame and blame’ culture;
- budgetary cuts and pressures. As one pastoral leader in a secondary school described it: ‘Budgets are a massive stress on staff in schools’. Several schools were planning or consulting on redundancies when interviewed¹⁸; and
- school reforms, such as the Additional Learning Needs (ALN) Transformation Programme (WG, 2018) and the New Curriculum for Wales (WG, 2017), which were welcomed, but seen as increasing demands upon school and staff time, attention and resources.

3.36 Qualitative research with schools also identified that (pre-pandemic) some school staff felt that the pressures associated with the job were increasing. The impacts upon individuals and the school were described as serious. As a secondary school head teacher explained: ‘One teacher is going on long term sick for the third time for stress, and others have also struggled’. As another interviewee described it, dealing with pupil mental health difficulties and their workload was: ‘Very stressful. [It] makes work life balance very difficult, it’s hard to switch off, overwhelming, very isolating [it’s a] massive burden on our own mental health’.

3.37 As the responses of these interviewees and the comments from a secondary school SENCo (below) illustrate, a lack of confidence (in relation to addressing pupil mental

¹⁸ For example, as a leader in an all-age school said: ‘Staff well-being is high on my agenda for when we all come back [the interview took place after lockdown]. We are a “red” school and there is a lot of re-structuring happening which is very stressful for staff’. Similarly, a primary school head commented: ‘We’re facing a reduction in the budget next academic year... the risk is that I have to make a decision to cut the two posts that deliver the nurture programme. The loss to pupils and parents will be massive...it’s not an exaggeration to say that we will struggle to meet the needs of our children. ... It does keep me awake at night and is detrimental to my well-being’.

health difficulties) and problems accessing services, were also having a negative impact upon staff stress and well-being:

‘Teaching is hard enough, but there are many days when I feel like an unqualified social worker. We’re not qualified to make decisions around mental health and we have to accept what the pupils tell us. We’re not qualified to do anything else. We make referrals to CAMHS, pupils don’t always meet their thresholds and we have to do an emergency plan with the parent. We’re fortunate we have the suicide and self-harm pathway here’.

3.38 The impact of this upon staff was succinctly summed by a primary school ALNCo: ‘When children are in distress it is distressing for staff to deal with’.

3.39 However, issues linked to confidence in dealing with mental health and well-being and accessing services (which the pilot programme aims to address) did not appear to be as significant as factors such as workload and budget cuts (which are not addressed by the pilot programme), as the drivers of staff stress and ill-being.

The impact of COVID-19 upon school staff mental health and well-being

3.40 The pandemic has had a marked negative effect upon the mental health and well-being of the UK population. The most common issues affecting well-being during the first national lockdown were worries about the future, feeling stressed or anxious and/or feeling bored (Marshall and Bibby, 2020). The negative impacts upon people’s mental health were driven by a range of factors including social isolation, fears about and/or the loss of employment and/or income, fears about the impact upon people’s own health and/or their family’s health, restrictions upon people’s coping mechanisms such as socialising and exercise, and restrictions upon access to mental health services (Marshall and Bibby, 2020; NHS Benchmarking, 2020).

3.41 School staff may have been more insulated from some of the negative effects of the pandemic given, for example, their job security, but may also have felt more exposed when working in schools, compared to those who could work from home. It is therefore reasonable to expect negative impacts upon school staff mental health and well-being. While mental health improved after the end of the first lockdown for most groups, it remained below pre-pandemic levels, and some groups, such as those with underlying health conditions, continued to experience an increase in anxiety (Marshall and Bibby, 2020).

School staff experiences of the first lockdown

- 3.42 The accelerating speed of the crisis in early 2020 was a challenge, as it gave schools and services little time to prepare. As one primary school leader described it, during the first lockdown: 'The change was so sudden it was almost impossible for staff to react'. School staff have also had to cope with a massive change in their working practice in a very short space of time. Continued uncertainty about the timing and process for a phased return of all pupils to schools was also a cause for concern.
- 3.43 The crisis had negative impacts upon staff well-being. One primary school leader reported that there was a lot of pressure on staff because the school was asking staff to do what everyone else was being told not to do (i.e. go into work). Initially it was felt that some school staff were just relieved to be out of the pressure (which was described as a feature of daily school life). However, many others struggled with the swift and sharp changes required in their professional practice, including the shift from classroom to online learning and in some cases staffing hub schools caring for key workers and vulnerable pupils, in a very short space of time.
- 3.44 Alongside the changes in their professional practice, it was emphasised by CAMHS In-Reach practitioners that school staff were also coping with the impact of the crisis on their own lives, and challenges such as home schooling, caring for others, self-isolating and shielding and, in a few cases, sickness and bereavement. CAMHS In-Reach practitioners also reported that some staff who were self-isolating or shielding have felt guilty at not being able to support colleagues in schools.
- 3.45 Concerns about pupil mental health and well-being (outlined above) also affected staff well-being, particularly where staff felt powerless to help. Schools (and staff) were reported by CAMHS In-Reach practitioners to be increasingly concerned about vulnerable pupils becoming more vulnerable as the lockdown continued.

The second lockdown

- 3.46 School staff experiences of the second lockdown were somewhat different. Schools had longer to plan and prepare, but teachers and school leaders reported increasing demands linked to increased expectations about the continuation of learning. These included the delivery of blended learning, with both online and face-to-face provision and dealing with the challenges of assessing progress and differentiating provision. As a head teacher of a primary school described it:

‘Currently, staff have no control over progress, where are the pupils up to, how do we support them if they’re at different levels, how do we feed back to them? Staff are worried about their own children. Everything for us at the moment is off the cuff, we’re reacting where we’ve been used to planning for everything’.

- 3.47 As a primary school leader in North Wales put it, school staff are struggling with: ‘Anxiety related to Covid. Some are home schooling their own children. Teachers have had to change in style of learning and teaching, they’ve had to become adept at IT quickly. It can be overload. ...the changes came so quick and fast, it was easy to feel you were drowning. We’ve had training on IT, on well-being, adapted our way of teaching, it is overload, now we’ve decided we have to pace ourselves’.
- 3.48 The length of the pandemic and uncertainty about when and how schools would reopen was reported to have worn some staff down, and some staff interviewed during the third round of qualitative research were physically and emotionally exhausted. In addition to the demands of the work, including dealing with parents’ concerns and complaints, they reflected on the loss of ‘down time’ and coping mechanisms, such as talking in the staff room, and leisure activities (with, for example, cinema, pubs etc. all closed). This raised concerns about the capacity of staff to support pupils and take forward key educational priorities like the new curriculum and ALN Transformation Programme.

4. The CAMHS In-Reach to Schools Pilot Programme: Models

Introduction

- 4.1 Following announcement of the CAMHS In-Reach pilot by the Welsh Government in September 2017, the programme's theory of change was developed at a national meeting in March 2018. A National Co-ordinator for the programme was appointed in April 2018, supported by senior staff at PHW, and the programme started delivery in schools in September 2018. Originally intended to run until summer 2020, in autumn 2019 the programme was extended to the end of 2020 to coincide with the end of the evaluation, and then extended again to the end of the 2020/2021 school year, given the impact of COVID-19 upon programme delivery.
- 4.2 As the pilot programme's theory of change illustrates (figure 1.1), the programme aimed to build capacity (including skills, knowledge and confidence) in schools, improve schools' access to specialist liaison, consultancy and advice when needed, reduce school staff stress and improve their well-being.
- 4.3 Although the pilot programme's theory of change (figure 1.1) outlined mechanisms - how it was envisaged that change and the desired outcome would be achieved - it did not prescribe exactly how this would be delivered in each area. As this section outlines, this provided scope for each area to identify how best to complement and build upon existing provision and respond to the challenges and opportunities created by the differing sizes and geographies of each pilot area.

The North Wales Model

- 4.4 There are 16 secondary schools, one middle school and 104 primary schools in Wrexham and Denbighshire, spread across two large LAs. The size of the area and number of schools to be included were considered a key challenge. Because, as example of practice 2 illustrates, sCAMHS was felt to already have strong links to schools, this element of the pilot's theory of change was not initially developed in North Wales.

Example of practice 2. Schools' Access to sCAMHS in North Wales

sCAMHS in North Wales has a long history of working with schools and the voluntary/community sector, building up skills to support young people with mental health and well-being issues, through running courses such as Friends for Life and the Youth Mental Health First Aid (YMHFA) course, building the capacity of education/voluntary and community sectors to provide support for young people, and schools purchasing courses such as Seasons for Growth from the third sector; sCAMHS and EP in Wrexham have a weekly drop-in for professionals that often offers informal workshops along specific themes depending on requests made. This continuous consistent source of support for almost a decade is much appreciated locally. Similarly, sCAMHS in Denbighshire has a link worker system based around the secondary schools, that primary schools can access.

4.5 A local steering group was established in November 2017. Chaired by an NHS Assistant Director, it included representation from both health and education¹⁹. Consultation with stakeholders to inform the development of the pilot model started in early 2018 and in the summer of 2018 head teachers were offered four options²⁰ and invited to select the training they would like within the project. They chose:

- Youth Mental Health First Aid; and
- Five Ways to Well-being (including the UK 'time to change' campaign which aims to challenge the stigma and stereotyping around mental health).

4.6 A Band 7 Team Lead was appointed in June 2018, supported by a full time Band 6 sCAMHS Mental Health Practitioner and Band 3 Project Support Administrator (part time, 0.6) who provided operational support (e.g. to co-ordinate and arrange all the training and purchasing of materials).

¹⁹ Initial members included: Assistant Director (East) Children Services Lead (Chair); School Nursing Manager (East and Central); Principal Public Health Wales Officer; Pilot Project Manager; sCAMHS Service Managers - Wrexham and Denbighshire; Service Manager Disability & Neurodevelopment, Children's Service, Central and East; North Wales Head of Child Psychology and Psychological Therapies, Consultant Clinical Psychologist; Head of Education Wrexham and Education Manager, Denbighshire.

²⁰ YMHFA, Five Ways to Well-Being, Friends Resilience, Deal Programme (Samaritans), promotion of Time to Change.

4.7 Following consultation with schools to identify their training needs, in September 2018 the pilot programme started work with schools, special schools and PRUs.

The pilot model focused upon:

- YMHFA training, a two-day course which aims to teach people the 'skills and confidence to spot the signs of mental health issues in a young person [aged 8-18], offer first aid and guide them towards the support they need' (MHFA, 2021);
- staff well-being through whole staff training upon the Five Ways to Well-being, and Stress in the Workplace training; and
- whole-school approaches to mental health through the school management review and emotional health and well-being policies²¹.

4.8 The team considered 'buy in' from school leaders as vital and focused upon engaging them first.

4.9 The Stress in the Workplace and Five Ways to Well-being sessions and YMHFA training have had the most take up from schools. Table 4.1 shows the total number of staff trained over the period 2018-2019. To provide some context for this, there are 892 teachers and around 760 support staff in Denbighshire and 1,099 teachers and around 1,172 support staff in Wrexham. If we assume the data counts each participant only once, this means around 10 per cent of staff in the region have engaged with the training focused upon pupil mental health and well-being and around 70 per cent have engaged with the training focused upon staff mental health and well-being. The take up of the school management review has been slower, and by November 2019, only eight schools had taken it up, despite the pilot's efforts to publicise it. Training is generally delivered during staff meetings (at schools' request) and it is reported that backfill money for staff attending has encouraged and enabled attendance.

²¹ The Management Review tool was initiated and led by the Education Manager for Denbighshire and the Well-being Policy Initiative was initiated by the Education Health and Well-being Lead in Wrexham. Healthy Schools Co-ordinators drafted the policy and a joint consultation event was held in 2019.

Table 4.1. Training delivered by the North Wales Pilot on learners’ mental health and emotional well-being and staff mental health and emotional well-being.

	Wrexham			Denbighshire			Total
	Primary	Secondary	other	Primary	Secondary	Other	
YMHFA	71	24	46	49	25	30	245
Anxiety conference	-	-	-	-	-	-	123
AMHFA	25	6	3	15	11	8	68
Stress & MH in the workplace & 5 Ways to WB	714	423		364	1,023		2,641

Source: North Wales Pilot

4.10 In 2019, after the announcement of the extension of the pilot programme, three further areas or work were identified:

- an enhanced Consultation Model, discussed in section 6;
- delivery of the Adult Mental Health First Aid (AMHFA) course, targeting head teachers and senior leaders; and
- targeting harder to reach schools.

Welsh language provision

4.11 The pilot provides most training materials bilingually, including typed handouts and publicity. However, none of the team are fluent Welsh speakers, and therefore cannot deliver through the medium of Welsh. Although there are a number of Welsh medium schools in Denbighshire and Wrexham, during the qualitative research, Welsh medium schools expressed gratitude for what was seen as much needed support, even though it was not delivered through the medium of Welsh.

Impact of COVID-19

4.12 During the first national lockdown (March-July 2020) the pilot’s Senior Mental Health Practitioner was ‘activated to be ready’ to undertake mental health assessments. This included on-line training, sourcing uniform (scrubs), and e-learning on how to support medical staff. However, she was not called upon to do any work. Other staff were deployed to support the response and two agency staff were let go. The pilot restarted work with schools In September 2020, when some face-to-face training was delivered. However, as the numbers of COVID-19 cases in schools increased

again in autumn 2020, delivery of the pilot moved online. The challenges and opportunities this created are discussed further in section 5.

The West Wales model

- 4.13 There are seven secondary schools and 39 primary schools in Ceredigion, distributed across a large primarily rural area. The size of the area and number of small rural primary schools were considered key challenges. The steering group was formed in March 2018 and included representation from health, education, voluntary sector, school counselling services and social care, and is chaired by an educational psychologist.
- 4.14 In March 2018, a full-time Band 7 Team Lead, a Band 6 Schools In-Reach Practitioner, a Band 5 Assistant Psychologist and a part time Administrator were appointed. The team consulted the seven secondary schools in Ceredigion and also four primary schools, in the summer of 2018. The initial needs assessment identified a wide range of areas of concern for schools including pupils' anxiety, self-harm and eating disorders.
- 4.15 In September 2019, the Schools In-Reach (SIR) pilot began work with seven secondary schools and eight primary schools and initially focused upon five areas:
- consultation, focused upon formulation, decisions, and planning to address (i) low level problems through one-to-one discussions with schools, and (ii) more complex problems through a multi-disciplinary approach, Team around the Family (TAF);
 - liaison, acting as the link between health, education and social care:
 - signposting;
 - training; and
 - well-being.
- 4.16 The team has used TAF meetings as their principal entry point into schools, enabling them to offer consultation, liaison and signposting and advertise their training offer through newsletters and emails to schools. TAF meetings were reported by CAMHS In-Reach practitioners to provide a swift and established entry point to schools and avoid creating another layer of meetings. The training offer included a mix of online self-directed learning and more bespoke workshops for schools.

Example of practice 3. Ceredigion's consultation models

In Ceredigion, consultations range from a low-level discussion with one or two members of school staff who have expressed concern about a pupil, to an in-depth, multi-disciplinary exploration of symptoms and causes. CAMHS In-Reach practitioners provide advice and/or recommendations, including, for example, advice on the appropriateness of a referral to sCAMHS or signposting to another service. However, as outlined in section 5, CAMHS In-Reach practitioners also aim to get the staff attending the consultation to come up with the solutions themselves, to upskill them and increase their confidence.

In supporting staff to come up with solutions through a multi-disciplinary exploration of symptoms and causes, the team facilitates a formulation using a process developed by Nick Lake, Mary Dobbin and Stephanie Kennedy. It is described (by CAMHS In-Reach practitioners) as a 'biopsychosocial' model that values expertise of each professional when considering 'what might be the contributing factors towards the child's presentation', while the multi-disciplinary approach helps ensure consistency between them and support to the child and family.

4.17 In Ceredigion, a tiered approach to training has been developed, and a training menu has been given to all primary and secondary schools and this has increased uptake. The three tiers are:

- tier 1, an online e-learning module which provides an introduction to identifying mental health difficulties in children and young people for school staff, and which rolled out in early 2020;
- tier 2, delivered face-to-face, through courses typically lasting 30-60 minutes, providing training in areas such as mindfulness, stress and anxiety relief²²; and

²² The full list is: the sCAMHS Service; Mindfulness; Stress; Anxiety; Low Mood & Depression; Self-esteem; Eating Disorders; Gender Identity; Self-harm & Suicidal Ideation; and Five Ways to Well-being.

- tier 3, more interactive training, delivered through sessions typically lasting 60-120 minutes, and gives staff tools to use in different situations so that staff are confident in using these techniques for low-level intervention²³.

4.18 The pilot reports that there have now been over 1,000 staff trained. To provide some context for this, there are 585 teachers and around 537 support staff in Ceredigion²⁴. However, direct comparisons between the numbers of staff trained and total numbers of school staff cannot be made, as it appears that many of the participants completed more than one of the courses.

4.19 In 2019, after the announcement of the extension of the pilot programme, additional staff were recruited, and the team has developed a liaison role between the Crisis Assessment and Treatment Team (CATT) and schools, and also supports crisis assessments. However, for much of 2019 and 2020, one of their staff was absent, due to illness, constraining their capacity.

Welsh language provision

4.20 None of the CAMHS In-Reach practitioners are fluent Welsh speakers and they only offer their services in English, although as they now have a Welsh speaker in the team they are able to offer some translation at training events. The pilot's policy is to send material to the Welsh Translation Service. They acknowledge that this means it can cause delays in sending out material, as it can take up to two weeks for translation. School staff (in West Wales), interviewed through the qualitative research, raised concerns about the lack of Welsh language provision; for example, as one secondary school leader put it: 'There is no one on the team that can speak Welsh and everything they provide to us is in English'. This may reflect the wider challenges about recruiting specialist staff who speak Welsh, but the failure to translate material is difficult to justify and runs against the pilot's policy. It is not clear if this was, for example, due to a delay in sending out material in Welsh.

Impact of COVID-19

4.21 During the first national lockdown (March-July 2020) SIR was put on hold due to COVID-19 and closure of schools. Staff within the team were deployed back to

²³ The full list is: Mindfulness Techniques; Anxiety; Controlling Stress; Low Mood & Depression; Self-esteem; Self-harm & Suicidal Ideation; Assessment/Referral Practice; Reflective Practice; and Getting the Lowdown.

²⁴ Source: StatsWales (2019): [teachers by local authority, region and category](#), and [support staff by local authority, region and category](#). The number of support staff includes higher level; teaching assistants, special needs support staff and pastoral support staff, but exclude other support staff such as IT, laboratory, workshop or resource technicians, examination officers and business managers.

sCAMHS to support with Single Point of Contact (SPoC). In September 2020, some face-to-face training was delivered, and face-to-face consultations in some schools resumed. However, as the numbers of COVID-19 cases increased again, delivery of the pilot moved online. Much of the pilot training was already offered online, which made this transition easier.

The Mid and South Wales model

- 4.22 There are 10 secondary schools and 55 primary schools in Torfaen, Blaenau Gwent and South Powys. The pilot was developed to complement Gwent's transformation project (see example of practice 4) and the existing support sCAMHS in Powys provided to the two Powys secondary schools in the pilot.

Example of practice 4. Implementing a Seamless System of Health Care and Well-being

Gwent's transformation project, Implementing a Seamless System of Health Care and Well-being, focuses upon early intervention, prevention and improved population well-being, including the redesign of sCAMHS to deliver improved access to better services, closer to home. This led to the development of the Single Point of Access for Children's Emotional Wellbeing and Mental Health (SPACE) well-being panels. In Powys, sCAMHS workers offered consultations to secondary schools on a monthly basis.

SPACE-Wellbeing is a Gwent-wide initiative. Requests for support from schools and services are triaged by a multi-agency team which decides the best placed service(s) to meet a child or young person's needs. A co-ordinator manages requests, going back for further information if required, and decisions are made by the panel about the most appropriate approach(es) to take and services to get involved to support the child or young person. The initiative aims to ensure that children and young people are able to access the right help the first time and that there is no duplication of support across services. All referrals for sCAMHS go via SPACE-Wellbeing.

Adapted from NHS (n.d.) and qualitative research

- 4.23 The steering group formed in 2018 and includes representatives from health and education (inclusion services), school health nurses, school counsellors, health

schools and, since 2019, educational psychologists. It was chaired by the Regional Head of sCAMHS transformation. The pilot identified its purpose as, in a CAMHS In-Reach practitioner's words: 'How do we help our education staff and the wider system to feel more confident managing lower-level mental health difficulties?' Two full time Band 7 practitioners were appointed.

4.24 'In-Reach is coming' engagement events were held. These included contacting 72 schools to arrange visits, and ask:

- what work are you doing to support pupil emotional health and well-being?
- what work are you doing to support staff emotional health and well-being? and;
- what do you want from In-Reach?

4.25 This highlighted a range of work around pupil mental health and well-being, such as Thrive and Social and Emotional aspects of Learning (SEAL), but very little around staff well-being. It was also necessarily constrained by the limits of schools' knowledge. As one practitioner put it: 'The problem is you don't know what you don't know'. The interface between the pilot and other initiatives was explored, in order to avoid duplication, ensure consistency of messaging and enable joint working. As an example, because attachment was a big issue for primary schools, the pilot liaised with the Gwent Attachment Service who deliver training on this to schools.

4.26 Given the pilot's purpose and schools' engagement, the pilot developed three pillars:

- training included developing 'bespoke' packages and supporting schools to access programmes like YMHFA, Paper Tigers and Trauma Informed Schools (discussed further in section 5). The initial training offer²⁵ was developed with support from two clinical psychologists and written in the Spring of 2019. The final training menu is outlined in example of practice 5;
- rapid access to consultation (advice, signposting, strategies) via email, telephone and face-to-face (discussed further in section 6); and

²⁵ Understanding and Responding to Distress; Child and Adolescent Psychological Development; Attachment; Restorative Approaches; and Motivational Interviewing.

- support for staff well-being, including workshops and training focused upon Five Ways to Wellbeing; Taking Care, Giving Care; Action for Happiness (discussed further in section 7).

4.27 In South East and Mid Wales, training has focused on mental health issues through the YMHFA training and through sessions on staff well-being (such as the Five Ways to Wellbeing and Everyone Matters workshops²⁶). In addition, modular training covering areas such as childhood psychological development and understanding and responding to distress was developed by a psychology-led team and then piloted in spring and summer 2019. Pre-COVID-19, training was offered via In-Service Training (INSET) and twilights, staff meetings and open events at 4pm for individual schools. The pilot also offered bespoke, one-off workshops. The pilot has offered open access training, but attendance at this has been poorer.

Example of practice 5. The Mid and South East Wales Training Menu

The training menu in Mid and South East Wales comprises a series of two-hour training modules; one or two hour staff well-being workshops; the two day YMHFA course; and the 10 day Trauma Informed Schools diploma.

The modules include:

- Introduction to Attachment
- Child and Adolescent Psychological Development
- Understanding and Responding to Distress
- Understanding and Responding to Suicidal Ideation & Self-Harm
- Introduction to Disordered Eating and Body Image
- ADHD: An introductory workshop
- An Introduction to Building, Repairing and Maintaining Relationships using a Restorative Approach
- Motivational Interviewing in Schools
- Bereavement

²⁶ These included tasters in areas like mindfulness, well-being and giving and taking care.

The Staff Wellbeing workshops include:

- Five Ways to Wellbeing
- Taking Care, Giving Care
- Action for Happiness
- Compassionate Cultures
- Road to Wellbeing

4.28 As tables 4.2. and 4.3. illustrate, in 2020-2021, 332 staff in Blaenau Gwent took part in training on pupils' mental health and well-being, and 92 staff took part in training on staff mental health and well-being. To provide some context for this, if we assume that each staff member only attended one training session, this would mean just under one third (29%) of school staff took part in training on pupils' mental health and well-being and less than one in ten (8%) took part in training on staff mental health and well-being²⁷. However it is likely that some staff will have attended more than one course, so this estimate is likely to overstate the proportion of staff who received training. Tables 4.4 and 4.5 provide the equivalent data for South Powys.

²⁷ There are 506 teachers and around 620 support staff in Blaenau Gwent (Source: StatsWales (2019): [teachers by local authority, region and category](#), and [Support staff by local authority, region and category](#)). The number of support staff includes higher level; teaching assistants, special needs support staff and pastoral support staff, but exclude other support staff such as IT, laboratory, workshop or resource technicians, examination officers and business managers.

Table 4.2. Training on pupils' mental health and well-being in Blaenau Gwent 2020-2021

Module	No. of participants
Introduction to Trauma	50
Anxiety	43
ADHD	42
Development	41
Bereavement	40
Attachment	35
YMHFA	22
Self Harm	19
Emotional Distress	19
TIS Diploma	11
Distress	10
Total	332

Source: Mid and South Wales Pilot

Table 4.3. Training on staff mental health and well-being in Blaenau Gwent 2020-2021

Module	No. of participants
Art of Brilliance	26
5 Ways to Wellbeing	25
Keys to Happiness	24
Stress Control	12
Compassion Cultures	5
Total	92

Source: Mid and South Wales Pilot

Table 4.4. Training on pupils' mental health and well-being in South Powys 2020-2021

Module	No. of participants
Attachment	52
Trauma Informed schools return to school (Covid)	52
Child/Adolescent Psychological Development	37
YMHFA	23
Attachment	23
Introduction to Attention deficit Hyperactive disorder	17
Trauma Informed Schools	5
Trauma Informed schools 10 day diploma	4
EYMHFA	3
Grief, Loss & Bereavement	3
Understanding & responding to Suicidal ideation & self harm	0
Understanding & supporting anxiety & worry	0
Introduction to Trauma	0
Disordered Eating & Body Image	0
Restorative Approaches	0
Motivational Interviewing	0
Total	219

Source: Mid and South Wales Pilot

Table 4.5. Training on staff mental health and well-being in South Powys 2020-2021

Module	No. of participants
5 ways to well being	189
Art of Brilliance	34
Stress Control	23
Taking Care, Giving care	16
Everyone Matters Workshop	14
CC - Compassionate Cultures	3
5 Ways - keys to happiness	2
Foundation Mindfulness	1
Total	282

Source: Mid and South Wales Pilot

4.29 The team has developed links with a named lead in each school which has engaged, and advertises its support through termly newsletters, posters, and emails to schools, well-being leads and ALNCos. They also target schools where, for example, a potential issue or concern is identified through a SPACE-Wellbeing panel. Consultations are offered to schools on either a regular scheduled basis

and/or a responsive, demand-led model (school visits backed up by phone and email contact as needed).

Welsh language provision

- 4.30 Although resources have been translated, none of the team is fluent in Welsh and all training is delivered in English. A small number of schools in the pilot area are Welsh medium schools and the lack of Welsh medium provision is sometimes highlighted in feedback on evaluation.

Impact of COVID-19

- 4.31 During the first national lockdown (March-July 2020) the two CAMHS In-Reach practitioners were redeployed to support sCAMHS, only working one day a week on the pilot programme. In September 2020, some face-to-face training was delivered, and face-to-face consultations in some schools resumed. However, as the numbers of COVID-19 cases increased again, delivery of the pilot moved online and training course were adapted; for example, the pilot began delivering a one-hour short version of Five Ways to Wellbeing online, which was judged not to work as well as face-to-face provision, but has been broadly taken up by schools.

Implementation and co-ordination

- 4.32 Implementation of the pilot is regarded by members of the pilots themselves, also schools and services interviewed through the qualitative research, as generally good. After a slow start in some areas, engagement with schools and co-ordination with other services was reported (by both schools and services interviewed through the qualitative research) to have improved. The key challenges have been around staff recruitment, which has taken time, and managing staff sickness and absence which has had a significant impact upon capacity, given the small size of staff teams and reliance upon individual staff to deliver.
- 4.33 The involvement of stakeholders from education in the pilot has been mixed. As outlined above, in each pilot area, education staff such as educational psychologists and LA inclusion leads have been members of steering groups and schools have been consulted. However, the involvement of schools in steering groups has been limited. As one school leader explained, while they were keen, and joined the steering group, they judged that the time costs of attending meetings could not be justified, saying once travel was factored in, they were out of school for nearly the whole day.

- 4.34 It took time for the pilot to get going, particularly in Mid and South Wales, although as sections 5, 6 and 7 illustrate, once it did, it was very well received. This reflected in part the need to build links with, and understanding of, schools. The time needed to recruit staff, combined with the disruption to delivery caused by COVID-19 (discussed further in sections 5 and 6) meant that the pilot struggled to use the additional funding in 2020/2021 as effectively as could have been expected.
- 4.35 As sections 5, 6 and 7 illustrate, the pilot programme sits in a complex and often crowded policy landscape and needs to be co-ordinated with training and professional learning to support whole-school approaches to mental health and well-being and with services and pathways to accessing specialist services. Multi-agency steering groups have been important in helping ensure the development of the pilot was informed by and co-ordinated with other work in this area. However, this has been a challenge for the pilots.

5. School staff confidence and skills

Introduction

5.1 Staff skills and confidence around mental health issues can help:

- enable early identification of concerns or mental health difficulties which can facilitate early intervention and can help stop problems escalating²⁸;
- schools manage lower-level difficulties and ‘hold onto’ pupils rather than ‘handing them on’ to specialist services; and
- reduce staff stress (linked to staff concerns about pupil mental health and well-being) and improve staff well-being.

Staff confidence in identifying concerns or mental health difficulties

The baseline position

5.2 The baseline school staff survey and the first round of qualitative research with schools identified that, before the pilot, staff confidence in identifying that a pupil might have mental health difficulties was generally high. However, staff confidence in their own abilities to assess pupil mental health difficulties was more mixed. Around two thirds (66 per cent) of all staff either agreed or strongly agreed that they felt confident in discussing mental health and well-being needs with individual pupils. Increasing confidence was seen as important here and as the Framework on embedding a whole-school approach to mental health and well-being puts it, it is important for pupils to ‘know that there is someone to turn to who will set their problems in context and help them move on’ (WG, 2021, pp. 20-21). However, markedly fewer staff said they felt confident when speaking to parents or carers about these needs, with a little over half (56 per cent) agreeing or strongly agreeing. This reflects differing staff roles and responsibilities; for example, ALNCoS/SENCoS and/or pastoral teams are often responsible for assessing pupils identified as potentially having mild mental health difficulties, while specialist services like sCAMHS are responsible for assessing those pupils with more complex and/or

²⁸ For example, as the Framework on embedding a whole-school approach to mental health and well-being put it: ‘Studies show that what matters to learners is that teachers listen, are encouraging and positive, take an interest in them as people and empathise with their difficulties. However, this is only possible if staff have the confidence and time to actively listen to children and young people and respond appropriately even to challenging or concerning topics’ (WG, 2021, p.50).

severe mental health difficulties. This model means that not all staff would be expected to have this expertise.

- 5.3 This division of labour means that expertise should be distributed across the system, rather than expecting everyone to be an expert. It should also help ensure that staff do not operate beyond their competence; for example, school staff are not, and should not be expected to be, mental health experts, and should not take on the diagnostic and therapeutic roles played by specialist services like sCAMHS. As a primary school pastoral lead described: 'It would be wrong to say that we are confident. We are kind and caring and we know them [our pupils] well, but we are not experts and it's an issue that the experts are not readily available the time you need them...we need that specialist support when we need it'.
- 5.4 Qualitative research highlighted how staff confidence was linked to experience of identifying and dealing with mental health issues and their role (and therefore, for example, the professional learning undertaken in relation to their role). This was reflected in responses to the survey, which identified that ALNCos/SENCOs and pastoral staff were more confident than other staff groups in assessing needs²⁹.
- 5.5 The qualitative research also highlighted that confidence is not enough, schools are often busy and noisy places and finding the time and space to talk to pupils or parents or carers to explore and begin assessing possible difficulties, is often hard. A primary school teacher described how: 'This morning a little girl came to me and gave me a note that said, "Can I talk to you please?" I have a full class, I cannot just drop them all and go out with her. I have to wait until I can find a time later and hope we won't be interrupted'.

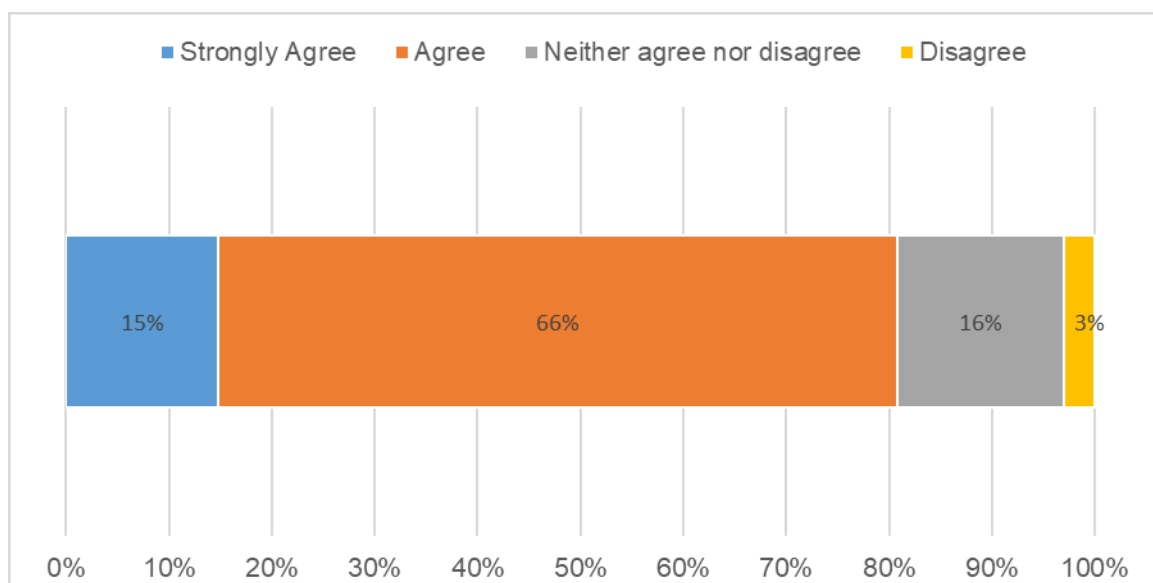
Similarly, a secondary school teacher described how, having had the training from the pilot programme, she knows how she should respond when a pupil comes to her: 'But there are 30 others outside the door waiting to come in' and another school leader commented: 'We have enough people with expertise, but no time – this is key'. They explained that they accessed training: 'But the big question is if you have the time to implement what you learn'.

²⁹ Pastoral staff and SENCOs/ALNCos were more confident than other staff groups in talking to a parent or carer about their child's mental health (69 and 72 per cent respectively agreed or strongly agreed) compared to 45 per cent of other staff groups who agreed or strongly agreed.

The end-line position

5.6 As Graph 5.1. illustrates, by early 2021, responses to the end-line survey suggest that staff confidence identifying concerns or mental health difficulties was relatively high, with around 80 per cent agreeing or strongly agreeing that they were confident that they could identify that a pupil may have unmet mental health needs³⁰.

Graph 5.1. Responses to the statement: I am confident that I can identify that a pupil may have unmet mental health needs.



Source: *People and Work, CAMHS In-Reach end-line survey 2021 (n=203)*

5.7 This was supported by the responses of school leaders answering on behalf of the school (n=15) who all agreed or strongly agreed that they were confident that staff in their school could identify that a pupil may have unmet mental health needs.

5.8 This finding from the survey is broadly supported by the qualitative research. This also suggests that the way in which schools now think about behaviour as an expression of mental health difficulties suggests increasing awareness and understanding, which may mean that more problems are now being identified.

Staff confidence in managing lower-level mental health difficulties

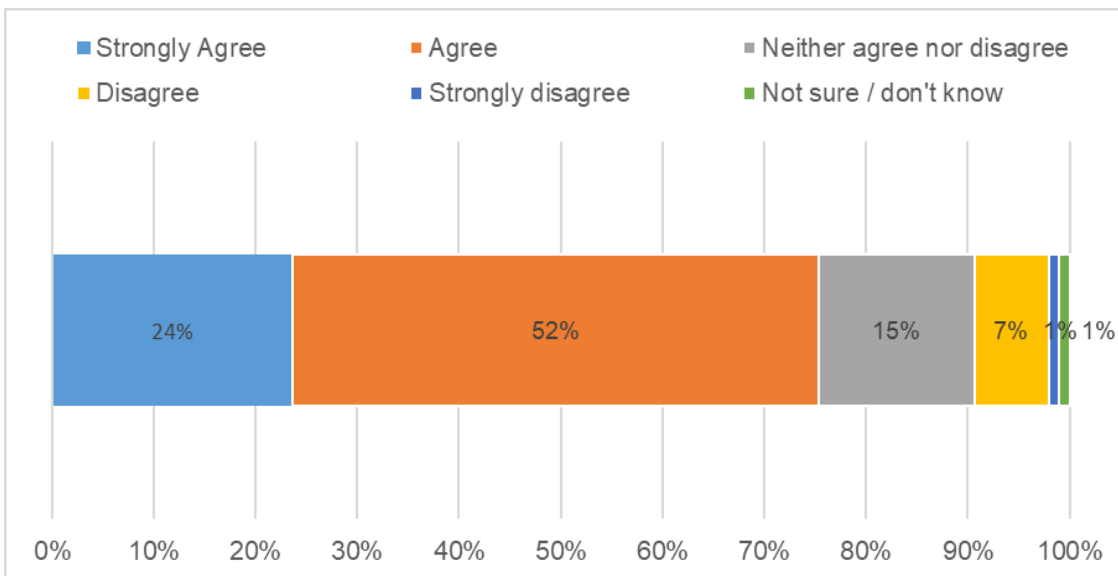
5.9 As Graphs 5.2-5.3 illustrate, staff confidence in addressing pupil mental health difficulties is somewhat lower than their confidence in identifying that there is a

³⁰ As outlined in section 2, responses to the base and end-line survey should not be directly compared.

problem. As outlined above, this is similar to the pattern observed in the baseline survey; for example:

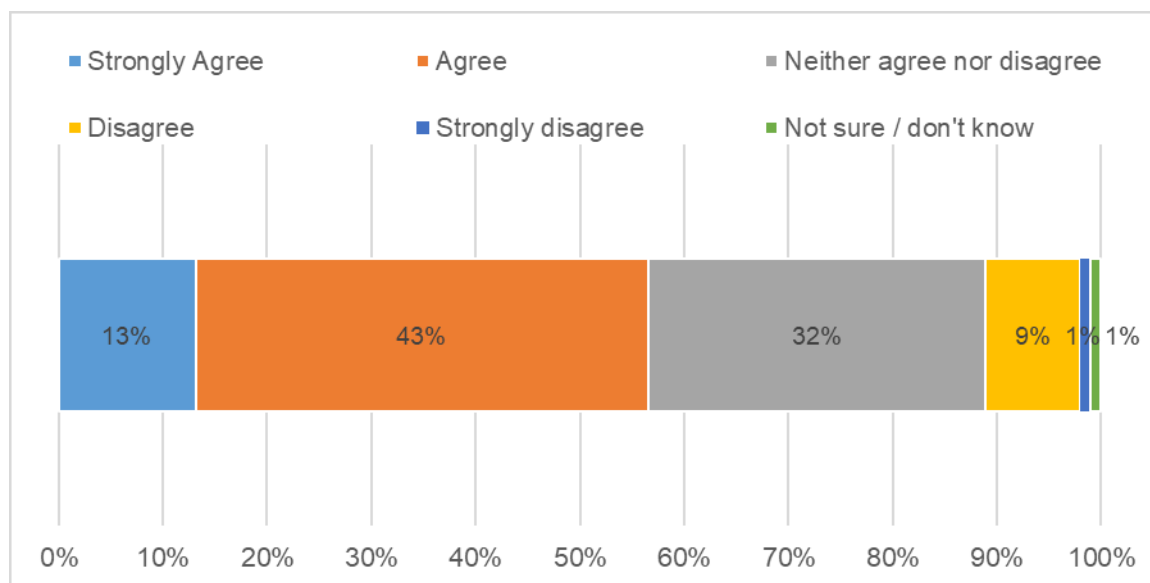
- as Graph 5.2. illustrates, around three quarters of staff in the end-line survey were confident discussing mental health and wellbeing needs with individual pupils. This was supported by the responses of school leaders answering on behalf of the school (n=15), with 13 agreeing or strongly agreeing that they were confident that staff in their school could discuss mental health and well-being needs with individual pupils. There was little difference in responses between those staff who had received training and those who had not.
- As Graph 5.3. illustrates, just over half of staff in the end-line survey were confident meeting the needs of pupils with mental health difficulties. Staff who had received training (n=71) were more positive, with almost 80 per cent strongly agreeing or agreeing. School leaders answering on behalf of the school (n=15), were also more positive, with 10 agreeing or strongly agreeing that they were confident that staff in their school could meet the needs of pupils with mental health difficulties.

Graph 5.2. Responses to the statement: I feel confident to discuss mental health and well-being needs with individual pupils.



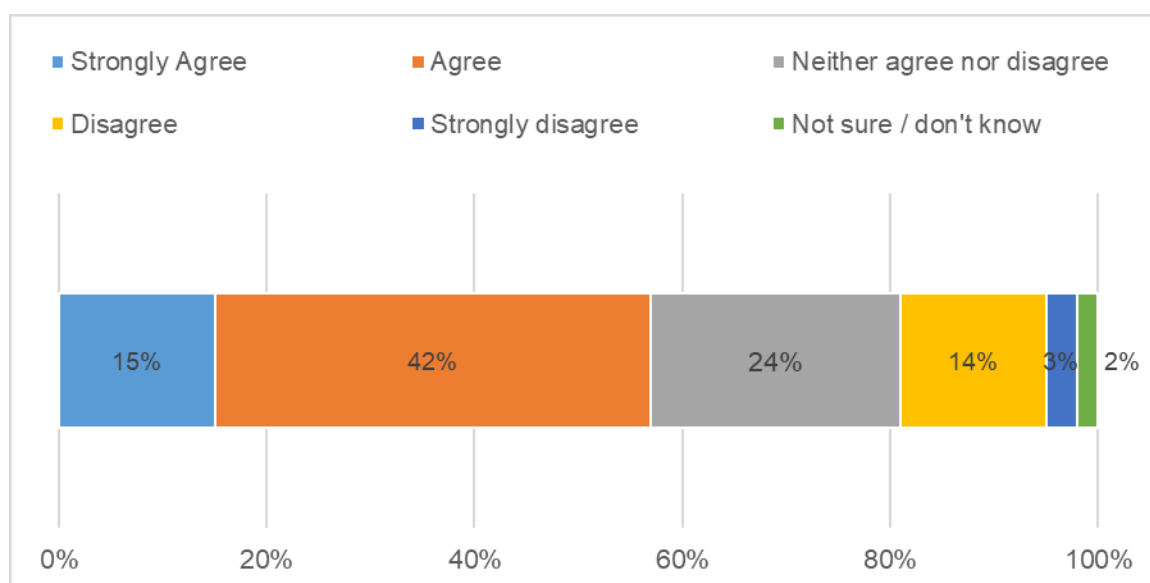
Source: People and Work, CAMHS In-Reach end-line survey 2021 (n=203)

Graph 5.3. Responses to the statement: I feel confident meeting the needs of pupils with mental health difficulties.



Source: People and Work, CAMHS In-Reach end-line survey 2021 (n=203)

Graph 5.4. Responses to the statement: I feel confident to speak to a parent or carer about their child's mental health.



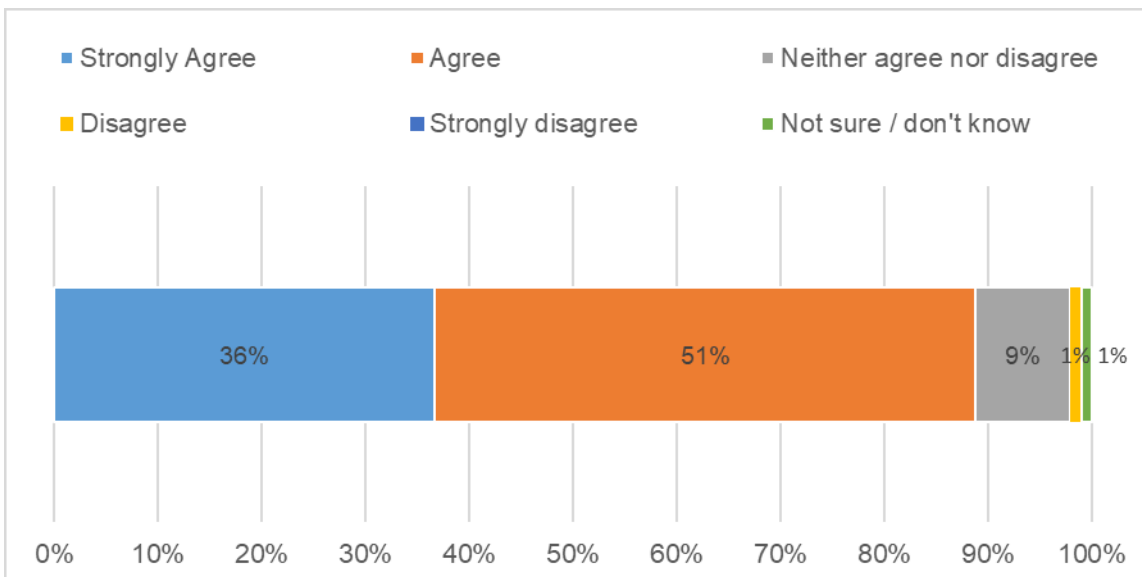
Source: People and Work, CAMHS In-Reach end-line survey 2021 (n=202)

5.10 As in the baseline survey, staff were confident that they knew the limits of their own knowledge and when they needed advice and support. Almost 90 per cent of staff surveyed in the end-line survey (n=201) either strongly agreed or agreed, when asked whether: 'I am confident identifying when I need advice or support to better understand or address a pupil's mental health difficulty'. All but one of the staff surveyed in the end-line survey who had received training (n=71) strongly agreed or agreed, and all school leaders answering on behalf of the school (n=15), strongly agreed or agreed that they were confident that staff could identify when they

needed advice or support to better understand or address a pupil's mental health difficulty.

5.11 As Graph 5.5. illustrates, overall, almost 90 per cent of school staff were confident in their school's ability to meet needs and all school leaders answering on behalf of the school (n=15), strongly agreed or agreed that they were confident in their school's ability to meet needs. Although not directly comparable, it is interesting to note that this was higher than the baseline survey. Moreover, there was little difference in response from staff in primary and secondary schools, despite evidence from Estyn inspections that primary schools tend to have stronger provision for pupils' health and well-being compared to secondary school (Estyn , 2019)³¹.

Graph 5.5. Responses to the statement: My school is effective at promoting the mental health and well-being of pupils.



Source: *People and Work, CAMHS In-Reach end-line survey 2021 (n=202)*

5.12 Despite this confidence, there is evidence from analysis of the SHRN Student Health and Wellbeing Survey that pupils' perceptions of levels of school support for students who feel unhappy, worried or unable to cope has declined in the last two years. Between 2017 and 2019, both year 8 and year 11 statistical models (developed by DECIPHER) suggest a decline in the perceived level of school support for students who feel unhappy, worried or unable to cope. Although the

³¹ In comparing the responses to the survey and Estyn's judgment, it is important to note that Estyn's standard or measure ('several strong aspects') is weaker than the standard or measure used in the survey ('my school is effective'). There were also differences in the focus of the survey and Estyn, with Estyn more broadly focused upon health and well-being, meaning the two sets of data are not directly comparable.

decline in perceived levels of support was smaller in pilot schools compared to non-pilot schools, particularly for year 8 pupils, the model suggests that there was no statistically significant difference in the change in proportion of pupils in pilot and non-pilot schools who reported this (DECIPHer, 2021). Further details on this are provided in the appendix.

Pilot training

- 5.13 As outlined in section 4, in order to build staff skills and confidence, each of the three pilot areas has offered training. The training offer is diverse and different in each pilot area. It ranges from e-learning and one-hour training sessions, through the two-day YMHFA course to the 10-day Trauma and Mental Health Informed Schools Diploma programme. The costs and time commitment therefore vary considerably³². The training also covers a wide range of areas, including mental health conditions, such as anxiety and depression; neurodevelopmental conditions, such as ADHD; causes of mental health difficulties, such as trauma and difficulties with attachment; behaviours such as suicide and self-harm, and techniques and strategies such as motivational interviewing. In addition, as this section outlines, in two areas (South and West Wales) a ‘training plus consultation’ model that integrates training with follow up support (via consultations), has been developed.

Staff responses to the training on pupil mental health and well-being

- 5.14 The training has been well, and often very well, received. This is evidenced in responses to the survey, qualitative research with schools and services and feedback on training collected by the pilot programme³³. As table 5.1. illustrates over 90 per cent strongly agreed or agreed that the training (delivered by the pilot): ‘Has increased my knowledge and understanding of pupils’ mental health problems and how to deal with them’.

³² Some of the training is very cheap to deliver, such as online, self-directed course. In contrast, the 10-day Trauma and Mental Health Informed Schools Diploma + backfill costs around £2,000 per participant.

³³ For example, it was striking how many 10s were recorded when participants were asked: ‘How helpful was the training today on a scale of 1=10?’ - where 1 is ‘very unhelpful’ and 10 is ‘extremely helpful’.

Table 5.1. Staff responses to the statement: The training (delivered by the pilot) has increased my knowledge and understanding of pupils' mental health problems and how to deal with them.

	No.
Strongly Agree	22
Agree	28
Neither agree nor disagree	2
Disagree	1
Strongly disagree	0
Not sure / don't know	2
Total	55

Source: People and Work end-line survey 2020

5.15 This positive response reflects the combination of strong, relevant, and often thought-provoking content and engaging and professional delivery by mental health specialists; for example, as a primary school well-being lead put it:

‘The YMHFA changed my approach to mental health and well-being. The quality of the training was excellent and the manual has now become a Bible. It gave me an overview of the impact of mental health on children and young people and understanding of mental health issues, it was invaluable. There was a concentration on older children, but we’ve been able to adapt it to our age groups. It’s given me an insight into different conditions, more of a knowledge base. I’m more aware of signs and symptoms and it’s given me a confidence in my role. We’re fortunate here in that we have good access to CAMHS, before I was quick to call them, now I’m calmer and can talk to them with conviction about pupils. CAMHS will often give us different strategies to try out and I am more confident now as my understanding is more in-depth’.

5.16 For some staff the training has been a real ‘eye opener’ or ‘thought provoking’ (as participants put it in written feedback on the training) even if they have had comparable training in areas like ACE in the past. As a member of pastoral support team in a secondary school put it:

‘The ACE training allowed staff to think outside the teaching box, made them more aware of other things in the background. It has shifted that “well, they just need to get over it” attitude. It’s emphasised that we don’t know what their story is, what are the missing pieces of the jigsaw. It’s a challenge for staff who have little time outside of teaching, marking, preparing, but it has given them a better understanding’.

- 5.17 In contrast, a minority of staff who contributed to the qualitative research, or who gave written feedback, were more lukewarm about the training; for example, some reported that the training confirmed what they already knew, describing it a ‘recap’ or ‘refresher’ (or similar, in written comments) rather than enabling them to learn new things. Nevertheless, as one primary school leader put it: ‘It was reassuring to know that’s what I’d been doing for years, but I didn’t call it that. To get confirmation that my process was ok, was great’. Therefore, although the impact upon skills was sometimes modest, the impact upon confidence could still be considerable.
- 5.18 Delivery by experienced clinicians is a key strength of the pilot programme. School staff interviewed as part of the qualitative research consistently reported that the CAMHS In-Reach practitioners understood the issues, and could bring real world examples, fostering trust and confidence in the training. This was supported by written feedback on the pilot training and has also been identified in other studies (Weare, 2015). However, it was also observed by interviewees from specialist services that delivery by health rather than education staff may have meant it took time for the CAMHS In-Reach practitioners to understand schools and their cultures, systems and dynamics, and to build relationships. As outlined in section 4, this may have slowed and weakened delivery in the early stages (e.g. where the language of health rather than education was initially used). Equally, as outlined in section 6, the investment of time by health staff in getting to know and understand schools helped build bridges between health and education.

Co-ordination and complementarity

- 5.19 A range of other services, including Primary Mental Health Support Services (PMHSS), EP, social services and voluntary sector organisations, such as Action for Children, may deliver similar training to the pilot programme. In Powys, PMHSS have delivered YMHFA training and, as a primary school leader described it:

‘GwE [the North Wales Regional Educational Consortia] provide a lot of training/resource around mental health. I’ve done some of their training around mental health as a leader and we spent time unpicking what well-being means, they had a well-being wheel and looked at ways of measuring.[The (Looked After Children)] LAC team provide training on ACEs, trauma informed approach, interventions such as Unearthing. All the staff have done the ACEs. 2 of our TAs have done a lot of training during COVID on a range of issues and interventions, we wouldn’t have been able to release them at this level, if it wasn’t for COVID.

The Behaviour Support Team hold a drop-in for TAs every Thursday morning where they look at different topics such as mental health, ACEs’.

5.20 This means it would be difficult to isolate the impact of pilot training because training is being developed and delivered by different services and organisations. This has created concerns about duplication of training and also the lack of opportunities or planning for structured progression across different types of training. In each pilot area efforts have been made, primarily through mapping of training and the work of pilot steering groups, to ensure the pilot’s training offer is joined up with that of other services. However, in all three areas, there have been challenges; for example:

- in North Wales, despite the strong partnership working between EP services and health in the steering group, it has been difficult to co-ordinate the pilots’ training with that offered by the North Wales Regional Educational Consortium (GwE);
- In South Wales co-ordination between the pilot’s training offer and that provided by EP services has improved, but remains somewhat *ad hoc*, and it has been difficult to co-ordinate with training delivered by the LA in Powys, as the pilot only covers two of the 13 school clusters in the county;
- In Ceredigion there is discussion and interest in how training for school staff relates to training for parents (e.g. that delivered by Family Services in Ceredigion) but there are concerns that this goes beyond the scope of the pilot.

5.21 In order to improve planning and co-ordination, it was suggested by an interviewee from a specialist service that a ‘steering group’ (or similar) at local/regional level would be useful in planning training provision. This could include the CAMHS In - Reach Pilot Programme; Whole School Approaches teams; EPs and inclusion teams; healthy schools staff; AoLE Hwb leads; mental health champions and those providing ACE training. Although it may be more appropriate to do this planning at a regional, rather than local level (as RPBs will be responsible for taking forward the work on embedding a whole-school approach to mental health and emotional well-being), this suggestion provides a useful indication of the range of services that needs to be considered.

5.22 Nevertheless, despite the concerns, it is notable that the pilot training is consistently reported by stakeholders, including school staff and services interviewed through the qualitative research, as adding value to, rather than duplicating, existing provision; this reflects:

- the quality and relevance of the training which often builds upon and complements other training by, for example, refreshing but also building upon and extending earlier training, such as training around ACEs and trauma, and which helps schools understand why a pupil is struggling and what to do (e.g. strategies);
- the gaps in some types of (non-pilot) training provision, for example in Ceredigion it is reported that no one else delivers mental health training; and
- the limited capacity of some services to deliver training and the reliance upon often time-limited funding, which means (non-pilot) training provision can be sporadic or only available at certain times of the year (and therefore less accessible and responsive when schools want it).

The training plus consultation model

5.23 The model, which integrates training and consultations, is one of the distinctive features of the pilot in West and Mid and South Wales (as outlined in section 4, the consultation model was introduced in North Wales towards the end of the pilot) and helps consolidate the training. As one of the CAMHS In-Reach practitioners observed, the problem with training is: 'If you don't live and breathe it, you forget it'. This reflects the ways in which training material which is not immediately relevant is swiftly forgotten (the 'use it or lose it' principle) (Glaveski, 2019).

5.24 As example of practice 6 illustrates, consultation helps address the 'use or lose it' problem, as it enables CAMHS In-Reach practitioners to 'guide' staff and help them identify and connect what they already know from their training, rather than 'telling' staff what to do, as one CAMHS In-Reach practitioner put it. It provides opportunities to link training to specific cases or concerns in schools, and link and signpost to other services, sources of information and training. Being alongside schools in this way helps build capacity (skills) and confidence and provides reassurance which, as outlined in section 7, helps to reduce staff anxiety; for example, as one secondary school head put it:

'What's important is knowing that there is someone there, a route, a pathway, someone there when you need them... [name of CAMHS In-Reach practitioners omitted] can be the voice of reason, to us it can be a massive thing, but her experience [means] she can] put it in perspective. It makes us more efficient and means we don't scare the parents and can prompt us to ask the questionthe

confidence to say things, as you know you're saying the right things and you can say so, which helps maintain our relationship with parents'.

- 5.25 Confidence and skills are important because, as the guidance on Embedding a Whole-School Approach to Mental Health and Well-being identifies: 'It supports a move away from a 'refer on' culture, to one where staff feel confident enough to be able to 'hold on', knowing they are supported and that their value as the person who knows the young person best within the school setting is recognised' (WG, 2021 p.45).
- 5.26 As with the delivery of training, delivery of the consultations by experienced clinicians is seen as a key strength; for example, as the head of a secondary school put it: 'Having someone with the expertise made a world of difference'. The quality of the relationship between CAMHS In-Reach practitioners and school staff, including the development of school staff trust and confidence in CAMHS In-Reach practitioners is also critical.

Example of practice 6. The Training plus Consultation Model

The example of practice illustrates the links between training and specialist advice, liaison and consultancy. As one of the CAMHS In-Reach practitioners described it: 'After 11 live (face- to-face) sessions of YMHFA, one teacher contacted us for a consultation on eating disorders, was worried about a pupil. They had talked to mum who had taken pupil to GP twice but been told not to worry. In the consultation I got the teacher to think about the pupil and the YMHFA training and it became clear this was a real concern. The pupil had lost 4 stone in a year. We rang the emergency liaison team and got an appointment that afternoon and immediately pupil was admitted as an in-patient because [the pupil] was so unwell. The teacher could act, building on the training and was supported by the pastoral lead. The point was that the teacher was seeing a day-to-day decline whilst the GP cannot'.

- 5.27 The model in which CAMHS In-Reach practitioners guide and facilitate staff through consultations (as example of practice 6 illustrates), rather than taking a referral and undertaking an assessment and developing a plan themselves, builds capacity. It also provides scope to identify schools' training needs. However, for some school staff, being able to simply refer to a CAMHS In-Reach worker in school would often

be preferable, given the competing pressures upon their time and attention.

Moreover, practitioners accept that in some cases, staff lack the 'headspace', as one CAMHS In-Reach practitioner put it, to be guided, and the CAMHS In-Reach practitioners become less facilitative and more 'solution focused'.

5.28 As Table 5.2. illustrates, evidence from the end-line survey suggests that around 80 per cent of staff who had been trained and supported by the pilot (n=70), valued the consultation. Responses were most positive in Mid and South Wales where schools had more access to advice and consultancy (given the smaller size of the area covered relative to the size of the CAMHS In-Reach team). Responses from staff who had been supported, but not trained, by the pilot (n=43) were less positive (only around a quarter strongly agreed or agreed), which is consistent with evidence of the value of the 'training plus consultation' model. However, only half of school leaders answering on behalf of the school who had been supported by the pilot (n=12), agreed or strongly agreed that the advice and / or consultation (delivered by the pilot) has increased their school staff's knowledge and understanding of pupil mental health problems and how to deal with them. This may be because advice and support was only just being piloted in North Wales, and almost half the responses from to the whole-school questionnaire were from schools in North Wales.

Table 5.2. Responses to the statement: The advice and or consultation (delivered by the pilot) has increased my knowledge and understanding of pupils' mental health problems and how to deal with them.

	No.
Strongly Agree	26
Agree	31
Neither agree nor disagree	9
Disagree	0
Strongly disagree	0
Not sure / don't know	4
	70

Source: *People and Work, CAMHS In-Reach end-line survey, 2020*

5.29 The impact of consultations upon staff confidence and, by extension, reduction of staff anxiety is seen as important and is discussed further in section 6.

5.30 The model of health or education professionals, such as staff from PMHSS or EP providing consultations in schools is not a new one, and as section 6 outlines, in each of the pilot areas other types of consultation operate alongside the pilot programme consultations. Some of the services offering consultations, such as

PMHSS or EP also deliver training, but their capacity to deliver consultations and training is more limited than the pilots’.

A responsive, rather than systematic training model

5.31 The range of training offered supports a tiered model that aims to cover:

- universal skills and knowledge: what all staff need to know;
- advanced skills and knowledge: what some staff need to know; and
- specialist skills and knowledge: what specialist staff need to know.

5.32 This model helps provide expertise within schools, increasing their capacity to deal with pupil mental health difficulties without recourse to external support and, by increasing capacity across school staff groups, can help share the ‘burden’ of dealing with often complex cases across staff within schools³⁴; for example, as one interviewee from an education service described it:

‘The pilot needs to reach the whole school. From the lollipop person and the caretaker to the senior management team and everyone in-between.

Safeguarding doesn’t depend on role or seniority; it depends on the relationship you have with a young person or child and that could be anyone within the school. It depends on the link with the child, the rapport you have. A male caretaker in a primary may be the only positive male role model in a little boy’s life and may be the person he can talk to. Everyone needs a basic awareness of children and youth mental health; others may require the First Aid and CAMHS follow-up courses, but everyone needs something’.

5.33 However, an analysis of what staff at each tier need to know has not been carried out by the pilots and would, arguably, be beyond the scope of the pilot programme³⁵. It has also been observed that it is easier to define the more advanced and specialist skills than it is universal skills, which may be more amorphous and contested.

5.34 Moreover, a range of different models of professional learning, including changes to Initial Teacher Education (Estyn, 2019), coaching, mentoring, self-directed study and participation in professional learning communities (Hill, 2013) alongside the

³⁴ Although complex and serious cases will be referred to specialist services most of those pupils will still be attending school while having treatment, or return to school after treatment, and so there is a need for staff to know how to support even these pupils.

³⁵ Examples of work in this area include Matrics Plant (2021), work focused upon Levels of Psychological Understanding required by the workforce.

models of training and consultation developed by the pilot, are likely to be needed to meet staff professional learning needs at each level.

A responsive and demand-led training model

5.35 The training offer is responsive and demand led, often delivered or accessed when it is needed (e.g. schools having problems with pupils who self-harm) increasing its relevance. However, arguably because it is responsive and optional (particularly in Ceredigion and Mid and South Wales) with staff able to choose from a broad menu of training options, it is not necessarily systematic, and may end being rather piecemeal. Some schools reported taking a more strategic response by identifying training that all staff must do and allowing them to opt into other sessions, but others leave it all up to individual staff members. This has meant that take up of some elements of the training menu, such as motivational interviewing in Mid and South Wales, has been low.

5.36 Crucially, the effectiveness of the pilot programme in matching staff to appropriate types of training (e.g. in terms of content and level) depends upon schools; in particular, it depends upon schools':

- engagement with the pilot;
- understanding of their staff training needs (and as interviewees from the pilot and services observed, schools: 'Don't know what they don't know'); and
- choosing and matching staff to the appropriate training courses and enabling them to take part in the training (e.g. by providing supply cover).

5.37 It was reported by schools (in interviews) and by CAMHS In-Reach practitioners that releasing staff can be difficult. As one education service put it: 'To be honest the professional learning offer is good, there's almost too much choice and it's a balance of upskilling staff and carrying on with the teaching, at the moment you don't want supply teachers in your school'.

5.38 INSET days are often booked up and the pilot training has had to 'compete' with training on areas like ALN transformation and curriculum reforms. As a secondary school leader put it: 'We have staff training days in-house and you have to fight for your topic to be included. There are many competing priorities'.

The importance of leadership and schools' culture

5.39 Support and commitment from school leaders is seen vital in both prioritising training (so, for example, staff can be released and also encouraged to go) and in

enabling what is learned in training to be applied or practised in schools. Without the latter, there is a risk that the pilot just creates islands of change within schools with the same people going on training³⁶. The scope for them to drive change can be limited if they do not have decision making powers and they are often not the people who need convincing. As one of the CAMHS In-Reach practitioners observed: 'The normal pattern for schools is to send a member of staff on training and then that person feeds back but it doesn't work – and the feedback is often inaccurate. We can follow up the training and offer whole school involvement'.

- 5.40 CAMHS In-Reach practitioners reported that evidence suggests that the most effective training involves either the whole school, or at least two people from each school, one of them in a senior leadership role. The research on embedding whole-school approaches highlights the importance of institutional, rather than individual, learning to drive change (Weare, 2015). Where schools were open to this, the pilot programme delivered whole-school training, and as a secondary school pastoral lead put it, the pilot: 'Has been instrumental in changing the direction of the school which we are very grateful for'.
- 5.41 However, the literature around cultural change in schools suggests that training, while important, is only one of a number of conditions necessary to enable and drive change (EEF, 2021; Weare, 2015) and the evidence from the pilot emphasises the importance of leadership support, in order to change the policies and culture of a school.
- 5.42 Developing an 'authentic' whole-school approach to mental health and emotional well-being is challenging, particularly in secondary schools which are larger and more complex than primary schools. Whole-school approaches will often need to be: 'Developed incrementally, with the total commitment of the senior leadership team, starting small with realistic expectations and proceeding strategically' (Weare, 2015), and the Framework on embedding a whole-school approach to mental health and well-being (WG, 2021) suggests a process driven, cyclical approach, based upon three stages: scoping, action planning and implementation, and evaluation. Research identifies that:

³⁶ HSC Wrexham and Denbigh: 'You tend to find the same people tend to go on these courses, so they are building up a lot of skill, experience and information around well-being and tend to be interested in the subject as well'.

- there needs to be an overarching framework and (if needed) changes in the culture, climate and ethos of the whole school; and
- that the different elements of a whole-school approach, such as a focus upon trusting relationships between students and staff, and between staff, services and specific interventions ‘need to be implemented with clarity and fidelity’ and underpinned by effective leadership, professional learning and effective monitoring and evaluation (Weare, 2015).

- 5.43 While leadership from the Senior Leadership Team (SLT) was seen as important, CAMHS In-Reach practitioners and interviewees from education services stressed that a number of different people in a school could exercise leadership and help drive change. As one described it: ‘Leadership is key. Individuals in significant posts who have a personal commitment to the issue. People who are passionate about the theme who want to do the best for their pupils. Sometimes, it could be in their job title such as well-being lead; it could be a personal interest of theirs and they are very happy to run with it and push for implementation within’.
- 5.44 This was supported by CAMHS In-Reach practitioners who talked about the possibility of ‘top down’ and also ‘bottom up’ approaches to driving cultural change. The latter involved individuals championing change, if they could broach the ideas with SLTs; for example, as a primary school wellbeing lead put it: ‘I’ve spoken to the SLT about the [pilot’s] training and we’ve plans to send more staff on this training. The appetite is definitely there’.
- 5.45 Cultural change was (unsurprisingly) seen as easiest where schools were open and receptive to the ideas and ethos of a whole-school approach to emotional health and well-being, and the pilot was therefore pushing at an ‘open door’. The impact of training was therefore seen as often dependent on the culture and ethos of the school. It was noted by CAMHS In-Reach practitioners that the training required staff to engage and, in some cases, change their mind set. It was observed that a lot is demanded of teachers and they ‘want to be teachers not social workers’. Therefore, as one CAMHS In-Reach practitioner put it: ‘A lot of the training depends on the timing of the training, people’s motivation and the culture of school’ and: ‘Leadership is vital too; the courses have to be endorsed; people have to be led’. Nevertheless, examples were given where the pilot helped catalyse a change in a school’s ethos (‘opening doors’ which were previously stuck). The main examples of

this were shifts from behaviour to relationship polices in schools; for example, as one secondary school pastoral lead described it:

‘Coming out of the special interest training that we had was Trauma Informed Schools and from that we thought about our behaviour policy. It has been a traditional sanction and punishment with a bit of reward policy. Since then, we have appointed a gentleman in charge of restorative practice. My ALNCo and him are developing – well it is a work in progress – they are developing a relationship policy to replace the behaviour policy. We will have sanctions or consequences but we will be trying to move to a restorative approach, and that has come out of what we are trying to do. Restorative is about what we do with kids rather than to kids. So, say if a kid tells a teacher to “fuck off” we talk about it and it may be the teacher played a song that was played at his granny’s funeral and it triggered him, so it’s moving from blame and shame to how to put things right and build relationships’.

Assessing the impact of staff training

5.46 As outlined in section 2, a robust measurement of the impact (difference) the pilot programme made to staff skills and confidence was not part of the evaluation design. Nevertheless, the qualitative research, review of training feedback and survey data discussed above, suggests that the training is felt to have increased staff skills and confidence, and this can enable staff to identify problems earlier, talk to pupils and, where appropriate, to ‘hold on’ not ‘hand on’ pupils. This means, as an interviewee from sCAMHS put it: ‘A pupil can go to the person they have the most connection with or trust the most’. Similarly, as one of the interviewees from an education service put it:

‘You will often hear [school staff say] “we’re not trained, we’re not mental health practitioners”. This fear could be allayed through training. We have a referral culture. There’s a waiting list for counselling. Sometimes young people just need time, love, care, a chat, to be heard, to be listened to. The training can offer reassurance and safety for staff. However, access to this does need to be ongoing. The training can highlight when there should be a need for referral. Not every young person needs to be referred on’.

5.47 As outlined above, the qualitative research also suggests where the school senior leadership team was supportive, or at least open to the training, it could contribute to changes in school policy. As one pastoral lead in a secondary school put it:

'The pilot has allowed us to develop a whole school approach. It is now seen as everyone's responsibility. The pilot has had a positive impact, it's difficult to measure, difficult to attribute given the many programmes and training that are available, but has been a positive force in on-going development, we can only be the better for it'.

Training for other staff groups

- 5.48 Training, particularly if online, can be opened up to non-school staff, such as school nurses, school counsellors, youth workers and education welfare officers. Qualitative interviews showed that training other services that are involved in supporting pupils alongside the school and also training across a school cluster, helps develop shared culture, knowledge and language which supports joined up working and transitions between schools. As an interviewee from a youth service put it: 'Staff appreciate that they are getting the same training as schools – so we are all working from the same hymn sheet'.

The impact of COVID-19 upon the delivery and value of training

- 5.49 COVID-19 disrupted the delivery and take up of training, particularly during the first lockdown when schools were scrambling to adjust and as outlined in section 4, some CAMHS In-Reach staff were redeployed and requests for consultations fell during the lockdowns, as schools were not seeing pupils. Lockdowns also had uneven effects on schools' ability to release staff; for example, schools and CAMHS In-Reach practitioners reported that the closure of schools, and the shift to online training, meant it was sometimes easier for support staff to attend training and that some school staff could do training during the school day. The pandemic also increased schools' concerns about some pupils' mental health and well-being, which increased some schools' interest in the training. Pilots, therefore, saw the second lockdown as an opportunity to offer more training, including daytime training. However, some school staff and in particular, school leaders, had been even busier as they balanced online teaching, classroom teaching with some pupils and home-educating their own children (making it more difficult for them to engage with the training). This may have made the impact of training more diffuse, hindering contributions to whole-school approaches.
- 5.50 Delivery online is seen by schools and CAMHS In-Reach practitioners as having some benefits. Most notably the savings in time and money associated with not having to travel and the increased accessibility of online training. It was seen as

having accelerated moves to deliver online. However, it was felt by CAMHS In-Reach practitioners that these benefits were outweighed by the costs such as:

- the reduction in staff engagement, as CAMHS In-Reach practitioners put it: 'They can hide behind the screen'; it 'Can feel like a monologue'; you 'Don't get feedback or discussion'; and
- technical issues including problems with connectivity and hardware, which, as one In-Reach practitioner put it: 'Can be a nightmare at times'.

5.51 Similarly, the shift to online and telephone consultations was seen as having benefits in terms of the time saved and greater flexibility, which increased accessibility. As one practitioner put it: 'I think being flexible is key, and what the individual preference is, would they prefer face-to-face or Microsoft Teams due to time restrictions. Being flexible with school staff around consultation I think has improved participation. I do think face-to-face connection is irreplaceable though'.

5.52 It was also reported to have made it easier to involve a wider range of non-school staff, such as youth workers, who support pupils and schools. However, as the quotation illustrates, it was felt by CAMHS In-Reach practitioners that these benefits were outweighed by the costs. As they described it, the challenges included:

- the loss of opportunities to better understand schools; for example, as a CAMHS In-Reach practitioner put it: 'You get a sense of the school culture when there in person';
- the loss of opportunities to model practice; for example, as a CAMHS In-Reach practitioner put it: 'We connect and attune with others face-to-face, we want to model what we want educators to provide', and it was reported in West Wales that it was not possible to do formulations through Microsoft Teams meetings; and
- build relationships. As a CAMHS In-Reach practitioner put it: 'Consultation face-to-face is a rich experience, being able to read the body language, and really building the relationships, trust and reliability'; 'out of choice I would have a face-to-face consultation because of building up that relationship with the staff which is key to establish trust'. Those CAMHS In-Reach practitioners who were new to post in 2020, highlighted this in particular, commenting: 'It's hard to build those quality connections via online'.

- 5.53 More positively, during the qualitative research, some schools reported that interest in training had grown due to the pandemic and the training meant that they were better able to cope with the impacts of COVID-19; for example, as a school leader in a secondary school put it, when asked if they felt that the pilot programme meant they were better prepared for the impacts of the pandemic, they replied: ‘Yes, I would say we were better prepared, especially in terms of anxiety. With mental health more on the agenda, we were able to think through the consequences of the impact of Covid-19’.
- 5.54 However, this was not a uniform response, which may reflect the extent to which the impacts of the pandemic were so unexpected and wide, that training could not hope to adequately prepare staff for its effects.

6. Access to specialist advice, liaison and consultancy

Introduction

- 6.1 As outlined in section 5, while schools can, should and do, assess pupil mental health difficulties, they are not trained mental health experts, and they should not seek to diagnose conditions. Instead, assessment of severe and complex mental health difficulties should be undertaken by specialist services such as EP and sCAMHS. As a head teacher in a primary school put it: ‘We can’t be mental health practitioners. We teach. It’s good to have some skills and information, but we need a mental health service that complements us and that is by our side, touching base with us on a regular basis’.
- 6.2 As outlined in the introduction, concerns have been raised about access to specialist services (see e.g. Children’s Commissioner for Wales, 2020; NafW, 2018; WG, 2015c). These concerns were supported by qualitative research with schools and services, which identified that access to specialist support was generally felt to have deteriorated in recent years as a result of a combination of increasing demand for services and cuts in provision; for example, as a primary school head teacher described it: ‘Ten years ago CAMHS was good, they used to come to SEN consultations – we used to have sessions with the SENCos from cluster schools, occupational health, educational psychology..... but now no one is available. Accessing support is awful’.
- 6.3 Another primary school head teacher explained: ‘Like most schools, we are aware of the stress that CAMHS are under. For us, it means that they are difficult to get a hold of. Sometimes you can be told it’ll be a week before they ring you back and then they aren’t always the easiest to deal with’.
- 6.4 There were also concerns about what has been described as the ‘missing middle’ caused by the hollowing out of services between schools and increasingly specialist services whose thresholds had been raised (NafW, 2018; Children’s Commissioner for Wales, 2020). As a primary school head teacher reported: ‘CAMHS and social services will often not offer support as the pupils don’t meet thresholds or criteria’.
- 6.5 These difficulties in accessing specialist support mean that interventions can be delayed and problems can escalate, as a primary school head teacher commented: ‘We cannot get children to the right place, and even when there is a recognised

need it can take a long time to get help'. Moreover, as section 7 outlines, the delays and worries this causes for staff can impact upon staff mental health and well-being.

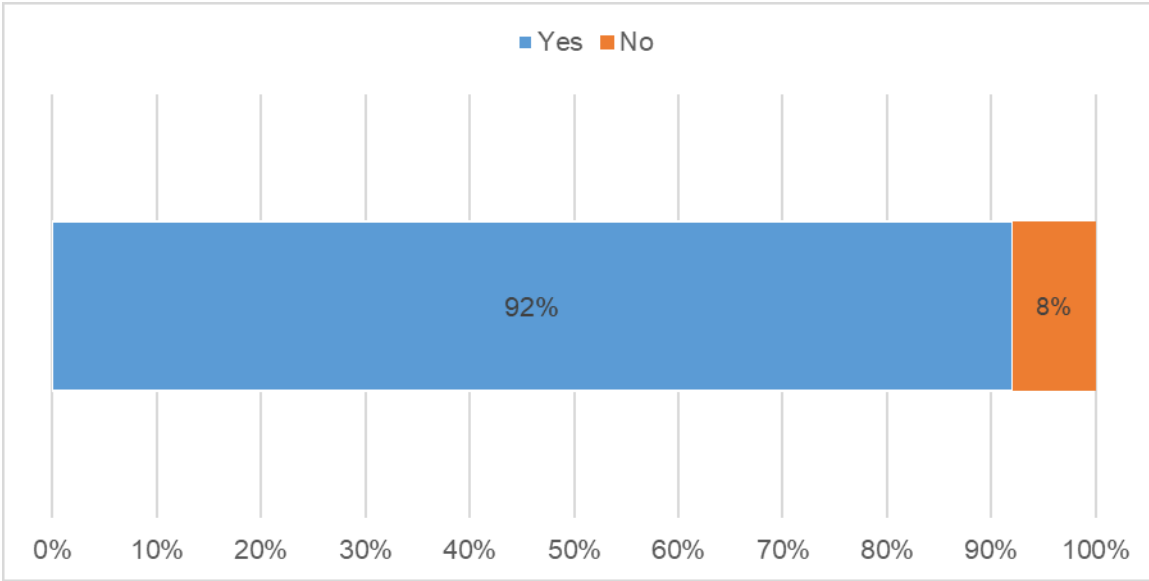
- 6.6 In response, the pilot programme's original theory of change (see figure 1.1) identified improving schools' understanding of roles, responsibilities and referral pathways as the main mechanism for ensuring that schools are: 'Able to direct pupils to specialist liaison and consultancy and advice when they need it' (as an outcome of the pilot programme).

Training and awareness-raising around referral pathways

- 6.7 Although training and awareness-raising around referral pathways was the main mechanism in the pilot theory of change for providing access to specialist advice, liaison and consultancy it has not proved important in practice; for example, as one of the CAMHS In-Reach practitioners described it: 'The referral pathways are clear through the Single Point of Access and the pilot reinforces the existing pathways'. Although Ceredigion is doing this now³⁷, there has been little formal training in other pilot areas, as this was not felt to be needed. As Graph 6.1 illustrates, this is consistent with the responses to the survey, with over 90 per cent of respondents in the end-line survey agreeing that they knew how to access further advice or support when a pupil may have mental health difficulties. Similarly, 14 out of 15 school leaders answering on behalf of the school agreed that if needed, staff in their school know how to access further advice or support when they identify that a pupil may have mental health difficulties.

³⁷ They are developing a pack of all services grouped into categories (neuro, physical, social, behavioural etc...) and their eligibility criteria, who can refer and how to contact – they will print it and also put it online; it was initially for GPs but will be made widely available – however, it has become very complicated.

Graph 6.1. Responses to the statement: If needed, I know how to access further advice or support when I identify that a pupil may have mental health difficulties.

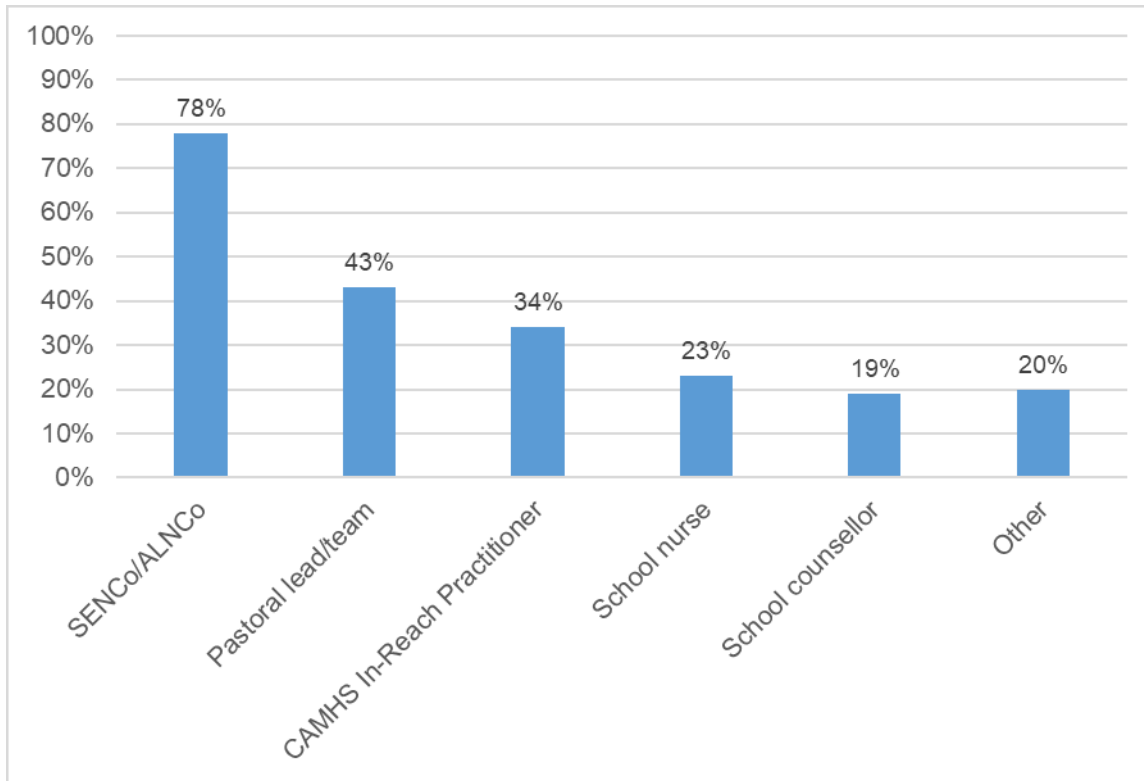


Source: People and Work, CAMHS In-Reach end-line survey 2021 (n=202)

6.8 As Graph 6.2. illustrates, within schools SENCo/ALNCo are the most commonly identified source of support, followed by pastoral teams/leads and CAMHS In-Reach practitioners. This was similar to the pattern in the baseline survey. Although not directly comparable, it is worth noting that the proportion of staff identifying that they would go to a CAMHS In-Reach practitioner was, as expected, higher in the end-line survey (34 per cent) compared to the baseline survey (26 per cent). These findings emphasise, however, that CAMHS In-Reach practitioners only worked with a small proportion of staff and pupils. They reinforce the need for a systematic approach to training, outlined in section 5, to ensure those who need more advanced and specialist skills and knowledge in a school or school cluster (such as SENCo/ALNCo and pastoral leads), can obtain them.

Graph 6.2. Responses to the question: Who would you go to in school for further advice and support when you identify that a pupil may have mental health difficulties?

(Staff could choose more than one option, so totals add up to more than 100%).

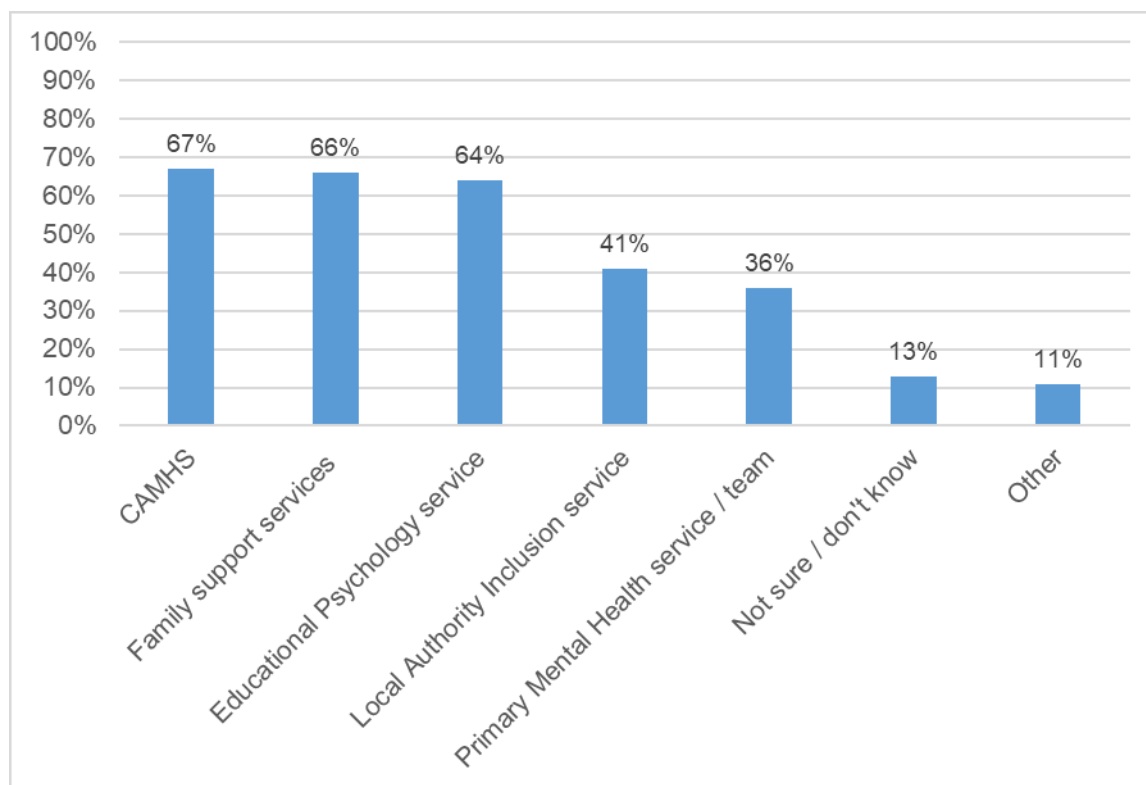


Source: *People and Work, CAMHS In-Reach end-line survey 2021 (n=183)*

6.9 As Graph 6.3. illustrates, CAMHS, family support services and EP were the most commonly identified sources of external support in the end-line survey. This is similar to responses in the baseline survey. The pilot’s relationship to these other sources of support is discussed below.

Graph 6.3. Responses to the question: Which services would you go to for advice and support?

(Staff could choose more than one option, so totals add up to more than 100%).



Source: *People and Work, CAMHS In-Reach end-line survey 2021 (n=181)*

- 6.10 There is, however, an important distinction to be drawn between knowledge of referral pathways and how to refer, which schools are generally confident in, and knowing when and who to refer to, where schools are often less confident. As a primary school head described it: 'There has been no change in the agencies we work with but ...[name of CAMHS In-Reach practitioner omitted] is the way in now' and as a primary school SENCo described it: 'Referrals are easier now than they used to be'.
- 6.11 Before the pilot started, school staff sometimes lacked confidence in being able to meet a pupils' needs and/or identify which service was best placed to support a pupil. This lack of confidence could lead to what a number of interviewees from the pilot programme and services, described as 'scattergun' referrals, where schools, who did not know what to do, made multiple referrals in the hope of getting some help.
- 6.12 As section 5 outlines, both the training and consultancy are reported to have made an important contribution to addressing scattergun referrals. Training, such as the

YMHFA course, is reported to be valuable in giving school staff the confidence and skills to know if a pupil's difficulties are unlikely to require specialist support. As one CAMHS In-Reach practitioner put it: 'I think there's been an enhancement of what's on offer, we've encouraged people to use the pathways available, we've reinforced information, given people confidence and crucially, given people the language to make good referrals, especially for those who've been on the Youth Mental Health First Aid course'.

- 6.13 Training has also increased awareness of the range of support services and through signposting, advice and consultancy, in Mid, South and West Wales, In-Reach practitioners advise on when to refer and who to refer to (i.e. while schools generally know the referral pathways, CAMHS In-Reach practitioners help them choose the right pathway). As a senior leader in a primary school described it: 'She offers expertise and signposting – you can ring her and describe a child and she will say this is not a CAMHS issue but ring these people'. This is in line with the Framework on embedding a whole-school approach to mental health and well-being, which identifies that: 'A collaborative joined-up approach should enable each school to access consultation, liaison and advice from specialist mental health services. Advice and discussion should occur prior to any referral and alternative signposting should be considered prior to referral to more specialist services' (WG, 2021 p.54).
- 6.14 Consultation sessions, discussed further below, enable staff to talk through their concerns and get advice on whether they should refer and who they should refer to, and also how to refer effectively (e.g. what information will be required). Without this help, as a primary school head teacher reported: 'You can spend an afternoon preparing a referral to be told 'No Further Action', that's frustrating for staff and the family and the school still have to cope'.
- 6.15 Moreover, as example of practice 7 illustrates, schools may be more confident to act without referring, because they know, as one school interviewee put it: '[name of CAMHS In-Reach practitioner omitted] has got my back'. Access to CAMHS In-Reach practitioners often provided confidence and reassurance that schools are doing the right thing and ensure that they can easily access further advice and support if needed. As an interviewee from CAMHS observed: 'Support from CAMHS In-Reach practitioners might simply provide reassurance that school staff should continue what they are already doing to support a pupil'. Similarly, as a primary

school SENCo commented: 'Sometimes it is a good thing to have someone experienced to say that you are doing well'.

Example of practice 7. Supporting the School to support Richie

The example of practice illustrates how the pilot's specialist advice, liaison and consultancy model can provide school staff with reassurance that they can support a pupil without making a referral to specialist services. As a CAMHS In-Reach practitioner described it:

The pastoral lead for a secondary school requested consultation from In-Reach regarding a year 7 pupil 'Richie'.

The school is concerned as Richie appears to have struggled with the transition to secondary school in that he becomes highly anxious in many lessons, often asking to leave the class several times to use the toilets and having a panic attack in assembly. Richie has started refusing to come to school on a Tuesday, and the school feel this is because he feels very worried about PE lessons.

In-Reach provided a consultation slot with the pastoral lead. The In-Reach practitioner asked the pastoral lead in the school how they were and how they felt supported. In-Reach asked about the home context and what emotionally available adults Richie had around him. The discussion continued to explore what school had already put in place (a Time Out pass, a quiet place in school). In-Reach were able to explore how Richie might be thinking, feeling and coping with worry and the neuroscience behind this (psychoeducation). In-Reach provided leaflets and work sheets to better explain and other coping strategies for school to introduce to Richie. In-Reach encouraged the pastoral lead to share with Richie and other staff strategies that support him to create a better understanding within his school context. In-Reach and the pastoral lead felt that containment and helping Richie feel psychologically safe within school needed to be the first priority. The pastoral lead felt reassured by In-Reach that the approaches she had come up with as short-term goals were appropriate.

As there were several pupils presenting in similar ways in year 7, it was negotiated that it may be useful for In-Reach to provide further training around strategies to a wider staff group, so a workshop around anxiety was planned as part of the school's next Twilight activity.

This early intervention was enough to contain Richie in school and stopped a referral needing to come to the SPACE-Wellbeing panel. Staff felt empowered to have approaches and strategies they could use with other pupils as a result of the training.

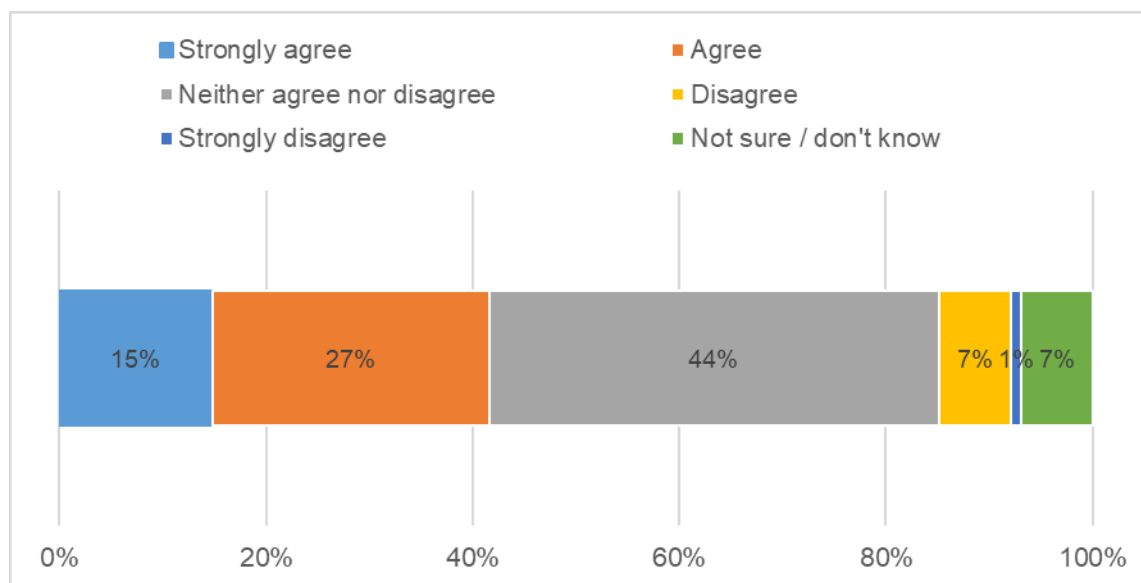
Example of practice provided by the Mid and South Wales Pilot

Access to specialist support, pre-critical point referrals

- 6.16 The pilots' work to support schools' decisions making about referrals can speed up processes and increase efficiency. It means schools can make better informed decisions about when and who to refer. This can reduce time wasted:
- on inappropriate referrals (it means schools are more likely to refer once and refer to the right service/agency the first time, rather than making scattergun referrals);
 - on submitted referrals being returned as they lack sufficient information; and/or
 - on waiting for assessments that are not needed.
- 6.17 The time wasted increases costs and demands upon services, which then can increase waiting times.
- 6.18 Better informed referrals can also increase demands upon services, which can sometimes be welcomed by services which have struggled to generate demand from schools (e.g. as they are now aware of the support offered).
- 6.19 However, there are structural constraints on the impact of the pilot programme upon access to specialist support, most notably the constrained capacity of specialist services relative to demand. As one primary school leader put it: 'CAMHS's door is almost shut' and, as a secondary school head teacher commented: 'You need more capacity, not more policies'. Referral pathways can also constrain the pilot impact; for example, in West Wales:
- while the CAMHS In-Reach practitioners work with schools, and can shape their referrals, the pilot has had limited impact on other services, like GPs who may still refer to sCAMHS, even if an intervention or referral to another service would be considered more appropriate by sCAMHS; and
 - school nurses are advised to contact the SPoC and talk to the screening team to decide if to refer or not, rather than talking to CAMHS In-Reach practitioners, because this existing pathway is considered to be working well.
- 6.20 These structural constraints, combined with the impact of COVID-19 upon services (discussed below) may explain why, as graph 6.4 illustrates, the perception of support from sCAMHS remains mixed amongst staff surveyed in the end-line survey of 2021. Of those who had accessed sCAMHS, only around 40 per cent strongly agreed or agreed that they felt supported by sCAMHS. School leaders answering

on behalf of the school (n=13), were similar, with just five agreeing or strongly agreeing that they felt supported by sCAMHS. While not directly comparable, it is worth noting that these responses are similar to responses in the baseline survey (46 per cent of staff surveyed who had accessed sCAMHS either agreed or strongly agreed that they felt supported by sCAMHS).

Graph 6.4. Responses to the statement: I feel supported by CAMHS.



Source: *People and Work, CAMHS In-Reach end-line survey 2021 (n=183)*

6.21 This is also broadly consistent with the analysis responses to the SEQ by DECIPHer, which found that responses to a series of questions about access to and support from CAMHS³⁸ in pilot areas were broadly similar to responses from schools in non-pilot areas in 2020. As a cross-sectional analysis, these results should be treated as indicative evidence of the pilot’s impact (or lack of impact).

³⁸ Schools were asked: (1) Do you have a named person within your local Child and Adolescent Mental Health Service (CAMHS) who you can contact for help and support? (response options: ‘yes’, ‘no’, ‘don’t know’); (2) In the last two years, approximately how often has your school been in communication with your local CAMHS? (response options: ‘weekly’, ‘fortnightly’, ‘monthly’, ‘about once a half term’, ‘about once a term’, ‘less than once a term’, ‘never’, ‘don’t know’); (3) If you made any [CAMHS] referrals, did the student(s) get access to treatment? (response options: ‘yes, all’, ‘yes, some’, ‘no’, ‘don’t know’); (4) To what extent do you feel supported by your local CAMHS? (response options ranged from ‘1. very supported’ to 5. ‘not at all supported’, and ‘don’t know’).

Table 6.1. Cross-sectional comparison of outcome measures between pilot and non-pilot schools.

	Pilot schools (No.)	Non-pilot schools (No.)
Named CAMHS contact		
Yes	21	84
No	5	26
Don't know	0	6
Freq. CAMHS communication At least fortnightly	14	61
Accessed treatment post-CAMHS referral		
Yes, all	2	5
Yes, some	16	53
No	0	0
Don't know	0	0
Perceived level of CAMHS support Feel supported (1 or 2 on scale)	8	39

Source: DECIPHer

Delivery by highly skilled mental health professionals

6.22 As with the delivery of training, delivery of consultations by experienced clinicians is a strength. They are, with a few exceptions, consistently described by school staff (interviewed through the qualitative research) as understanding the issues, trusted, building people's confidence, and knowledgeable, knowing when to refer on, to whom and how to refer. At their best, they have also got to know and to understand schools and education, so their advice is practical and useful to schools. Their advice allows for the constraints that schools, which are busy, noisy environments, and in which staff have multiple demands upon their time and attention, impose on what it is possible/feasible for staff to deliver/do.

Access to consultations

- 6.23 The pilot model provides schools with direct access to some of the expertise CAMHS offers. However, unlike some areas in the English school link pilots (discussed in section 4) it does not provide a 'full' CAMHS offer to schools; for example:
- CAMHS In-Reach practitioners were intended to only work with and advise staff (they do not see, assess and/or work directly with the child or young person); and
 - they only advised on mental health issues, and would, for example, signpost concerns about neurodevelopmental issues to the ND service (which is generally part of sCAMHS).
- 6.24 The pilot programme's focus is upon supporting and advising school staff on how they can better support the mental health needs of pupils, so the support work is done by school staff, rather than the CAMHS In-Reach practitioners, working directly to assess and support an individual pupil and manage their care (as a sCAMHS service might). This helps increase staff skills and confidence and means that practitioners' time is not taken up with assessments or therapeutic work, which would take precedence over supporting staff, as has happened with sCAMHS. This approach also means that the pilot can be more responsive, as it is easier for CAMHS In-reach practitioners to arrange meetings with schools, if pupils and parents, who may object to a referral and/or struggle to find the time to attend, are not involved. As a primary school head teacher remarked: 'The perception is if we make a referral, there's something wrong with my child', there's stigma. Similarly, a secondary school head observed that parents may be more accepting as it does not involve a formal referral to sCAMHS. However, as discussed below, in practice the model can be difficult to sustain, particularly when, as was often the case, the focus of a consultation was on an individual pupil, or they are asked to work with parents.

An accessible service for schools

- 6.25 CAMHS In-Reach practitioners' accessibility, particularly in Mid and South Wales, is seen as a key strength by school staff (but the size and rurality of Ceredigion, coupled with the smaller size of the team, meant the service was perceived as less accessible). It enabled school staff to access support when they needed it, helping share the burden of decision making and reducing staff stress. Practitioners were described as someone a staff member could ring even late on a Friday to talk

through the scenario and come to a decision, so they are not left on their own. As one secondary school SENCo described it:

[Names of CAMHS In-Reach Practitioner omitted and replaced with 'she'] I can't praise them enough. She worked with CAMHS so I knew her before which helped matters. I asked for advice about a child we had referred to CAMHS and she knew the child. We also thought there was attachment issues and child protection issues – so it was getting too much for me to sort this out.... We went down the child protection avenue in November ... and within a month he was taken from his home. She put me on the right route. He also got an autism diagnosis with their help. ... I lost a lot of sleep over this as I knew I was breaking up a family, [but he] seems better now, he has settled well with foster parents so I feel better now. I wouldn't want to go through this again. I've been doing the job for 20 years and this is the worst case I've experienced. It's been an emotional roller coaster'.

- 6.26 The model of health or education professionals from PMHSS or EP providing consultations in schools is not a new one, and as section 5 outlines, in each of the pilot areas, other types of consultation operate alongside the pilot programme consultations. Where these are working well, they are valued by schools; for example, a secondary school head teacher described:

'We have a once a month consultation with CAMHS and we can always ask the school nurse, who will come in. Also we have got superb support in the local surgery. We have support from the youth service. A youth worker comes in one day a week and we also have three youth intervention service worker sessions a week [through TAF]... they do an hour a week with a child. We have school counselling and online counselling support. Pupils can speak to a counsellor face-to-face – they come in one day a week'.

- 6.27 The pilot consultation model complements this, by offering more accessible lower-level support, and support that is focused upon building staff skills and confidence, rather than directly assessing and/or supporting a pupil. It is consistently reported by school staff (interviewed through the qualitative research) to be quick and easy to access as it does not have the cumbersome referral processes or long waits for an appointment or monthly scheduled session often associated with other types of services. One primary school ALNCo said that: 'I have her [the CAMHS In-Reach Practitioner's] phone number [and can phone] for professional advice without having

to fill in ten sheets of paper and wait weeks for a referral is invaluable'. Similarly, as the pastoral lead in a secondary school put it:

'If anything came about from this learning from In-Reach it would be that it would be so useful to know that there was a [name of CAMHS In-Reach practitioner omitted] who could come in every day or even once a fortnight to have on-site and so you could go to her and say "what would you do about that" and "could you attend this meeting". I am always asking if she can attend meetings and she always says "no, but this is what you need to say at that meeting"'.

- 6.28 As the quote above illustrates, it enables school staff to build a relationship with someone they know and trust, rather than a faceless organisation. As an interviewee from sCAMHS observed: 'Having the same person to speak to is of great importance' and as, a primary school well-being lead reported (when discussing their relationship with services such as sCAMHS): 'Occasionally, when we send detailed referrals and we're working with someone we haven't worked with before, there is a sense that we're not believed. It's very different with agency staff than when we have a history of previous working experience'.
- 6.29 In contrast, while other services such as PMHSS may also offer telephone consultations, they were generally reported to be less accessible. As an interviewee from an education service reported:
- 'We already have the drop-in run by CAMHS/Ed Psych at [name of school omitted]. This can be a bit hit and miss if I'm honest. It has gone electronic in recent months and there is some of it that would be good to retain. However, the closer you get to a school, the more access can be offered staff to specialist advice. The drive to the drop-in might be a barrier [as the drop-in is based in one school, which other schools have to travel to], the organising you'd have to do to get there. ...The CAMHS person can get to know the school, the pupils, drop in on staff meetings, be visible, build up relationships and offer a level of support, quality advice and information and on-going support that will feel safe for staff and build confidence'.

Example of practice 8. North Wales CAMHS Education Link workers

sCAMHS in Denbighshire has introduced CAMHS Education Link workers (CELs). In order to address schools' concerns about how the post related to the CAMHS In-Reach pilot support, a RAG rating system was introduced:

- In-Reach concentrates on 'green' low level mental health issues,
- CEL Workers concentrate on 'amber' mid-level mental health issues and
- sCAMHS provide intervention for the 'red' issues.

In-Reach focused upon advising and building schools' capacity, while CELs workers can, for example, offer face-to-face work with young people, family members and parents.

6.30 However, the pilots sit in a complex service landscape and the differing purposes of these different types of consultations have not been fully worked through, although as example of practice 8 illustrates, a RAG system is being piloted in North Wales, and in South Wales, as case study 9 illustrates, a joint model of consultation bringing together CAMHS In-Reach, EPs, Community Psychology and Families First delivering joint clinics is being trialled.

Example of practice 9. Proposal for Multi-agency consultations in Mid and South Wales

In Mid and South Wales school staff can access consultation and advice from EP, Families First, and/or Mental Health In-Reach to Schools. In some cases, a request for consultation/help may come through separately to each individual service, often regarding the same child and the same presenting problem or concern. These services have different areas of speciality but because there may be complex and overlapping features in the presenting needs of some children, proposals for staff to access one multi-agency consultation rather than separate consultations with each professional are being developed. This would bring together staff from EP, Families First, Mental Health In-Reach to Schools, Community Psychology and the Youth Service.

It is planned to offer school clusters, one day per half term, allowing for four sessions, bookable in advance and run online via Microsoft (MS)Teams.

Consultations would be anonymous and last for up to 45 minutes and would be for a child or young person experiencing emotional health and well-being issues proving particularly difficult to address.

Adapted from the Mid and South Wales pilot's material

Engaging primary schools

- 6.31 The responsive, face-to-face consultation model requires sufficient staff time. The large size of Ceredigion and large number of small schools created challenges for the delivery of a face-to-face consultation model and the focus instead was upon TAF meetings in secondary schools (discussed below). Similarly, where CAMHS offer consultations to schools (North Wales, Powys) they only/mainly offer it to secondary schools or to a cluster.
- 6.32 Unlike Mid and South Wales where 47 primary schools were engaged, only seven out of 55 primary schools in West Wales engaged with the pilot's offer of advice and consultations (as distinct from training). This was attributed by CAMHS In-Reach practitioners to lower levels of need, especially in smaller schools, where the number of year 6 pupils is small and it may be easier to manage problems. It was also noted that sCAMHS receive very few referrals from primary schools.
- 6.33 Although engagement of primary schools in Mid and South Wales with the pilot's consultation offer was stronger, school staff interviewed through the qualitative research often reported that they were increasingly seeing pupil mental health difficulties emerging in younger age groups. Therefore, there were calls to extend the pilots' offer to cover younger age groups (i.e. below year 6).

Working with children, young people and/or parents or carers

- 6.34 Although as outlined above, it has strengths in some ways, the decision not to directly work with children, young people and/or parents or carers constrains CAMHS In-Reach practitioners' impact; for example:
- it relies upon schools' knowledge and insights and as CAMHS In-Reach practitioners reflected, it is: 'Really beneficial if you're discussing that child...to understand, [to be able to talk to them if they are there in the room with you] and it runs counter to principle, of person-centred planning, which identifies that we should all [be] talking together [to identify] what's the best way forward?'

- it also means that opportunities to ensure strategies used in school are also implemented at home may be lost. As CAMHS In-Reach practitioners reflected: 'I feel like there's a real gap with parents and there's clearly a need for parents to have our support too', and another reflected that if they could work with parents or carers, they could also: 'Help and support the child at home with support in place'. This, it was reported, would help ensure greater consistency of support, which would be better for the child or young person.
- It was also observed by CAMHS In-Reach practitioners that because parents are not part of the process, they can be 'impatient' and try to go sCAMHS via their GP.

6.35 Schools echoed this and one respondent said that they would very much value the In-Reach practitioner attending meetings with the child/parent instead of just giving advice about how to handle the meeting. This may reflect lower levels of staff confidence in talking to pupils and parents or carers, discussed in section 5.

6.36 However, the boundaries of the advice, liaison and consultancy role (in Mid, South and West Wales) are fluid. Parents have been involved in some cases and CAMHS In-Reach practitioners have come close to doing assessments of some pupils and providing ongoing support. This flexibility has helped relationships with schools but creates tensions and may be difficult to sustain or manage (e.g. if there is increasing demand for this from schools).

Contribution to multi-disciplinary groups

6.37 More complex cases, which require multi-disciplinary input, can be referred to TAF meetings (as is the case in Ceredigion) or the SPACE-Wellbeing panel (as is the case in South Wales – see example of practice 10), to which CAMHS In-Reach practitioners can contribute.

Example of practice 10. The SPACE-Wellbeing Panel

An interviewee from sCAMHS described how typically, four to five clinicians attend the SPACE-Wellbeing panel, and the community embedded team support them. The clinicians look at what is needed. Some cases are straightforward, some do not meet sCAMHS's threshold, so they need to work with the referrer. Collaborative work is seen as important. SPACE-Wellbeing has not reduced their workload- as they put it, they would just have turned away people before - but that left a needy population of young people with difficulties, but not a mental health problem, with no support. Equally, they reflected that is not helpful to give these young people a mental health diagnosis just to get some help from sCAMHS.

- 6.38 CAMHS In-Reach practitioners' involvement in multi-disciplinary meetings is reported by practitioners to help:
- ensure they and other services have a richer and more holistic understanding of pupils' needs and circumstances;
 - build practitioners' understanding of each service, what it can offer and who it can work with; and
 - improve communication between schools and services and ensure consistency of responses.
- 6.39 In addition, in West Wales, the TAF provided a swift and established entry point into schools for the pilot and avoided creating another layer of meetings; and in Mid and South Wales, participation in SPACE-Wellbeing meetings is reported to be valuable in identifying pupils who may otherwise be missed, and identifying training needs; for example, when strong themes emerge around a school, the CAMHS In-Reach practitioners reach out to the school and offer support. This has helped engage some schools which had previously not engaged with the pilot.
- 6.40 However, the multi-agency model is less responsive than direct In-Reach consultations with schools because meetings are scheduled in advance, with a fixed frequency, such as once a month, and reduces the scope to build capacity in schools. Therefore, it is seen as a complement to, not a substitute for, bilateral consultations with school staff.

The relationship between CAMHS In-Reach practitioners and sCAMHS

- 6.41 In Mid and South and particularly in West Wales, CAMHS In-Reach practitioners play an important liaison role between sCAMHS and schools. Subject to parental consent, they can help make sure the school knows what is happening post-referral and can help schools implement advice and supportive strategies following a referral. This can help break down barriers between schools and services like sCAMHS and enable a more joined up response, in the sense of enabling joint work between health and education.
- 6.42 After a referral to sCAMHS, schools will only hear the outcome if parents or carers, or potentially the child or young person, tells them. This means referrals can feel for schools like the dead end of a one-way street. The problems this can cause and the importance of communication was highlighted by a school leader in a primary school:
- ‘Getting access to [s]CAMHS is a lengthy process... [although] they are getting quicker. The pupils often go out for their intervention and the teachers are not aware of what’s being asked of the child. I feel it would be good if we were more aware of what the intention is and what is expected of the child, that we meet somewhere in the middle, as staff can support the pupil if they know what strategies are being suggested. We had one child receiving CBT and was using a grounding technique and we could have put support strategies in place if we’d understood the intervention and intent’.
- 6.43 In addition to issues linked to parental consent and communication, relationships between schools and sCAMHS can be weakened by factors such as cultural differences between schools and sCAMHS, the pressure upon sCAMHS and resulting high thresholds and waiting list, and withdrawal of support for schools (in some areas) which can make them appear inaccessible. As a secondary school well-being lead explained: ‘Prior to [CAMHS] In-Reach we didn’t have anything. Working with [name of CAMHS In-Reach practitioner omitted] has been good. Before that [s]CAMHS was very detached from us. Communication wasn’t free flowing’. Similarly, a sCAMHS worker described how they could count on two hands the number of times they had liaised with, or even contacted, a school. They recounted that the only time sCAMHS contacted a school was to ‘hand over’ a pupil to the school and give the school a list of what they should be doing (and there were schools who said that they did not even get this).

Example of practice 11. Ceredigion's Consultation Pathway

In Ceredigion, CAMHS In-Reach practitioners identified that sCAMHS were sometimes not aware that they (sCAMHS) were working with pupils with whom the CAMHS In-Reach practitioners were also working with schools to support. The CAMHS In-Reach pilot practitioners also identified that sCAMHS might uncover issues or needs that schools might need to address, such as bullying, through their work with an individual pupil, but that it was not clear if this was always fed back to schools. In response, a consultation pathway has been developed to improve communication between sCAMHS and schools. This was described by the CAMHS In-Reach practitioner as: 'Making links and ensuring that things are not missed'. It is facilitated by a new 'correspondence check list' that provides the legal basis for CAMHS In-Reach practitioners sharing information between sCAMHS and schools.

- 6.44 Where there was parental consent, CAMHS In-Reach practitioners could play a key link or liaison role between schools and sCAMHS. As example of practice 12 illustrates (through CAMHS In-Reach practitioners' explanations of how they would respond to the scenario) whilst the CAMHS In-Reach practitioner might be the messenger in such cases (e.g. of the assessment done by sCAMHS) they can also help schools make sense of and implement the message from sCAMHS. The one caveat was around schools in Powys whose catchment area crossed the ABUHB and PTHB boundaries (so they had pupils who would be supported by sCAMHS in ABUHB and also pupils who would be supported by sCAMHS in PTHB). This complicated the pilot's liaison role with sCAMHS, as the CAMHS In Reach Practitioner supporting schools in South Powys was based with ABUHB sCAMHS until 2020 when, following the extension of the pilot, a new CAMHS In Reach Practitioner based with PTHB sCAMHS was recruited to work with the South Powys schools (making the liaison role with PTHB sCAMHS simpler and more direct, but the liaison role with ABUHB sCAMHS less direct).

Example of practice 12. Supporting Mollie

At one of the workshops organised to discuss how each pilot operated, a CAMHS In-Reach practitioner presented the following scenario: In-Reach have been contacted by the Head of Year in a secondary school, requesting a consultation with a practitioner regarding a year 10 pupil, 'Mollie'.

They explained to participants at the workshop (who were all CAMHS In-Reach practitioners) that they are told by the school prior to the consultation that they are aware via parents that Mollie was admitted to hospital over the weekend after taking an overdose of paracetamol. Mollie is now home but has not yet returned to school. Both school and parents are keen for Mollie to return next week to re-establish her usual routine and social contact.

School are aware that Mollie had a mental health assessment from sCAMHS before being discharged, but are not aware of any recommendations coming from this.

School's main concerns are: a) they want advice as to how to encourage Mollie back to school without putting undue pressure on her; b) staff close to Mollie would like support from In-Reach as the overdose was a shock to them. Mollie had not been on their radar as a vulnerable pupil and they are feeling that they may have missed something. Mollie has never accessed any other help prior to this and is described by the school as an academically bright pupil.

The responses of CAMHS In-Reach practitioners in each pilot area to this scenario are summarised below.

Mid and South Wales	North Wales	West Wales
Ensure there is parental permission to contact sCAMHS. Follow up to see if any issue pertinent to the school e.g. bullying – liaison role; also consultancy role with the school. Developing a plan of action to help support	There is no direct role for the pilot (as the pilot does not offer consultations) this would be covered by self-harm pathways and crisis team or sCAMHS who would, with parental	Action depends on parental consent; the new liaison role between the crisis team and Schools In-Reach can share information and support the school, help reduce their anxieties, discuss how they'll manage it and

<p>the young person return to school and address staff concerns (e.g. if staff put too much pressure on her she'll overdose, so we'll focus upon practical things like reducing timetables; how schools can be emotionally available; who to contact if they're worried). We'll offer reassurance and guidance and signpost to training e.g. YMHFA and specific modules like responding to suicide, to increase staff confidence.</p>	<p>consent, give support to the school.</p>	<p>also share the training menu.</p>
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6.45 The role the pilot can play in improving communication not only from sCAMHS to schools, but also from schools to sCAMHS, was illustrated by a staff member in the PCMHSS who recently moved from an area covered by the Mid and South pilot to an area that is not. They described how they see the pilot as 'the missing link' in their new job and how valuable the CAMHS In-Reach practitioner had been as a link who could check with schools about a person and enable them to consult with teachers on any ISCAN³⁹ questions. They went onto to describe how:

'There was a child I had worked with for a long time who was very anxious about germs, had OCD and was very afraid of COVID. After a lot of sessions we referred the child to [s]CAMHS but there was a waiting list. The family were really worried about what was going on and [name of CAMHS In-Reach practitioner omitted] could link with the school and see the deterioration and keep CAMHS

³⁹ ISCAN is the Gwent Integrated Services for Children with Additional Needs. It offers a single point of access for children and young people aged 0-18 years of age with or without an existing diagnosis who are displaying concerns in two or more areas of their development.

informed. Her role also helped with safeguarding because she gets information from every avenue. We get parent and social services information but we don't get information from school about things like peers, attendance, behaviour – the [name of CAMHS In-Reach practitioner omitted] gives us a wealth of this info'.

Links to sCAMHS

- 6.46 In Ceredigion and Powys the pilot is more 'embedded' in sCAMHS, making it more of an extension of sCAMHS than it is in South Wales, where it is more separate or 'independent' from sCAMHS. The closer links in Powys and Ceredigion mean that the pilot more directly addresses the constrained capacity of sCAMHS, as it sits outside the Mental Health Measure (which is reported by staff in sCAMHS and the pilot to draw sCAMHS's attention to assessment under part 1 of the Measure⁴⁰ at the expense of other work). As one of the CAMHS In-Reach practitioners observed, sitting outside the Measure lets them do things sCAMHS would like to do, such as liaison with schools (discussed above) which sCAMHS does not have capacity to do. In contrast, in South Wales, the two CAMHS In-Reach practitioners made a deliberate decision to 'step out' of sCAMHS and to position themselves more closely with schools. This helped them learn more about the culture of schools, helping ensure that support is tailored to school contexts, and strengthening their valuable role as a bridge between schools and sCAMHS.
- 6.47 Interviews with staff from sCAMHS suggest that staff in pilot areas have come to recognise and value the distinctive role CAMHS In-Reach practitioners play, as the role has become more established. However, there is little evidence of the CAMHS In-Reach practitioners influencing the way sCAMHS operate in the pilot areas. This was not part of the intent of the pilot but may be an area that could be developed in the future.
- 6.48 The pilot's relationship to sCAMHS could be important in the future. There are concerns that if the pilot model is absorbed into sCAMHS, the distinctive nature or added value of the role would be lost. Given the pressure upon sCAMHS, CAMHS In-Reach practitioners expressed concerns that the responsive, accessible and capacity building support they offer could be squeezed out by doing sCAMHS assessments (they could get 'swamped' as one put it), in the same way this sort of work in schools by EPs and sCAMHS has been squeezed out by the demands for

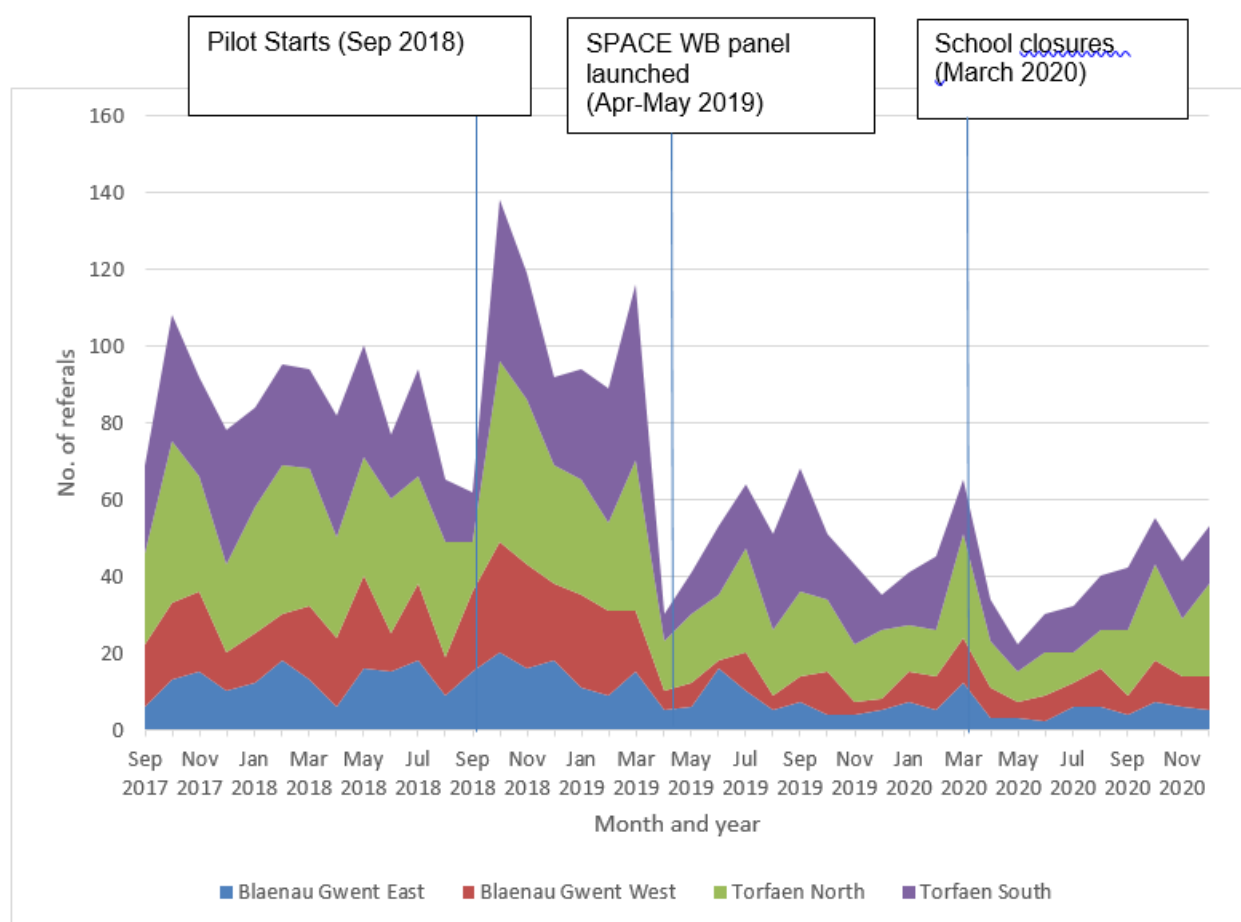
⁴⁰ Section 1 of the Measure includes a target for assessments to be conducted within 28 days of referral.

assessments. As one CAMHS In-Reach practitioner observed: 'Capacity waxes and wanes within sCAMHS, if there's a pressure to meet targets, time for consultation can be leaned on and this obviously impacts on delivery. ...Capacity is undoubtedly an issue that can hinder the process, transient staff, staff turnover, a shortage of experienced practitioners'.

Impact upon referrals to sCAMHS and the Impact of COVID-19

- 6.49 Interviewees from specialist services such as sCAMHS were clear that it is not possible to measure the impact of the pilot upon the number, timeliness and/or appropriateness of referrals to sCAMHS. This reflects the level of 'noise' in the data and the range of other factors, including changes in service structures, other initiatives such as SPACE-Wellbeing, and in Powys, the pre-pilot offer of sCAMHS consultations in schools, reported by sCAMHS there to have 'massively reduced inappropriate referrals' and the impact of COVID-19. The delays before the pilot really got going would also make it difficult to identify any correlation between the pilot's operation and the number of referrals. This all means it is difficult to disentangle any effect of CAMHS In-Reach on referrals as illustrated by Graphs 6.5 and 6.6. It is therefore not possible to test the qualitative evidence (discussed above) that indicates the pilot has improved efficiency and reduce the number of unnecessary or inappropriate referrals.

Graph 6.5. The number of referrals to sCAMHS in Blaenau Gwent and Torfaen September 2017-November 2020.



Source: ABUHB sCAMHS

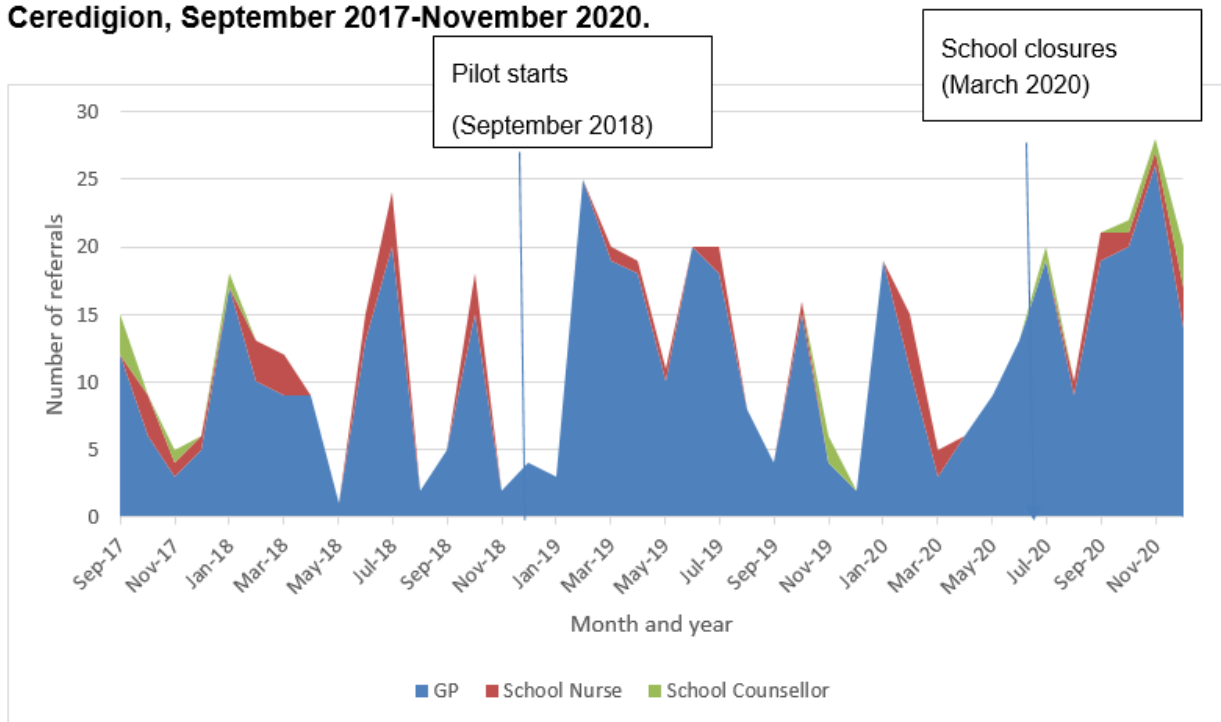
6.50 As graph 6.5 illustrates, sCAMHS in ABUHB had experienced a reduction in referrals after the pilot and more importantly the SPACE-Wellbeing panel had started, which helped reduce the number of ‘inappropriate’ referrals to sCAMHS. Following the closure of schools in March 2020, there was another sharp decline, albeit from a lower base. Referrals picked up as schools reopened in autumn 2019, and were higher than the comparable period in 2018, before sCAMHS reported that they declined again following the closure of schools in early 2021. There is anecdotal evidence from sCAMHS that the complexity and/or severity of cases has increased with, for example, an increase in eating disorders⁴¹. This is thought to be linked to lockdown, and/or delays in identifying and addressing children and young

⁴¹ This is thought to be linked to lockdown and, for example, young people trying to exercise control in an increasing uncertain world.

people’s mental health difficulties during lockdown (which may have meant problems escalated).

6.51 Because most referrals to sCAMHS in West Wales come from GPs, and the impact of the pilot upon referrals was expected to be small (e.g. where enhanced support in schools meant parents were less likely to seek support from a GP). As graph 6.6 illustrates, there has been an increase in the number of referrals to sCAMHS in Ceredigion in each of the last three years. The volatility in the number of referrals from month to month make it difficult to draw any clear conclusions, although there were somewhat fewer referrals in the spring and summer of 2020 (during lockdown) and more in the autumn and winter of 2020 than might be expected, based upon patterns in 2018 and 2019.

Graph 6.6. Referrals to sCAMHS by GPs, school nurses and school counsellors in Ceredigion, September 2017-November 2020.



Source: HDUHB sCAMHS

Both Denbighshire and Powys sCAMHS reported that referrals dropped in April, May and June of 2020, before picking up again in July and again in August. As in Ceredigion, they also reported an increase in the complexity of referrals, with both Ceredigion and Denbighshire reporting increases in crisis referrals.

6.52 A broadly similar pattern of referrals was reported by CAMHs In-Reach practitioners themselves, who experienced a sharp drop in requests for support from schools

during each lockdown, followed by an increase in requests for support when schools reopened. CAMHS In-Reach practitioners in Mid, South and West Wales also reported that towards the end of the second lockdown, consultations started to pick up, with schools keen to plan how to meet the needs of pupils when they returned in Spring 2021 (at that time, North Wales was only just starting to pilot a consultation model).

The impact of COVID-19 upon delivery

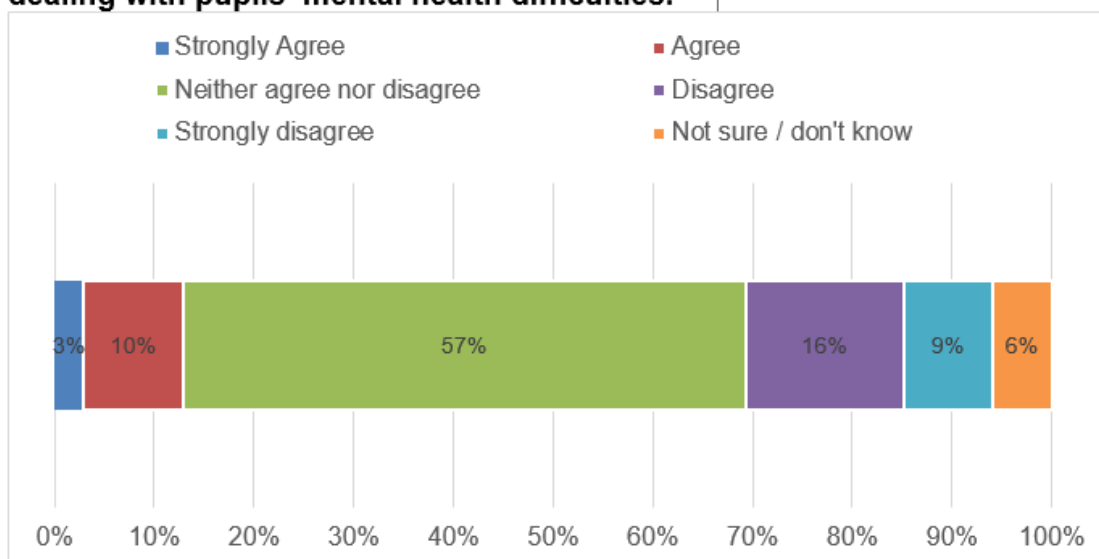
- 6.53 Restrictions on contact meant that CAMHS In-Reach practitioners moved to deliver consultations online (e.g. via MS Teams). As outlined in section 5, this was felt to have both advantages and disadvantages. Some school staff reported that it was harder to access specialist services like sCAMHS during lockdown; a difficulty which was also observed in other parts of the UK during lockdown as, for example, services sought to work out how to deliver online and were coping with staff absence linked to the pandemic (NHS Benchmarking, 2020). The difficulties accessing services were reported by some schools to increase the value or, in the case of North Wales, expected value of advice and consultation. As a secondary school leader described it: 'The consultations with [name of CAMHS In-Reach practitioner omitted] will upskill staff and ensure that we're better prepared. What we've seen with other services during COVID is that they've moved over to the phone and children close down, other services aren't coming out, but children are reluctant to talk over the phone or on-line'.

7. School staff well-being

Introduction

- 7.1 As outlined in the introduction, there have been longstanding concerns about school staff and in particular, teachers' and school leaders' levels of stress, and in response the pilot aims to reduce staff stress and improve well-being. The pilot programme's original logic model identified upskilling teachers and increasing their confidence as the main mechanism for achieving this.
- 7.2 School staff well-being is both important in and of itself, and also to support/enable Whole School Approaches. 'Well-being in schools starts with the staff: they are in the front line of this work, and it is hard for them to be genuinely motivated to promote emotional and social well-being in others if they feel uncared for and burnt out themselves' (Weare, 2015, p.6).
- 7.3 This was supported by the qualitative research; for example, as a primary school head described it: 'If we're not in a good place, we won't be much use to the children or their families' and CAMHS In-Reach practitioners observed that the climate and ethos of the school was crucial and that stressed staff are less receptive to pupil mental health needs, less likely to identify them and less able to support them.
- 7.4 As sections 3, 5 and 6 outline, the qualitative research with schools highlighted the stress that school staff often experienced when dealing with pupil mental health difficulties. Weaknesses in staff confidence and competence in dealing with mental health were seen as having a negative impact upon staff's own mental health and well-being. This was supported by responses to the base and end-line surveys. Graph 7.1. illustrates staff responses to the end-line survey in early 2021, with only a quarter reporting that they did not experience heightened levels of stress when dealing with pupil mental health difficulties. Responses from staff trained by the pilot (n=70) were comparable. School leaders answering on behalf of their school (n=14) also reported heightened levels of stress when dealing with pupil mental health difficulties, with 12 reporting that they always, often or sometimes, experienced this.

Graph 7.1. Responses to the statement: I experience increased levels of stress when dealing with pupils' mental health difficulties.



Source: *People and Work, CAMHS In-Reach end-line survey 2021 (n=196)*

7.5 Knowing what to do, but not having time and/or problems accessing specialist services (discussed in sections 6 and 7) was also seen as having a negative impact upon staff mental health and well-being; for example, as a deputy head teacher in a secondary school commented: ‘You can go home to bed at night thinking about whether we have done all we can – you can do everything you can for a pupil but they still may not be able to cope’. Similarly, a secondary school pastoral support leader described the burden of responsibility and guilt they experienced:

‘It is very stressful. You wonder if you’ve done the right thing. You want to be in a position where you know, there’s no more you could have done. We’ve been in A&E with pupils who are suicidal, camped outside CAMHS offices at eight am to find out what’s on offer to pupils. Its stressful talking to parents who may have mental health issues themselves and not coping. It’s particularly stressful when there’s a clock ticking on a Friday afternoon and you’re trying to get a hold of agencies. You have to walk away being able to sleep at night’.

7.6 However, as section 4 outlines, the qualitative research with schools also made it clear that staff confidence (or competence) and/or problems in accessing specialist services when needed were not the only cause of staff stress and poor well-being. Other factors included workload, pressure upon school budgets, accountability and reforms, such as the ALN transformation programme and the new curriculum for Wales. Given these wider concerns, addressing issues like workload is part of the

Framework on embedding a whole-school approach to mental health and well-being (WG, 2021).

Pilot mechanisms for change

- 7.7 As outlined in section 1, the pilot's theory of change identified increasing staff confidence and skills as the prime mechanism for reducing staff anxiety and improving staff well-being. However, the pilots also developed training and support to give people self-care skills and also time and space to reflect, directly focused upon improving staff well-being and reducing anxiety.

Increasing confidence and reducing anxiety

- 7.8 The impact of advice and consultations, discussed in section 6, upon staff confidence and, by extension, reducing staff anxiety is important and highlighted in the Framework on embedding a whole-school approach to mental health and well-being, which identifies that: '...School staff need to feel confident that they are doing all they need to and are not missing anything important in that supportive role' and that 'often a supportive telephone or face-to-face consultation with a mental health professional can prevent the escalation of a referral to specialist services' (WG, 2021, p.45).
- 7.9 This theme was picked up by one of the CAMHS In-Reach practitioners, who described 'containing' school staff worries by providing support so they no longer feel 'alone' and can share their concerns and know that someone else understands the frightening situations they can find themselves in and 'enabling' staff by recognising that school staff are often very able but may not acknowledge or have confidence in their abilities. As outlined in section 6, this was consistent with feedback from school staff when discussing the value and impact of consultations.

Promoting positive well-being and coping strategies: School staff engagement with wellbeing

- 7.10 As section 5 illustrates, in Mid and South and West Wales take up of, and feedback on, the pilot's staff well-being offer has been more mixed than the take up of the pilot's offer to support pupil mental health and well-being (discussed in section 5). In contrast, in North Wales, staff mental health and well-being had a greater focus than pupil mental health and well-being and the take up of training focused upon staff (such as Stress and Mental Health in the Workplace) was greater than that directly focused upon pupil mental health and well-being (such as YMHFA).

7.11 As table 7.1 illustrates, unlike responses to questions on the impact of training about pupil mental health and well-being, very few staff surveyed in the end-line survey strongly agreed that the training (delivered by the pilot) has helped them improve their own mental health and the proportion who neither agreed nor disagreed was much higher (40 per cent). However, due to a technical problem with the survey, the number of responses to this question was small (n=35).

Table 7.1. Staff responses to the question: The training (delivered by the pilot) has helped me improve my own mental health.

	No.
Strongly Agree	2
Agree	17
Neither agree nor disagree	14
Disagree	1
Strongly disagree	0
Not sure / don't know	1
Total	35

Source: *People and Work, CAMHS In-Reach end-line survey, 2020*

7.12 As example of practice 13 illustrates, there are success stories, but as a member of a pastoral support team in a secondary school put it: 'We did the Five Ways to Well-Being and whilst it was a challenge for some, it was helpful for others'. Interviews with staff and the survey of schools and written feedback collected by pilots on the training around staff well-being suggest the offer is a bit like Marmite. Some staff have really engaged with it and valued it, whilst others have either not engaged or report negative experiences of the training.

Example of practice 13. The Delivery of Mental Health and Well-being Workshops via Digital Means for Staff

In response to requests for the delivery of mental health and well-being workshops via digital means for staff, a CAMHS In-Reach practitioner described how sCAMHS SIR worked with the school:

sCAMHS SIR had already adapted to MS Teams as a mode of delivery for training sessions as a result of Covid-19 and the restrictions around face-to-face delivery. Working with the school and their time commitments, sessions were

booked in allowing staff to finish their teaching, make their way home and connect in the comfort of their own personal spaces.

The sessions delivered included: Stress in the Workplace, Five Ways to Wellbeing and eYMHFA (a blended learning experience of self-guided e-learning and facilitator-led webinars to consolidate delegates' learning).

During the Stress in the Workplace session we explored the definition of stress, how to recognise stress in yourself and others, causes of stress and strategies for managing stress. Delegates were also given a self-rated stress questionnaire for their own personal use to gauge stress levels.

During the Five Ways to Wellbeing session, we explored the understanding and ethos of Five Ways to Wellbeing and how education staff can begin to use Five Ways to Wellbeing strategies on a daily basis, helping both themselves, loved ones and colleagues.

Delegates were also given a Five Ways to Wellbeing pack full of resources to help them implement their strategies from personal well-being steps to whole school team planning sheets.

The CAMHS In-Reach practitioner went on to describe the impact that the support was felt to have made:

sCAMHS SIR were determined to ensure that education staff were able to access mental health and well-being training during these uncertain times. Feedback from schools highlighted the need for this to occur and the difficult issues education staff were facing. Offering a digital option that was as flexible as possible; creating a training option that was accessible and supportive was vital.

Since delivering this training the school has reported that they have embraced the ethos of Five Ways to Wellbeing and as a whole-school team have worked together to implement strategies to support each other as colleagues, sharing their strategies and ideas with children and young people. As a result of staff discussions and the training attended, well-being has now become a regular agenda item and focus of conversation in team meetings and one-to-ones. Furthermore, the school promotes contribution from all staff to feedback and informing the well-being ethos and promotes open communication channels and opportunities for well-being ideas and suggestions.

Staff feel better equipped to ask for help from management/peers/self-help sources. In addition, the self-care resources given during sessions have been shared with the children and young people who have reflected upon their own need to look after themselves and consider well-being as part of their daily routine.

Going forward, challenges for staff in the workplace to utilise strategies include time, management support and an ongoing shared ethos of a whole-school approach to keep the well-being messages alive.

Adapted from material provided by the West Wales pilot programme

7.13 Three broad reasons why engagement and satisfaction with the pilots' training and support for staff well-being was lower than that for training and support for pupil well-being were identified:

- firstly, schools and/or staff can struggle to prioritise staff well-being, particularly when schools and staff are facing multiple demands upon their time and attention (although, given the links between staff and pupil well-being this may be a false economy). As one interviewee from a service described it, while they had purchased training, they found school staff 'didn't have the head space' to come, given competing demands upon their time and attention; and
- there can be a stigma attached to discussing mental health issues and/or a reluctance or even fear about discussing and confronting mental health difficulties; for example, as one secondary school pastoral lead described it, in their school, work on staff well-being was: 'Still a work in progress' and: 'There is still a bit of a stigma with staff to say I need support with my well-being – staff are still reluctant'. CAMHS In-Reach practitioners described how some school staff wanted to 'compartmentalise' their working and home lives, meaning talking about stress and well-being could feel like an invasion of their privacy, while as a primary school leader put it, some school staff don't want to talk about the problems they face, they may be: 'Coping but [they] don't want to open the can of worms'.
- thirdly, even where staff recognise their difficulties, they may struggle with the solutions and may prefer to try to deal with it in their own way; for example, as

an educational psychologist put it: 'Some people are not comfortable or convinced by approaches such as mindfulness', while a CAMHS In-Reach practitioner said that others can feel patronised, or cynical about the value of 'yoga mats and stress balls'.

7.14 As a consequence, as one primary school leader described it in written feedback: 'Some staff found the whole experience uncomfortable and did not like participating in such a large group. They felt the experience was forced, pressured and awkward' and around one third of staff did not want to engage. Similarly, written comments in the baseline survey included:

'The training we received in Feb [2019] was not aimed at pupil well-being, but our own. It was a day of "workshops" delivered by people who, by their own admission, "were not experts". Complete waste of time' (teacher).

'There is great emphasis on pupil well-being however very little concern about the staff within the school. What supposed training was offered did not help and most staff felt more stressed as they could have done so much work in the time we listened to whale music' (teacher).

7.15 This resistance to engaging was illustrated by one of the CAMHS In-Reach practitioners who described school staff saying: 'Don't make me go to a workshop on stress if you want to improve my well-being'. Breaking down this resistance was a key challenge for the pilot. It was linked to school leadership and the culture of schools and the extent which staff well-being was prioritized and talked about. As one of the CAMHS In-Reach practitioners put it, school leaders: 'Need to lead by example'. However, even within schools where well-being was a priority, there could still be resistance from individual staff, and CAMHS In-Reach practitioners stressed the importance of winning people over and working with the willing rather than trying to force people to engage with the training on staff mental health and well-being. More positively, it was felt that awareness and acceptance of the importance of staff well-being was growing within schools and that the experience of the COVID-19 pandemic had accelerated this change.

Co-ordination

7.16 As with training around pupil mental health and well-being, a range of services deliver support and training around staff mental health and well-being. As a health schools co-ordinator put it:

'The Adult Resilience course is part of the Friends Programme that CAMHS deliver. GwE have done a workshop aimed at heads around well-being and I think they're doing one for teaching staff as well. The local authority has also delivered a workshop around staff well-being in Wrexham. It's part of the Corporate Health Gold Standard... this year it was on Zoom and there were workshops on mental health, drug/alcohol, mindfulness, yoga etc. You could dip in and out as you wanted'.

7.17 Similarly, as a secondary school pastoral lead in South Wales described it:

'There has not been a massive increase in uptake from staff for well-being training. That is probably an area we are still developing ... There are two main Housing Authorities here and Melin Housing Association have offered the school support for staff well-being, they have brought in masseurs and yoga for staff. On our training days they provide buffets of fruit. So that is still an area in progress'.

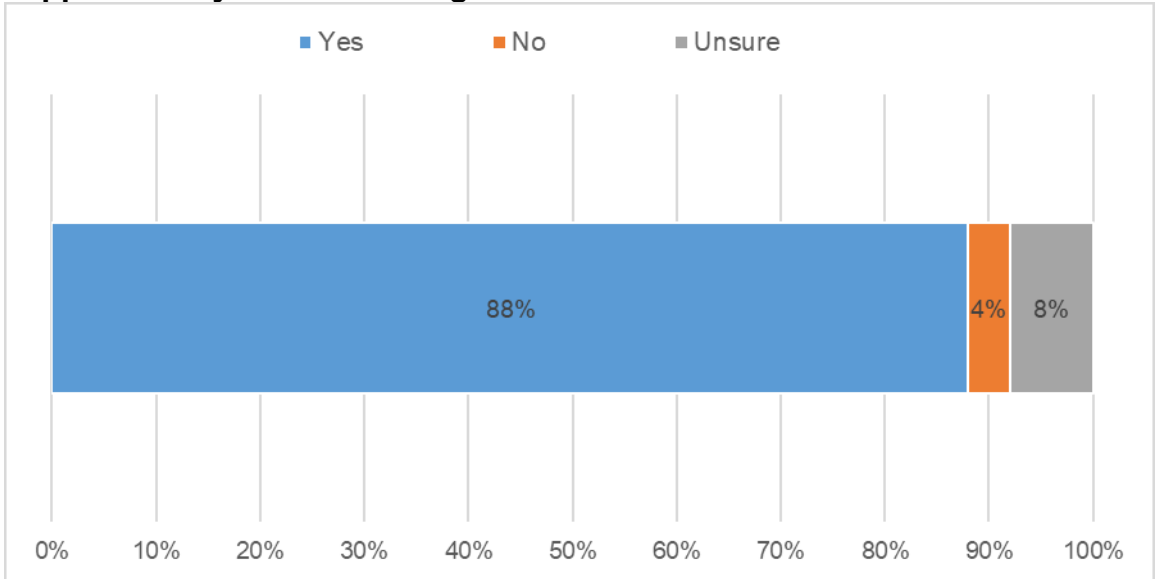
7.18 As with training around pupil mental health and well-being (discussed in section 5) there are concerns around co-ordination and how the pilots' offer relates to or links to other training and support. An interviewee from an education service in North Wales explained:

'I worry that schools are reaching saturation with programmes around well-being. They are offered a lot of courses through ourselves, Ed Psychs, CAMHS, GwE, independent organisations contacting them. How do they know what course to do and what course not to do? How do they know how they all fit together? There is a need for co-ordination of the offers, ensuring they complement each other. There's only so much release that schools can give. GwE are a bit out there on their own, making their own offers. I'm trying to tackle this at the moment'.

Sources of support and access to supervision and the impact of the pilot programme

7.19 As Graphs 7.2 and 7.3, illustrate, most staff surveyed reported knowing who to go to for support and would in some cases go to a CAMHS In-Reach practitioner. However, it was notable that school staff were markedly less positive when asked if their school was effective at promoting the mental health and well-being of staff, compared to their responses when asked if their school was effective at promoting the mental health and well-being of pupils.

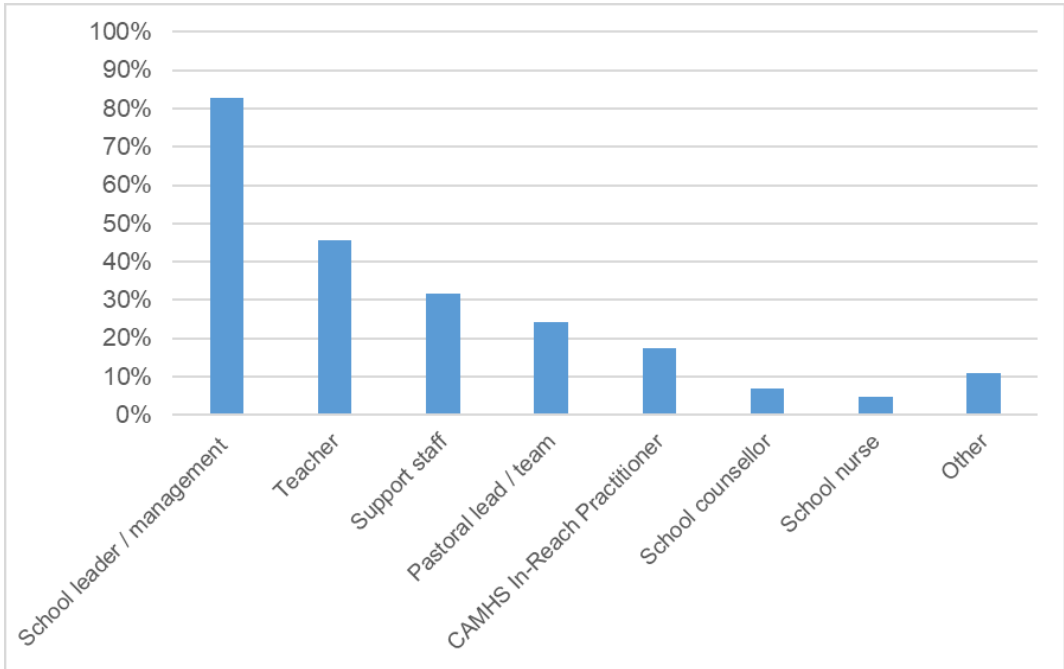
Graph 7.2. Responses to the statement: I know who to go to in the school if I need support for my own well-being.



Source: *People and Work, CAMHS In-Reach end-line survey 2021 (n=196)*

Graph 7.3. Responses to the statement: Who would you go to for support in your school?

(Staff could choose more than one option, so totals add up to more than 100%).



Source: *People and Work, CAMHS In-Reach end-line survey 2021 (n=173)*

7.20 However, a small number of staff in the surveys alluded to the lack of support for their mental health and well-being and some also highlighted in written comments a

social stigma about raising the issue; for example, in the baseline survey staff reported:

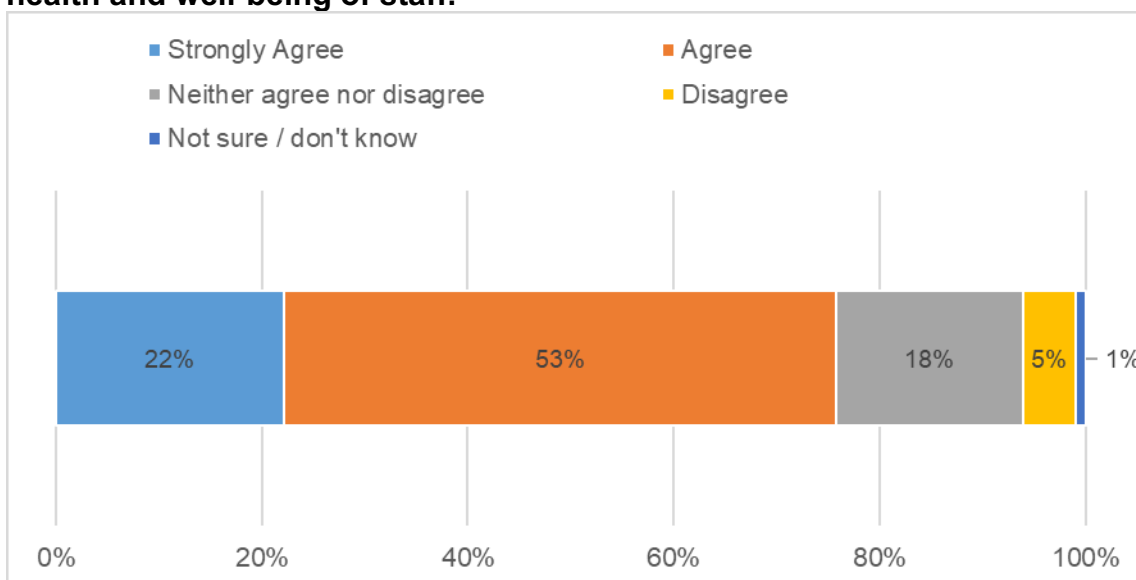
‘However, I feel that there is a gap within schools to address support for staff with their own mental health concerns - it is something that staff feel reluctant to discuss with SLT especially if they feel it would reflect on their ability to perform’.

‘Teachers’ mental health issues need to be addressed more robustly. Still a terrible stigma around anxiety/depression/menopause’ (secondary school teacher).

‘Staff (including myself) are still reluctant to admit they have stress for fear of reprisal of some kind’ (secondary school teacher).

7.21 Although direct comparisons between the base and end-line surveys cannot be made, it is interesting to note that responses in the end-line survey (75 per cent strongly agree or agree), illustrated by Graph 7.4 were more positive than those in the baseline survey (51 per cent strongly agree or agree). This may be because the pilot and/or COVID 19 has raised the profile of staff mental health. Responses from school leaders answering on behalf of their school (n=15) were more positive than the individual responses, with 13 strongly agreeing or agreeing that their school was effective at promoting the mental health and well-being of staff.

Graph 7.4. Responses to the statement: My school is effective at promoting the mental health and well-being of staff.



Source: *People and Work, CAMHS In-Reach end-line survey 2021 (n=203)*

7.22 Given the pressure on staff, many schools and staff greatly appreciated the pilot’s focus on supporting staff well-being, seeing this as a unique contribution; for

example, as a primary school head teacher described it: 'Staff well-being has never been considered before and [name omitted] feels that this is really important.... teachers are the only profession working with children that have no form of supervision..... the staff well-being focus is timely and important – the pressures of the job are increasing with tightening budgets'.

School staff's access to supervision

7.23 As the Framework on embedding a whole-school approach to mental health and well-being puts it: 'Staff ... need to be supported to maintain their own well-being and have access to appropriate supervision, particularly when dealing with more challenging issues, which have the potential to impact their own well-being' (WG, 2021, p51).

7.24 The lack of staff supervision is a particular concern. Teachers cannot routinely access supervision, unlike health and social care professionals, as one interviewee from an education service explained:

'Fundamentally, the system within education isn't the best at supporting training within school. You can have the best training in the world, but if on-going support isn't there to help you look at your stress and well-being, for some, it will be difficult to maintain. There is no culture or structure of support and supervision within schools. There are many competing priorities. How they are structured, how they operate, the scale of secondary schools, none of these ally themselves to a supportive supervisory structure. Supervision doesn't exist. I have a catch-up with the teams that I'm responsible for at least every six weeks. You don't have that in schools. It isn't right'.

'Primaries are smaller and more nurturing. The scale allows that. Staff know each other and their families. They know the families they work with'.

7.25 Similarly, as a CAMHS In-Reach practitioner put it:

'I'm also aware that during COVID, parents have disclosed distressing information to educational staff about domestic violence and sexual abuse and have wondered what support are teachers offered to cope with what they're hearing? I know from previous work how it impacts on me and how you get regular support to learn how to deal with it. Educational staff are not used to this, there is no clinical supervision. What pressure does this put on them, this disclosure of trauma? You can suffer trauma yourself by listening or hearing

about it. Staff may not have support at home or may not want to talk about it at home’.

- 7.26 The lack of supervision was reported by CAMHS In-Reach practitioners to lead to school staff ruminating and/or struggling to process their emotions and experiences.
- 7.27 In the absence of regular supervision, the space and time training and consultations offer staff to reflect upon and discuss their own mental health and well-being may be important, as well as the skills learned to help them relax and cope with stress. As one of the CAMHS In-Reach practitioners put it, the: ‘Consultation model may be a way that they can off-load and gain a level of support’. Given the lack of supervision, for some staff in Mid and South Wales, the CAMHS In-Reach practitioners were seen as helping by providing reassurance, the opportunity to talk through an incident and even the chance to just ‘off-load’ their concerns. In West Wales the pilot has offered ‘reflective sessions’ for school staff. However, they do not have the capacity to offer this to all school staff and it was also noted that this work needed clear boundaries, as CAMHS In-Reach practitioners are ‘not MH nurses or counsellors’, but as one CAMHS In-Reach practitioner described it: ‘it’s not a therapeutic session, it’s focused upon self-help’.
- 7.28 Providing adequate access to supervision was seen by CAMHS In-Reach practitioners as beyond the scope and capacity of the pilot and CAMHS In-Reach practitioners consistently reported that school staff’s access to professional supervision was needed, and also needed to be adequately resourced.

The pilot programme and COVID-19

- 7.29 As section 4 outlines, COVID-19 and policy responses, such as the closure of schools, had a marked and negative impact upon staff mental health and well-being. There was some evidence from schools that the pilots’ work on staff mental health and well-being meant that schools were better equipped to cope with the impact of COVID-19 upon staff mental health and well-being; for example, as a secondary school leader described it: ‘It’s allowed us to be clearer about the signs of extreme stress, the strategies we can employ, it’s raised awareness, it’s highlighted the issue amongst all staff. Because of covid-19 we are more isolated, our worlds have been thrown upside down. Mental health and well-being is being severely tested. I think we’d be in a worse position without the training’.

- 7.30 However not all schools were this confident that the pilot had made a difference to their capacity and some, for example, reflected on the challenges that the closure of schools had had upon their ability to monitor and support staff well-being. A secondary school pastoral lead described how: ‘This [work on staff wellbeing] is difficult as because of COVID we are not even seeing staff, except for the core group at school’.
- 7.31 Example of practice 14 below, uses CAMHS In-Reach practitioners’ explanations of how they would respond to the scenario to illustrate how each of the three pilot areas planned to respond to the sort of challenges schools anticipated facing when they fully re-open.

Example of practice 14. Pilot responses to a Scenario

In a workshop, one of the pilots presented this scenario to the CAMHS In-Reach practitioners:

During conversations you are having with schools upon their return to teaching after a lockdown period, head teachers and well-being leads raise concerns about the mental health and well-being of their staff as opposed to the children and young people who were settling in better than expected.

Heads/well-being leads highlight that their staff are experiencing loss, anxiety, low mood, stress and fear for their health and that of their families. They ask what can be offered to support with this.

The responses of CAMHS In-Reach practitioners in each area are summarised below.

North Wales	Mid and South Wales	West Wales
<p>Confirm the SLT are committed and identify what time is available, who can attend.</p> <p>Arrange 2 workshops, send out resources and</p>	<p>Initial meeting with pilot link in the school to discuss and understand the issues and outline the range of things on the menu that schools can choose from e.g. Five</p>	<p>Discuss with the school what the pilot can offer, such as: Five Ways to Wellbeing and reflective practice through group or 1:1 sessions.</p>

<p>packs on stress and Five Ways to Wellbeing.</p> <p>Produce a report for the school based on evaluation, with a view to them developing an action plan.</p>	<p>Ways to Well-being, stress control, art of brilliance, stress control, taking care, giving care, compassionate cultures.</p> <p>Deliver training and workshops as required.</p>	
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8. Key findings and recommendations

Pilot implementation and delivery

- 8.1. Qualitative research with stakeholders, a review of project documents and analysis of progress against the pilot programme's logic model indicate that, pre-COVID-19, after a somewhat slow start in some areas, the pilot programme's implementation and delivery were generally effective. For example, high quality training was offered to schools in all pilot areas, in order to address gaps identified in school staff's knowledge or skills; and named CAMHS In-Reach practitioners were offered to schools in Mid, South and West Wales, and provided rapid access to specialist advice, liaison and consultation. The slow start was linked to the time it took to get staff in post, reflecting the importance of recruiting skilled staff and the NHS recruitment processes, which can be lengthy. It was also linked to the time health staff needed to build links to, and understand, education structures and cultures. Recruiting highly skilled mental health workers, who took the time to build relationships with and understand schools, has been critical to the pilot programme's success.
- 8.2. The pilot was impacted by differences in context, most notably in terms of schools' pre-pilot access to specialist services and their relative prioritisation of this area of work, the pre-pilot professional learning offer to schools, in terms of pupil and staff mental health and well-being and the size and rurality of the areas covered. This led to the development of different approaches in each area; for example:
- in Mid, South and West Wales, a 'training plus consultation' model was developed that builds capacity for skills development by integrating training for school staff on pupil and staff mental health and well-being, with access to specialist advice, liaison and consultancy;
 - in West Wales, the large size and rurality of the county led to a focus upon providing specialist advice, liaison and consultancy mostly (although not exclusively) through multi- agency Team Around the Family (TAF) meetings in secondary schools. In contrast, in Mid and South Wales, where the areas covered were smaller, specialist advice, liaison and consultancy were mostly provided through bilateral meetings with school staff (rather than through multi-agency meetings, like TAF meetings); and

- in North Wales, there was greater focus upon staff mental health and well-being, alongside delivery of the Youth Mental Health First Aid course.

8.3. Qualitative research with schools identified that, across all three pilot areas, the quality of the training delivery has been crucial to the pilot's success (and in making this point, interviewees often unfavourably contrasted their experiences of training delivered by others to that delivered by the pilot programme). The role of CAMHS In-Reach practitioners to link training to real examples, and to embed it within specialist liaison, advice and consultancy, was reported to be very much valued by respondents. This model helps address the 'use or lose it' challenge, where the skills and knowledge acquired through training can be forgotten, or lost, if not regularly used (Glaveski, 2019). The model enabled CAMHS In-Reach practitioners to 'guide' staff through consultations and help them identify and connect what they already know from their training, rather than 'telling' staff what to do (as one CAMHS In-Reach practitioner put it). In the view of the research team (drawing upon the findings from the qualitative research), being 'alongside' schools in this way helps build capacity (skills) and confidence and provides reassurance, which helps to reduce staff anxiety. It can also help identify previously unidentified training needs in schools.

8.4. The pilot programme's theory of change (figure 1.1) proved a guide rather than a blueprint, given the differences in the way the pilot was developed and delivered in each area (outlined in paragraph 8.2.). Moreover, some elements of the theory became apparent only through the research and, as figure 8.2 illustrates, four key and mutually reinforcing mechanisms for generating change have developed:

- the qualitative research, survey of school staff and feedback on training provide evidence that training and access to advice and consultation increases staff skills, knowledge and confidence and provides reassurance that they are doing the right thing. There is evidence from the qualitative research that this means staff are more likely to be able to support pupils who turn to them for help to 'set their problems in context and help them move on', holding onto, and supporting, pupils themselves, rather than handing on pupils through, for example, a referral to a specialist service (WG, 2021). This is considered good practice (ibid.) and can therefore be expected to contribute to improved provision for pupils with mental health difficulties and to improved staff well-being.
- as the qualitative research illustrates, training and access to specialist advice, liaison and consultation can help ensure that decisions about when to refer, whom

to refer to and how to refer are made more swiftly, efficiently and effectively, even if not necessarily increasing access to specialist services like sCAMHS. This is considered good practice (ibid.) and can therefore be expected to contribute to improved provision for pupils with mental health difficulties, and to improved staff well-being.

- again, as the qualitative research illustrates, the liaison role improved communication between schools and specialist services like sCAMHS, increasing opportunities to provide continuity of support (provided by services and schools). This is considered good practice (Haggerty et al., 2003) and can therefore be expected to contribute to improved provision for pupils with mental health difficulties. In addition, the qualitative research suggests that by reducing staff frustration at not knowing what is happening, this can be expected to make a modest contribution to improved staff well-being.
- as the qualitative research, survey of school staff and feedback on training demonstrate, workshops and training focused upon reducing stress and improving well-being can contribute to improvements in staff well-being and to improved provision for pupil mental health. However, whilst the research revealed a common view that the pilot's work focusing on pupil mental health and well-being was of value, staff opinion was divided on the value of the work on staff mental health and well-being.

8.5. The four key mechanisms outlined above, while consistent with the pilot programme's theory of change (figure 1), were not fully articulated as causal mechanisms in the pilot's original theory of change. Figure 8.1. illustrates the mechanisms for change that the evaluation revealed.

Figure 8.1. Pilot mechanisms for generating change



The impact of COVID-19 upon the pilot programme

8.6. The impact of policy responses to COVID-19, such as school closures, social distancing requirements and the redeployment of pilot staff, both reduced demand from schools and, inevitably, constrained programme delivery from March 2020 onwards. While the pilot restarted work with schools in September 2020, moving much of its delivery online, subsequent local and national lockdowns in the autumn and winter of 2020 and early 2021 constrained its final year of operation. The disruption, coupled with lengthy recruitment processes in the NHS, meant that the pilot struggled to make as effective use of the additional funding in 2020/2021 as might have been expected. Nevertheless, the closure of schools and moves to deliver training online also enabled the pilot to reach some staff it had struggled to reach previously.

The confidence and skills of teachers and schools in responding to pupils' emotional and mental health concerns

8.7. Qualitative research with schools identified that concerns about pupil mental health and well-being were felt to be 'huge issues' for schools, even before the impact of the COVID-19 pandemic in 2020 and 2021, which heightened schools' awareness of the issues and their concerns about pupil mental health and well-being. The evidence

from the base and end-line surveys and interviews with school staff suggests that most staff are confident in identifying if pupils have mental health difficulties but, overall, staff are less confident in discussing, assessing or supporting pupil mental health needs. Other research suggests gaps exist in staff knowledge in areas such as childhood development and in how best to support pupil health and well-being (Estyn, 2019). This increases the risk that school staff 'hand on' to other services, rather than 'hold onto' a pupil who has come to them for support. In addressing this, qualitative research with schools identified that the high quality of the training delivery and specialist advice, liaison and consultancy (by experienced mental health professionals) has been crucial, and feedback on training and specialist advice, liaison and consultancy has generally been very positive.

- 8.8. However, the effectiveness of the pilot's offer of training and (where piloted) specialist advice, liaison and consultancy depends not only upon the quality and relevance of the pilot programme offer, but also upon schools. Schools' (and school leaders') choices to engage with the pilot programme (a minority of schools did not) and to select, release and encourage the 'right' staff to be trained (matching roles with individual staff member's confidence, skill and knowledge development needs) are key determinants of effectiveness. The impact of training also depends upon staff being able to implement what they have learnt in school. Staff may, for example, forget what they have learnt, lack time to apply what they have learnt, or find that what they have learnt does not comfortably fit with their school's culture and ethos. The evidence from the qualitative research therefore suggests that, while the flexibility and responsiveness of the pilot model has been welcomed by schools, it did not provide a systematic approach to upskill staff and change practice. Understanding both what schools want and what they need is important here. Further work on identifying the skills needed by different staff roles will also be required to ensure that the professional learning offer to schools matches this. Similarly, while training and specialist advice, liaison and consultancy can support cultural change, it is not of itself sufficient to drive this without, for example, strong and informed leadership within a school.
- 8.9. These challenges are not unique to the pilot programme and were recognised by the pilot staff; for example, the pilot programme's consultations provided opportunities for CAMHS In-Reach practitioners to identify and/or suggest training needs, and the pilot has supported cultural change in some schools. There may also be scope to use the

learning from the pilot to inform an analysis of what different staff roles require. These are important challenges though, as evidence suggests that piecemeal implementation of whole-school approaches is less effective than genuinely holistic ones, and that a supportive culture and ethos is as important as the skills of individual staff (Weare, 2015). There is also a wider challenge around engaging schools and school leaders (the pilot struggled to engage a minority of schools) in this important agenda. The evidence from the pilot offers some insights into why schools might not engage (for example, if they do not see the need for support from the pilot) but no definitive answers to this important question.

Recommendation 1. The Welsh Government should consider the feasibility of identifying and mapping the skills and competencies required by staff performing different roles within schools. This should include skills and competencies required universally, and more advanced and specialist skills and competencies required by some staff within school, school clusters and/or support services. This should inform regional professional learning offers to schools and services and would support the development of a whole-school approach to mental health and well-being.

Recommendation 2. The Welsh Government should consider commissioning further research to better understand potential barriers and enablers to engaging schools and school leaders in developing the whole-school approach to mental health and well-being.

- 8.10. The research identified that although the pilot's offer of training and access to specialist advice, liaison and consultancy was very well received, it was sometimes challenging to ensure that the pilot's offer contributed to and complemented other training to support the development and implementation of a whole-school approach to mental health and well-being. The pilot steering groups lacked the authority to plan and co-ordinate the pilot's offer with that of other services' professional learning offers and relied upon their members' influence and the time and willingness of other services to collaborate with the pilot. The large number and range of services (including the voluntary sector) delivering training and support to schools and the footprint of the pilot, which spanned part, but not all, of the areas covered by health boards and regional educational consortia, also posed challenges here.
- 8.11. A range of different models of professional learning, including changes to Initial Teacher Education (Estyn, 2019), in-service training (including, but not limited to, that developed by the pilots), coaching (to which consultations may be analogous),

mentoring, self-directed study and participation in professional learning communities (which are somewhat analogous to special interest groups developed in Mid and South Wales) are likely to be needed, to meet staff professional learning needs (Hill, 2013). Ensuring that this professional learning offer is responsive to broad changes in needs over time (such as any long-term impact of COVID-19), the emergence of previously unseen needs in individual schools (such as responses to the death of a pupil), and/or changes in the workforce (as staff move on or change roles), will also be important (WG, 2015).

Recommendation 3. The Welsh Government should work with partners to ensure that the training plus specialist advice, liaison and consultancy offer is integrated into a wider professional learning offer, that encompasses initial teacher education and in-service training, including coaching, mentoring, self-directed study and participation in professional learning communities.

The effectiveness of the pilot in facilitating access to specialist support

- 8.12. The evidence gathered for this evaluation, including both the literature reviewed, (such as NafW, 2018; Children's Commissioner for Wales, 2020) and the qualitative research with schools and services, highlights difficulties in accessing specialist services, such as sCAMHS, given mismatches between need, demand, capacity and the configuration of services. This means intervention and support can be delayed, pupils (and their families) can be 'bounced' between services and pupils without diagnosable mental health conditions, but with very real needs, can struggle to access, or find, a service they 'fit' into. This has been attributed to the 'missing middle', the lack of services for those who fall short of thresholds for sCAMHS or neurodevelopmental services (ibid.). Therefore, the problems schools faced was broader than a lack of understanding of available referral pathways to specialist services (which the pilot programme was established to address).
- 8.13. The pilot increased capacity in schools to address low level mental health difficulties by upskilling staff and increasing their confidence in supporting pupils with these difficulties. The pilot also demonstrated the value of providing school staff with easy access to mental health expertise (through training, specialist advice, liaison and consultation) to help inform their decisions and provide reassurance that they were doing the right thing (meaning they do not, for example, feel they need to make a referral). This can also help ensure that schools' decisions about who, when and how

to refer to specialist services are better informed. By supporting early identification and support, this can also help prevent mental health difficulties escalating and reaching the complexity or severity where specialist services are needed.

- 8.14. However, although the pilot offered access to sCAMHS mental health expertise, the pilot programme did not extend the full sCAMHS offer to schools and is not a substitute for access to sCAMHS for those pupils with more severe or complex needs. Therefore, the impact of the CAMHS In-Reach Pilot Programme upon schools' access to specialist services has been more modest than the pilot programme's impact upon staff skills or confidence. This is reflected in a range of research findings: responses to the end-line survey, responses from pilot and non-pilot schools to the School Health Research Network (SHRN) School Environment Questionnaire (SEQ) on access to sCAMHS⁴², and also the qualitative research, which, taken together, indicate that only 30-40 per cent of schools feel supported by sCAMHS when needed. The extent to which the pilot has brought sCAMHS 'in-reach' of schools is therefore questionable, and this highlights the importance of action elsewhere in the system through, for example, the Together for Children and Young People (T4CYP) (2) programme⁴³, to ensure pupils and schools have timely access to specialist support when they need it.

Recommendation 4. The Welsh Government should work with partners to ensure that the pilot programme is developed as part of an integrated, whole-system, regional approach to developing and delivering services that support the emotional health and well-being of children and young people; for example, the pilot highlights the importance of taking forward the T4CYP (2) national framework for early help and support which aims to address the so-called 'missing middle', given the gap between schools and specialist services like sCAMHS. The learning generated by CAMHS In-Reach practitioners embedded in schools (for example, on the value of relationships between schools and health professionals and how sCAMHS are perceived by schools) can inform improvements in the culture and practice of services such as sCAMHS, aimed at enhancing support for pupils and schools.

⁴² Schools were asked a series of questions, as part of the School Environment Questionnaire including: 'To what extent do you feel supported by your local CAMHS?'

⁴³ The T4CYP programme was set up in 2015 to 'consider ways to reshape, remodel and refocus the emotional wellbeing and mental health services provided for children and young people in Wales'. It was extended in 2019 with a focus upon three areas: 'Early Help and Enhanced Support'; 'Working with Regional Partnership Boards'; and 'Neurodevelopmental Services' (NHS Collaborative 2021).

- 8.15. Equally, in those areas where CAMHS In-Reach practitioners have worked with schools, the qualitative research identified that support for schools was felt to have increased. It also found that the accessibility of CAMHS In-Reach practitioners, their expertise and the relationship of trust and understanding they have forged with schools (so their advice is grounded in an understanding of what is feasible for schools), are very much valued. It was striking how passionate and/or grateful some of those interviewed through the qualitative research, or who made written comments in the survey, were about the pilot, and in particular the support from their CAMHS In-Reach practitioners. In some interviews, schools were asked if they would have wanted a CAMHS In-Reach practitioner who worked as an sCAMHS worker in schools, who could, for example, undertake assessments. Schools reported that they would have welcomed this. In the view of the research team, this would also have increased sCAMHS capacity. However, it would have limited CAMHS In-Reach practitioners' scope to build capacity in schools (as their time would have been devoted to assessments rather than building capacity). It would also have encouraged schools to 'hand on' pupils to them, rather than, as the pilot supported them to do, to 'hold on' to cases.
- 8.16. It is also important to note that the pilot's impact upon schools' access to services is likely to be much greater for secondary schools compared to primary schools. The pilot has generally prioritised work with secondary schools and has sometimes found it harder to engage and support primary schools, particularly in large rural counties. Moreover, the pilot programme only works with pupils in the final year of primary school (year 6) and, during interviews as part of the qualitative research, primary schools frequently expressed frustration that the pilot could not work with younger children. This reflected their experience of an increasingly frequent early onset of mental health difficulties amongst primary school age children, and the lack of alternative services for young children (for example, school counselling services only work with children in year 6 and above).

Recommendation 5. The Welsh Government should work with partners to consider how to ensure schools (and children and young people) can have timely access to specialist support when they need it. This should include consideration of access to services for pupils below year 6. Models such as the pilot's training and specialist advice, liaison and consultancy offer can help schools make better informed decisions about who, when and how to refer (which are important) but which are not

a substitute for increasing the capacity of specialist services and ensuring that children and young people do not fall between different services.

The effectiveness of the pilot in improving staff mental health and well-being

- 8.17. School staff well-being is both important in and of itself, and to support pupil mental health and well-being (Weare, 2015). Levels of staff well-being and stress depend upon multiple factors, including factors the pilot aimed to change, such as a lack of confidence and competence and difficulties in accessing specialist services. However, levels of staff well-being and stress also depend, to a large degree, upon wider factors, including staff workloads, accountability, budgetary pressures and coping with changes such as Additional Learning Needs (ALN) and curriculum reforms, which the pilot did not directly address. The health impacts of COVID-19 and policy responses like school closures also added to staff stress and reduced their well-being during the third year of the pilot. The length of the pandemic and uncertainty about when and how schools would reopen was reported to have worn some staff down, and some staff interviewed during the third round of qualitative research were physically and emotionally exhausted. This raised concerns about the capacity of staff to support pupils and take forward key educational priorities like the new curriculum and ALN Transformation Programme.
- 8.18. The pilot's contribution is therefore likely to be one of reducing (but not eliminating) sources of stress, raising awareness, and the profile, of the importance of staff mental health and well-being and legitimating conversations about it; and helping staff cope better with stress (for example, through a focus on the Five Ways to Wellbeing⁴⁴).
- 8.19. However, it is important to bear in mind the scale of the challenge relative to the capacity of the pilot to address it, given the high levels of stress and poor levels of well-being reported by education staff in other research (see EWC, 2017) and the impacts of COVID 19 and policy responses like lockdown, upon the mental health of adults in the UK (NHS Benchmarking, 2020). Action on areas such as staff workloads and the lack of supervision for education staff supporting pupil mental health

⁴⁴ The Five Ways to Wellbeing: 'connect'; 'be active'; 'take notice'; 'keep learning'; and 'give', were developed by the New Economics Foundation as a set of 'evidence-based actions to improve personal wellbeing' (Foresight, 2008).

(highlighted through the qualitative research with schools and services as a key gap) will also be important.

Recommendation 6. The Welsh Government should work with partners to consider the need for, and viability of, providing access to supervision for school staff.

8.20. The value of the pilots' work to support staff well-being and mental health has been more contested than its work to support pupil mental health and well-being. Addressing this issue is complex and needs to take account of staff perceptions about how their mental health and well-being might be improved; for example, understanding how the stigma around mental health, and staff scepticism about how individual action to improve one's own mental health can be addressed, will be important. Further examination of lessons from the North Wales pilot, which has prioritised this area of work and had a strong focus upon ensuring support and commitment from school leaders, and lessons from initiatives such as The Education Support Project⁴⁵, are likely to be important here.

8.21. Finally, although the link between pupil and staff well-being is important, and (as figure 2 illustrates) complementary, it could be more appropriate for support for staff mental health and well-being to be the responsibility of adult mental health services or education services, rather than children's mental health services.

Recommendation 7. The Welsh Government should work with partners to consider the appropriate location of responsibility for training and support around staff mental health and well-being (as children's mental health services may not be the most natural home for this work) and how the scepticism some staff express and/or stigma about discussing mental health difficulties can be addressed.

Recommendation 8. The Welsh Government should consider commissioning further research to better understand how the challenges, such as the scepticism some staff express, and/or stigma, about discussing their own mental health difficulties can be addressed.

Conclusions and risks and challenges

8.22. The pilot has generally been very well received by stakeholders and especially schools. The evidence suggests that it has made important contributions to improving

⁴⁵ The Education Support Project offers a range of services including live digital events, resilience training, peer support groups, well-being support materials for Hwb, and telephone support services.

staff skills and confidence; access to specialist advice, liaison and consultation; and to improving staff mental health and well-being, which all support Whole-School Approaches to Mental Health and Well-being (WG, 2021). Therefore, there is a strong case for continuing the pilot and considering developing the pilot model in non-pilot areas.

- 8.23. The pilot demonstrates the value of providing school staff with easy access to mental health expertise to help inform their decisions and provide reassurance, supporting a 'hold on' rather than 'hand on' approach. However, the pilot programme is not extending the full sCAMHS offer to schools and is not a substitute for access to sCAMHS for those pupils with more severe or complex needs. Therefore, the impact of the CAMHS In-Reach pilot programme upon schools' access to specialist services has been more modest than the pilot programme's impact upon staff skills or confidence. This highlights the importance of action elsewhere in the system through, for example, the T4CYP (2) programme, to ensure pupils and schools have timely access to specialist support when they need it.
- 8.24. CAMHS In-Reach practitioners have been stretched, given the large numbers of schools and staff they worked with, and there are risks if the quality and quantity of support for individual schools is diluted (if, for example, the number of schools supported is increased, but the number of staff is not). The example of other services, such as Educational Psychology or sCAMHS, which have offered consultations to schools, suggests that protecting or 'ring fencing' the pilot's capacity-building role against the pressure to offer assessments and/or work directly with pupils, may be a challenge but is important as, without this, the responsiveness of the support offered to schools could be lost. Given the small size of teams in the pilot project, there is also a degree of fragility and vulnerability to staff absence, which can be difficult to manage, given the skills required and the importance of personal relationships developed with schools. There are concerns that the expertise and relationships of trust built up with schools since 2018 in pilot areas will be lost if staff move on, given uncertainty about future funding of the work. Finally, a small number of schools (contributing through the qualitative research), highlighted concerns that that pilot's specialist advice, liaison and consultation was only offered in English and examples of failures to translate pilot materials into Welsh were raised.

Recommendation 9. The Welsh Government should work with partners to ensure that the pilots in Mid, West, South and North Wales are continued and integrated into the work of Regional Partnership Boards (RPBs) and others to develop an integrated, whole-system, regional approach to developing and delivering services that support the emotional health and well-being of children and young people. Protecting (or ring fencing) the role of a CAMHS In-Reach practitioner will be important to ensure that its value and impact is not diluted by, for example, stretching their time too thinly across too many staff and/or schools or through pressure to work directly with children and young people. Consideration should also be given to how the pilot's Welsh language offer can be strengthened through, for example, Welsh speaking practitioners and ensuring the translation of written material.

Recommendation 10. The Welsh Government should work with partners to consider the roll out of the pilot's training plus specialist advice, liaison and consultation model to non-pilot areas, given the evidence of its value from the evaluation of the pilots. If the pilot is rolled out to new areas, recruitment of highly skilled and experienced staff will be important and the pilot demonstrated that this is challenging, particularly where posts are not permanent. The workforce development implications of this should be integrated into wider planning for sCAMHS services (for example, by the Welsh Government working with partners such as Health Education and Improvement Wales). As recommendation 12 highlights, evaluation of the implementation and effectiveness of the model in new contexts will also be important.

8.25. The evidence from the evaluation also makes it clear that, despite widespread support and praise for the pilot (amongst those who contributed to the study), the pilot programme was not intended, nor resourced, to address the 'crisis' in pupil or staff mental health and well-being on its own; for example, DECIPHER's analysis of the SHRN Student Health and Wellbeing Survey identified that pupils' perceptions of levels of school support for students who feel unhappy, worried or unable to cope, declined between 2017 and 2019.⁴⁶ Although the decline in perceived levels of support was smaller in pilot schools compared to non-pilot schools, particularly for year 8 pupils, there was no statistically significant difference in the change in

⁴⁶ It should be noted that September – December 2019 (when the 2019/20 Student Health and Wellbeing Survey was administered) was early in the lifetime of the pilot programme, particularly given the pilot's somewhat slow start. Therefore, it may have been too early for any impact of the pilot to be measurable. A comparison of student responses in 2017 and those in the next round of the Student Health and Wellbeing Survey in 2021, may offer a better measure of any impact of the pilot programme upon student's perceptions of school support for students who feel unhappy, worried or unable to cope.

proportion of pupils in pilot and non-pilot schools who reported this. This reflects the modest scale of the pilot programme (relative to the size of the challenge), the structural constraints on access to specialist services and the range of factors that impact upon staff mental health and well-being. It is therefore important to be realistic and pragmatic about what the CAMHS In-Reach programme can and should do (and what it cannot and/or should not try to do) as part of a wider strategy to promote whole-school approaches. Moreover, while the medium- and long-term impacts of COVID-19 upon pupil and staff well-being are not yet known, and are likely to differ for different groups, they are expected to be negative overall (see NHS Benchmarking, 2020). Effective action will require co-ordination of the range of initiatives launched to promote children and young people's mental health and well-being, to avoid unnecessary duplication and maximise synergies and ensure that there is a 'whole-system' approach to promoting pupil and staff mental health and well-being.

- 8.26. Although the evaluation findings are clear that the CAMHS In-Reach model should be developed and extended as part of a co-ordinated and collaborative whole-system approach to promoting children's and young people's mental health and well-being, it did not explore where responsibilities for taking this forward should lie. Stakeholders who could take this forward could include, for example, Regional Partnership Boards, Regional Educational Consortia, Local Health Boards, Local Authorities, Public Health Wales, the voluntary sector and schools.

Recommendation 11. the Welsh Government should consider working with partners to identify roles and responsibilities for taking forward the CAMHS In-Reach model and lessons from the pilot, as part of a co-ordinated and collaborative whole system approach to promoting children's and young people's mental health and well-being.

Recommendation 12. The Welsh Government should work with partners to ensure that there is robust monitoring and evaluation of the effectiveness of action to support pupil and staff mental health and well-being. This should include evaluation of the effectiveness of the roll out of the CAMHS In-reach programme work. Evidence of a decline in the proportion of pupils in both pilot and non-pilot schools who feel supported when they need help highlights the need to avoid complacency. The impact of COVID-19 has also changed the context for this work (and this may have implications for, for example, the need and demand for, delivery and/or effectiveness of the pilot model). The evaluability assessment of the Whole-School Approach to

Mental Health and Well-being aims to inform approaches to evaluation of interventions aimed at improving mental health and well-being and is likely to be valuable here. It is anticipated that findings of that assessment will be published in autumn 2021.

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10. Annex A. Research questions

The research questions for the study are to identify:

- the extent to which the pilot programme has achieved the six short and four medium-term outcomes⁴⁷;
- the unintended outcomes in the pilot programme;
- the additional value and quality measures that may exist outside the baseline measures;
- existing monitoring processes and how they might be improved;
- the extent to which the pilot programme has promoted collaborations within schools, between schools and with other partners;
- specific features of the pilot programme that had the biggest influence;
- features of the pilot programme that were less effective;
- the perceived impact of the pilots from schools;
- sustainability of the CAMHS In-Reach to Schools pilot programme;
- forms of working relationships between sCAMHS advisers and schools;
- experiences of those involved; the aspects that were most valued or caused difficulties and the differences between groups of people;
- perceptions of key stakeholders involved in the programme i.e. is it viewed as building on and consolidating existing initiatives and policies;
- the effect (if any) that regional variations have in terms of infrastructure and implementation;
- aspects of the programme that have worked well, barriers encountered and what could be improved;
- whether the programme complemented other WG/PHW policies;
- issues of relevance and sustainability of these approaches; and

⁴⁷ As outlined in the specification: the research outcomes for this evaluation should be measured by agreed baselines and activities at the scoping stage of the project and alongside the theory of change's outcomes (see figure 1.1).

- transferability and generalisability of successful approaches to other contexts.

11. Annex B SHRN Student Health and Wellbeing Survey Analysis

Outcome measures

Teacher talk

Pupils were asked to show how much they agreed or disagreed with the following statement: 'There is at least one teacher or other member of staff at this school who I can talk to about things that worry me' (response options: 'strongly agree', 'agree', 'neither agree nor disagree', 'disagree', 'strongly disagree').

A binary measure was created with pupils responding 'strongly agree' or 'agree' coded 1, and all other responses coded 0.

School support

Pupils were asked how much they agreed with the following statement: 'There is support at my school for students who feel unhappy, worried or unable to cope' (response options: 'strongly agree', 'agree', 'neither agree nor disagree', 'disagree', 'strongly disagree').

A binary measure was created with pupils responding 'strongly agree' or 'agree' coded 1, and all other responses coded 0.

Other measures

- Gender (boy or girl)
- Ethnicity (White or Black, Asian and minority ethnic)
- FAS (family affluence scale score)⁴⁸
- Time (binary measure indicating survey year; 2017=0, 2019=1)
- Intervention*time (interaction term that identifies any change in observed outcome in the treatment group in the post-intervention period – **this is the coefficient used to infer intervention effectiveness**)
- School-level fixed effects

Data analysis

Mixed effects logistic regression models were used to undertake 'difference in difference' analyses that estimated the extent to which any observed change in the above outcomes could be attributed to the pilot (intervention). The models were stratified by survey year in order to avoid issues of variable dependence, with data for year 8 and year 11 pupils in 2017 and 2019 pooled for statistical analysis (sample sizes are included in table 1). Models were also adjusted for compositional differences between schools (i.e. gender, ethnicity,

⁴⁸ Higher scores reflect greater family affluence.

and family affluence), all of which were grand mean centred for the purpose of analysis. Random effects were estimated for schools by survey year. Only schools that provided data in both 2017 and 2019 were included in analyses.

Table 1. Sample sizes

	Year 8	Year 11
Pupils		
2017	19,836	15,114
2019	21,779	16,939
Total	41,615	32,053
Schools		
Pilot	29	29
Non-pilot	139	134
Total	168	163

Results

Teacher talk

Between 2017 and 2019, both year 8 and year 11 models (table 2) suggest an increase in the proportion of pupils who feel there is a teacher they can talk to if they're worried, demonstrated by odds ratios of 1.16 and 1.10, respectively. However, in both models the coefficient used to determine intervention effectiveness ('intervention*time') was non-significant, hence there is no evidence of any significant variation in outcome between pilot and non-pilot schools.

This was not the focus of the analysis but it is interesting to note that amongst Y11 pupils, girls were more likely than boys to agree that there was a teacher they could talk to if they were worried. Also Black, Asian and minority ethnic (BAME) students in both year groups were less likely than white students to agree there was someone to talk to if they were worried.

Table 2. Likelihood of agreeing that there is at least one teacher or other member of school staff to talk to when worried (odds ratios with 95% confidence intervals)

	Year 8 (n=35,162)		Year 11 (n=28,880)	
	OR	P	OR	P
Time	1.16	<0.001	1.10	0.001
	[1.10,1.22]		[1.04,1.16]	
Intervention*time	0.97	0.688	1.10	0.210
	[0.84,1.12]		[0.95,1.28]	
Gender				
Boy	1 (Ref)		1 (Ref)	
Girl	1.05	0.064	1.20	<0.001
	[1.00,1.10]		[1.14,1.26]	
Ethnicity				
White	1 (Ref)		1 (Ref)	
Black, Asian and minority ethnic	0.73	<0.001	0.74	<0.001
	[0.68,0.80]		[0.68,0.81]	
FAS	1.02	0.005	1.04	<0.001
	[1.00,1.03]		[1.03,1.05]	
School-level fixed effects	Yes		Yes	
Random intercept	Yes		Yes	

OR=odds ratio; FAS=family affluence scale

School support

Between 2017 and 2019, both year 8 and year 11 models (table 3) suggest a decline in perceived level of school support for students who feel unhappy, worried or unable to cope, demonstrated by odds ratios of 0.80 and 0.65, respectively. Again, there was no evidence of intervention effectiveness in either model, although the coefficient neared significance in the Year 8 model (OR 0.88, P=0.086).

Table 3. Likelihood of agreeing that there is school support for pupils who feel unhappy, worried or unable to cope (odds ratios with 95 per cent confidence intervals)

	Year 8 (n=34,351)		Year 11 (n=28,503)	
	OR	P	OR	P
Time	0.80	<0.001	0.65	<0.001
	[0.76,0.85]		[0.61,0.69]	
Intervention*time	0.88	0.086	1.06	0.448
	[0.76,1.02]		[0.91,1.24]	
Gender				
Boy	1 (Ref)		1 (Ref)	
Girl	0.93	0.006	0.82	<0.001
	[0.89,0.98]		[0.78,0.86]	
Ethnicity				
White	1 (Ref)		1 (Ref)	
Black, Asian and minority ethnic	0.75	<0.001	0.88	0.005
	[0.69,0.82]		[0.80,0.96]	
FAS	0.99	0.382	1.02	<0.001
	[0.98,1.01]		[1.01,1.03]	
School-level fixed effects	Yes		Yes	
Random intercept	Yes		Yes	

OR=odds ratio; FAS=family affluence scale

2020 SHRN School Environment Questionnaire (SEQ)

Outcome measures

Named CAMHS contact

Schools were asked: Do you have a named person within your local Child and Adolescent Mental Health Service (CAMHS) who you can contact for help and support? (response options: 'yes', 'no', 'don't know').

Frequency of CAMHS communication

Schools were asked: In the last two years, approximately how often has your school been in communication with your local CAMHS? (response options: 'weekly', 'fortnightly', 'monthly', 'about once a half term', 'about once a term', 'less than once a term', 'never', 'don't know').

Accessibility of treatment post-CAMHS referral

Schools were asked: If you made any [CAMHS] referrals, did the student(s) get access to treatment? (response options: 'yes, all', 'yes, some', 'no', 'don't know').

Perceived level of CAMHS support

Schools were asked: To what extent do you feel supported by your local CAMHS? (response options ranged from '1 Very supported' to '5 Not at all supported', and 'don't know').

Sample

167 schools completed the 2020 SEQ (28 pilot schools). 8 pilot schools did not undertake the SEQ.

Results

As outlined in section 2, a cross-sectional rather than longitudinal analysis was judged more appropriate for the SEQ, as it relied upon subjective data provided by one staff member in each school. Therefore, these figures should be treated as indicative only.

Table 4. Cross-sectional comparison of outcome measures between pilot and non-pilot schools

	Pilot (no.)	Non-pilot (no.)
Named CAMHS contact		
Yes	21	84
No	5	26
Don't know	0	6
Freq. CAMHS communication		
At least fortnightly (weekly/fortnightly)	14	61
Accessed treatment post-CAMHS referral		
Yes, all	2	5
Yes, some	16	53
No	0	0
Don't know	0	0
Perceived level of CAMHS support		
Feel supported (1 or 2 on scale)	8	39

12. Annex C. End-line questionnaire

Introduction

People and Work has been commissioned by the Welsh Government to undertake this evaluation of the CAMHS In-reach to schools pilot programme. The pilot programme is an innovative approach across education and health to support school staff to identify, understand and be able to address low level mental health concerns of pupils. It is therefore important that evidence on the pilot programme's implementation and outcomes is robustly assessed, in order to inform a possible national roll-out of the programme.

This questionnaire will help to measure changes in staff (school leaders, SENCO/ALNCO, teachers and support staff) confidence, knowledge and understanding and their practice in relation to mental health and well-being. The questionnaire should take 10 minutes to complete.

This is the second questionnaire about the CAMHS In-reach to schools pilot programme. We are asking all staff to complete this questionnaire, whether or not you completed the first survey and even if you have not been involved in the CAMHS In-reach to schools pilot, we still want to hear from you.

We would like to collect information about your role and school, but we do not ask for your name and we will ensure that all data is anonymised so that you are not identifiable (please see the GDPR privacy notice on the next page).

What will the outcomes of the research be?

An interim report on the research will be published in 2020 and the final report will be published in early 2021. The reports will help inform the delivery of the pilot programme, decisions about any potential national roll-out of the programme, and identify lessons applicable to wider wellbeing policies.

Details about the research team

The People and Work research team is led by Dr Duncan Holtom, supported by Dr Sarah Lloyd-Jones, Rhodri Bowen, Heather Pells and Val Williams. If you wish to contact the research team, please e-mail Duncan Holtom at duncan.holtom@peopleandwork.org.uk

If you wish to contact the Welsh Government about this work, please contact Helen Shankster at Helen.Shankster@gov.wales

PRIVACY NOTICE – Evaluation of CAMHS In-reach Pilot

This is a summary. The full privacy notice can be accessed at: [Full privacy notice](#)

What personal detail do we hold and where did we get your details?

Your contact details were originally provided when you joined the pilot programme.

We do not ask for your name in this questionnaire, and we will try not to identify you, but because we ask for the name of your school and your role, you could be identifiable. Any personally identifiable information will be removed and results will be made anonymous before they are shared or published.

What is the lawful basis for collecting the data?

Participation is completely voluntary. The lawful basis of processing information in this data collection exercise is consent and public task (in this case the Welsh Government exercising its official role and functions).

How secure is any personal data submitted?

Personal information is always stored securely. People & Work has Cyber Essentials certification.

How long do you keep any personal data submitted?

People & Work will hold personal data during the contract period (November 2018-December 2020), and any personal data not already removed from survey responses will be deleted three months after the end of the contract.

Your rights

Under GDPR, you have the right to:

- Access a copy of your own data;
- Require us to rectify inaccuracies in that data;
- Object to or restrict processing (in certain circumstances);
- Ask for your data to be 'erased' (in certain circumstances); and
- Lodge a complaint with the Information Commissioner's Office (ICO) who is our independent regulator for data protection.

The contact details for the Information Commissioner's Office are: Wycliffe House, Water Lane, Wilmslow, Cheshire, SK9 5AF. Phone: 01625 545 745 or 0303 123 1113. Website: www.ico.gov.uk

Background

1. Please write the name of your school in the box below

2. Which Local Authority is your school in?

3. What type of school do you work at?

- Primary school
- Through age school / Middle school
- Secondary school
- Pupil Referral Unit
- Special School

4. What language medium school do you work in?

- English medium or predominately English medium
- Welsh medium or predominantly Welsh medium
- Dual stream
- Transitional

5. What best describes your role or roles in the school (please select all that apply)

- Teacher
- Support Staff
- SENCo or ALNCo
- Pastoral lead / team
- Other (please specify)
- School Leader / member of the senior management team
- School nurse
- School counsellor

Confidence and support

6. Please read the following statements and select the response that best describes how you feel

	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree	Not sure / don't know
I am confident that I can identify that a pupil may have unmet mental health needs	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I feel confident to discuss mental health and wellbeing needs with individual pupils	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I feel confident meeting the needs of pupils with mental health difficulties	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I feel confident to speak to a parent or carer about their child's mental health.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I am confident identifying when I need advice or support to better understand or address a pupil's mental health difficulty	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
My school is effective at promoting the mental health and well-being of pupils.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
My school is effective at promoting the mental health and well-being of staff.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

7. If needed, I know how to access further advice or support when I identify that a pupil may have mental health difficulties

- Yes
 No

Access to support

8. Who would you go to in school for further advice and support when you identify that a pupil may have mental health difficulties? (please select all that apply)

- | | |
|---|--|
| <input type="checkbox"/> SENCo/ALNCo | <input type="checkbox"/> School nurse |
| <input type="checkbox"/> Pastoral lead/team | <input type="checkbox"/> CAMHS In-Reach Practitioner |
| <input type="checkbox"/> School counsellor | |
| <input type="checkbox"/> Other (please specify) | |

9. Which services would you go to for advice and support? (please select all that apply)

- | | |
|--|---|
| <input type="checkbox"/> Local Authority Inclusion service | <input type="checkbox"/> CAMHS |
| <input type="checkbox"/> Educational Psychology service | <input type="checkbox"/> None (there are no services I would go to for advice or support) |
| <input type="checkbox"/> Family support services (e.g. Families First or Team Around the Child/Family) | <input type="checkbox"/> Not sure / don't know |
| <input type="checkbox"/> Primary Mental Health service / team | |
| <input type="checkbox"/> Other (please specify) | |

10. Please read the following statement and select the response that best describes how you feel: I feel supported by CAMHS

- Strongly agree
- Agree
- Neither agree nor disagree
- Disagree
- Strongly disagree
- Not sure / don't know

If you disagree, please explain why not below

Your well-being

Please read the questions and select the response that best describes how you feel

11. I experience increased levels of stress when dealing with pupils' mental health difficulties

- Always
- Often
- Sometimes
- Seldom
- Never
- Don't know / not sure
- Other (please specify)

12. I know who to go to in the school if I need support for my own well-being.

- Yes
- No
- Not sure

The CAMHS In-reach pilot programme

13. Are you aware of the CAMHS In-reach to Schools programme?

Yes

No

CAMHS In-reach pilot programme

14. Have you been supported by a CAMHS In-reach Practitioner, for example, by discussing the needs of a pupil or discussing the appropriateness of a referral to a specialist service like Educational Psychology or CAMHS?

- Yes
- No

15. The advice and / or consultation (delivered by the Pilot) has increased my knowledge and understanding of pupils' mental health problems and how to deal with them

- Strongly agree
- Agree
- Neither agree or disagree
- Disagree
- Strongly disagree
- Not sure / don't know

16. Have you received training, from the CAMHS In-reach to schools programme?

- Yes, in regards to **pupils'** mental health and/or well-being
- Yes, in regards to **school staff's** mental health and/or well-being
- Yes, in regards to **pupils' and staff's** mental health and/or well-being
- No
- If you have, can you please briefly describe what training you had.

Experiences of training delivered by the Pilot

17. Please read the following statement and select the response that best describes how you feel: the training (delivered by the Pilot) has increased my knowledge and understanding of pupils' mental health problems and how to deal with them

- Strongly agree
- Agree
- Neither agree nor disagree
- Disagree
- Strongly disagree
- Not sure / don't know

18. Please read the following statement and select the response that best describes how you feel: the training (delivered by the Pilot) has increased my knowledge and understanding of pupils' mental health problems and how to deal with them

- Strongly agree
- Agree
- Neither agree nor disagree
- Disagree
- Strongly disagree
- Not sure / don't know

19. Please read the following statement and select the response that best describes how you feel: the training (delivered by the Pilot) has helped me improve my own mental health and well being.

- Strongly agree
- Agree
- Neither agree nor disagree
- Disagree
- Strongly disagree
- Not sure / don't know

20. This is the second survey evaluating teachers' experiences of the CAMHS In-reach to schools pilot. Did you complete and return the first survey (circulated March to June 2019)?

- Yes
- No
- Not sure

Comments

21. Thank you for answering the questions. Do you have any other comments?