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Evaluation of the CAMHS In-Reach Pilot Programme: Interim Report

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Evaluation of the CAMHS In-Reach Pilot Programme
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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
ACE	Adverse Childhood Experiences
ADHD	Attention Deficit Hyperactivity Disorder
ALN	Additional Learning Needs
ALNCOs	Additional Learning Needs Co-ordinators
AoLE	Area of Learning Experience
ASD	Autism Spectrum Disorder
BBC	British Broadcasting Corporation
BCUHB	Betsi Cadwaladr University Health Board
CAMHS	Children and Adolescent Mental Health Service
CCG	Clinical Commissioning Group
CYP	Children and Young People
CYPE	Children, Young People and Education
DfE	Department for Education
EP	Educational Psychology
ESF	European Social Fund
EWC	Education Workforce Council
EWO	Education Welfare Officer
GP	General Practitioner
GDPR	General Data Protection Regulations
IT	Information Technology
LA	Local Authority
LHB	Local Health Board
MH	Mental Health
NHS	National Health Service
PASS	Pupil Attitudes to School and Self
PHW	Public Health Wales
PMHCSS	Primary Care Mental Health Support Services
PMHSS	Primary Mental Health Support Services
RPB	Regional Partnership Board
sCAMHS	Specialist Children and Adolescent Mental Health Services
SENCos	Special Educational needs Co-ordinators
SEN	Special Educational Needs
SHRN	Schools Health Research Network

SPACE - Wellbeing	Single Point of Access for Children's Emotional Well-being and Mental Health
TAF	Team Around the Family
T4CYP	Together for Children and Young People Programme
WG	Welsh Government
WASPI	Wales Accord on the Sharing of Personal Information
WNHSS	Welsh Network of Healthy School Schemes
YMHFA	Youth Mental Health First Aid

Summary

Context for the CAMHS In-Reach to Schools pilot programme

Most pupils in Wales have good mental health and well-being. However, around one in eight pupils have a mental health problem and around a quarter of pupils experience periods of feeling low (Hewitt, et al, 2019)¹. Widespread concerns that pupils' mental health and well-being is worsening and that schools and services like Child and Adolescent Mental Health Services (CAMHS) have struggled to meet rising demands have led to a range of initiatives, including the CAMHS In-Reach to Schools pilot programme.

The CAMHS In-Reach to Schools pilot programme in Wales

The CAMHS In-Reach to Schools pilot programme aims to build capacity (including skills, knowledge and confidence) in schools to support pupils' 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 staffs' stress. Initially conceived as a two-year pilot programme running from 2018 to the summer of 2020, in 2019 the pilot programme was extended to coincide with the final evaluation (due at the end of 2020). The pilot programme operates in three areas:

- South East Wales (covering Blaenau Gwent and Torfaen / Aneurin Bevan University Health Board and South Powys / Powys Teaching Health Board);
- West Wales (Ceredigion / Hywel Dda University Health Board); and
- North Wales (Wrexham and Denbighshire / Betsi Cadwaladr University Health Board).

The evaluation of the CAMHS In-Reach to Schools pilot programme

The aim of the evaluation is to understand how the CAMHS In-Reach pilot programme is working, whether the objectives of the pilot programme are being met and how the pilot programme is understood by stakeholders across the pilot regions.

The objectives of the evaluation are 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;

¹ The latest Health Behaviour of School Age Children survey identifies that around a quarter of pupils in years 7 to 11 reported feeling low more than once a week (p.31, Hewitt, et al, 2019).

- 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 pilots' areas is supporting pre-critical point referrals to CAMHS ²;
- 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 (WG) and 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.

A theory-based approach to evaluation, focused upon testing the CAMHS In-Reach to Schools pilot programme's logic model was used. In order to generate data to test the logic model 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, including both pilot documents and other research in this area;
- a baseline survey of school staff, with responses from 352 school staff from 85 schools across the three pilot areas;
- qualitative case-study research, including visits to 21 schools and interviews with 14 LA, LHB and voluntary sector services, such as educational psychology (EP), CAMHS and school counselling services (referred to as "qualitative research" in the report); and
- engagement as a critical friend to the national pilot programme team and the pilot programme team in each area.

The survey and case studies were intended to help measure the baseline position for schools and services at the start of the pilot programme. However, by the time the baseline survey was undertaken between March and June 2019 and visits and interviews were undertaken in the summer and early autumn of 2019, the pilot programme had been operational for about six to nine months. Although the chance to measure a pre-intervention baseline was missed, the judgment of the evaluation team is that is because, by the time the survey and school visits were undertaken, it is unlikely that the pilot would have had time to make much of an impact on the outcomes measured by the baseline survey and

² I.e. timely referrals to CAMHS before mental health difficulties escalate and become critical.

qualitative research with schools. Conversely, the delays provided greater scope to capture the early engagement of schools and services with the pilot, and initial experiences and perception of the impact of pilot activities, like training and consultations.

This report aims to present the baseline position for schools and services at the start of the pilot programme and also to outline the emerging evidence of effectiveness and likely impacts of the pilot programme, after approximately 15 months of work with schools.

Pilot programme implementation

The pilot programme is being implemented in three distinct areas with different-sized geographical areas, numbers of schools, degrees of rurality and service structures (most notably pre-pilot relationships between schools and CAMHS). These differences mean the baseline position in each area also varied. The differences have also shaped the emphasis each pilot area has placed upon the three key elements of the pilot programme's model:

- increasing school staffs' knowledge and understanding of pupils' mental health difficulties, through training and/or advice and consultations;
- helping schools access specialist advice, liaison and consultancy when they need it by, for example, improving school knowledge and understanding of referral pathways; and
- improving school staff well-being and reducing staff stress by, for example, training and workshops focused upon stress and well-being.

Pilot programme implementation and delivery was good overall. However:

- there have been problems with pilot programme staff recruitment and absence in Ceredigion, which was a particular challenge given the small size of the team;
- the size and rurality of areas, coupled with the number of schools relative to the resources and staffing, is a particular challenge in North Wales and, to a lesser extent, in Ceredigion and Mid and South East Wales; and
- engagement of some schools has been a challenge, and all three areas have tended to work more with secondary (or all age) schools, compared to primary schools.

School staffs' knowledge and understanding of pupils' mental health difficulties

The school staff survey and qualitative research with schools identified that, before the pilot, staff confidence in identifying that a pupil might have mental health difficulties was generally high. Schools reported relying upon pastoral relationships between staff and pupils and, particularly in secondary schools, analysis of pupil data to identify pupils' mental health difficulties.

The school staff survey and qualitative research with schools also identified that, before the pilot, staff confidence in assessing and supporting pupils' mental health difficulties was more mixed, but that this may reflect differing staff roles and responsibilities; for example, Additional Learning Needs Co-ordinators (ALNCos)/Special Educational Needs Co-ordinators (SENCOs) and/or pastoral teams are often responsible for assessing pupils identified as potentially having mild mental health difficulties, whilst specialist services like CAMHS are responsible for assessing those pupils with more complex and/or severe mental health difficulties. This model means that not all staff would be expected to have this expertise.

As table 1 illustrates, the three pilot areas have sought to strengthen school staffs' knowledge and understanding of pupils' mental health difficulties through training and consultation, advice and liaison with CAMHS In-Reach practitioners.

Table 1. Pilot approaches to increasing staff skills and confidence

Area	Training	Consultation, advice and liaison with CAMHS In-Reach practitioners
Blaenau Gwent	Yes	Yes
Ceredigion	Yes	Yes
Powys	Yes	Yes, in part ³
Torfaen	Yes	Yes
Wrexham and Denbighshire	Yes	Not initially, but this is now being developed

Source: interviews with project staff

Data from the school staff survey, qualitative research with schools and pilot self-evaluations show that school staff have generally valued the training. However, the effectiveness of the pilot programme depends upon schools choosing to engage (which not all have) and selecting the right staff to be trained and being able to release them (which not all schools have been able to do). The impact of training also depends upon the contexts school staff work in and whether, for example, they have enough time to apply their skills

³ In Powys, the CAMHS in reach practitioner works with primary schools and it was agreed that Powys Primary Care Mental Health Support Services (PCMHSS) would continue to provide routine consultation to pupils from Powys in Brecon and Crickhowell High Schools, while the CAMHS In-Reach practitioner would cover pupils from Gwent in those schools.

and knowledge. More broadly, the research evidence suggests that the pilot programme's work should be an integral part of a broader professional learning, including initial teacher training and other models of learning; for example, professional learning communities, and coaching and mentoring delivered by other partners, such as regional educational consortia, LAs, LHBs and the voluntary sector. This reflects both the volume of professional learning likely to be required (which is beyond the capacity of the pilots) and the case for a mixed economy, with professional learning delivered in different ways through different channels (see e.g. Hill 2013).

Schools' access to specialist advice, liaison and consultancy

The school staff survey, qualitative research with schools and other research studies identified that, before the pilot, schools generally struggled to access specialist advice, liaison and consultancy when they needed it, given high thresholds and waiting lists for specialist services. Access to specialist advice, liaison and consultancy was generally felt to have deteriorated, given rising demand for services and cuts in provision. However, there were isolated examples where schools reported that they have good access to specialist advice, liaison and consultancy.

As table 2 illustrates, the three pilot areas have sought to strengthen access to specialist advice, liaison and consultancy when schools need it, through three main strategies:

- providing Information and advice (e.g. on services and referral pathways);
- brokering access to / acting as an intermediary between schools and services; and
- offering consultation, advice and liaison with CAMHS In-Reach practitioners.

Table 2: Pilot approaches to improving schools’ access to specialist advice and support

Area	Information and advice (e.g. on services, referral pathways)	Brokering access to / acting as an intermediary between schools and services	Consultation, advice and liaison with CAMHS In-Reach practitioners
Blaenau Gwent	Yes	Yes	Yes
Ceredigion	Yes	Yes	Yes
Powys	Yes	Yes, in part ⁴	Yes, in part
Torfaen	Yes	Yes	Yes
Wrexham and Denbighshire	Yes	No	Not initially, although this is now being developed

Source: interviews with project staff

Data from the school staff survey, qualitative research with schools and pilot self-evaluation all suggest that where CAMHS In-Reach practitioners provide consultations, advice and liaison, this is improving secondary schools’ access to specialist advice, liaison and consultancy when they need it. However, there is less evidence that the pilot programme has had a large impact upon primary schools (as there has been less support provided), or upon primary or secondary schools staff knowledge of services (as this was generally high before the pilot). Moreover, schools’ access to specialist advice, liaison and consultancy when they need it, continues to be constrained by the demand-capacity gap most specialist services face. This is a challenge largely beyond the pilot programme’s scope.

School staff stress and well-being

Qualitative research with schools, data collected by the pilots and other research studies and, to a lesser extent, the school staff survey (which included only one question on this issue), identified high levels of stress amongst school staff, and in particular school leaders, before the pilot programme. Staff stress and low levels of well-being are a concern in and of

⁴ In Powys, the CAMHS in reach practitioner works with primary schools and it was agreed that Powys PCMHSS would continue to provide routine consultation to pupils from Powys in Brecon and Crickhowell High Schools, while the CAMHS In-Reach practitioner would cover pupils from Gwent in those schools.

themselves and also because there is evidence that high levels of staff stress and low levels of staff well-being undermine schools' efforts to promote pupils' well-being.

As table 3 illustrates, the three pilot areas have addressed the challenge of reducing staff stress and improving staff well-being through a mix of four key approaches:

- training in stress management and promoting well-being;
- training in recognising and meeting pupils' mental health needs (increasing staff skills and confidence);
- consultation, advice and liaison with CAMHS In-Reach practitioners (increasing skills and confidence); and
- improving access to specialist services (reducing stress linked to difficulties in accessing services).

Table 3. Pilot programme approaches to reducing staff stress and improving staff well-being

Area	Training in stress management and promoting well-being	Training in recognising and meeting pupils' mental health needs (increasing staff confidence)	Consultation, advice and liaison with CAMHS In-Reach practitioners (increasing confidence, providing reassurance)	Improving access to specialist services (reducing stress linked to difficulties accessing support)
Blaenau Gwent	Yes	Yes	Yes	Yes
Ceredigion	Yes	Yes	Yes	Yes
Powys	Yes	Yes	Yes, in part ⁵	Yes
Torfaen	Yes	Yes	Yes	Yes
Wrexham and Denbighshire	Yes	Yes	Not initially	No

Source: interviews with project staff

The school staff survey, qualitative research with schools and data from the pilots and other research identified that staff stress and well-being depends upon multiple factors; these include factors such as:

⁵ In Powys, the CAMHS in reach practitioner works with primary schools and it was agreed that Powys PCMHS would continue to provide routine consultation to pupils from Powys in Brecon and Crickhowell High Schools, while the CAMHS In-Reach practitioner would cover pupils from Gwent in those schools.

- staff competence in supporting pupils with mental health difficulties, and their access to services (such as specialist advice , liaison and consultancy when they need it), which the pilot addresses; and
- wider contextual factors like staff workload, having the time to help pupils, school reforms and accountability regimes, which are beyond the pilot programme's scope.

Therefore the pilot programme has the potential to help reduce (but not eliminate), sources of stress (e.g. by upskilling staff) and also help staff cope with stress and improve their well-being (e.g. through training and workshops on well-being). The evidence of an impact to date upon staff competence and confidence (discussed above) is stronger than the evidence of the impact of training and workshops to help staff manage stress and promote well-being, which have sometimes had mixed feedback from participants. It is also important to bear in mind the scale of the challenge here, 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.

Conclusions

Qualitative research with stakeholders, the review of project documents and analysis of progress against the pilot programme's logic model indicates that the pilot programme's implementation and delivery has been generally effective. Recruiting highly skilled workers has been critical to the pilot programme's success thus far. However, sustaining the quality of work is likely to be a challenge going forward because, as engagement with schools strengthens (which is a success of the pilot programme), the same sized staffing teams are delivering to, and working with, increasing numbers of schools, which risks diluting impact.

Fidelity⁶ to the pilot programme's theory of change has been strong overall, although different areas have emphasised or prioritised different aspects of the model; for example:

- in North Wales, there has been a strong emphasis on promoting staff well-being and on training, and less around increasing schools' access to specialist advice, liaison and consultancy when needed;

⁶ Fidelity describes "the consistency of what is implemented with the planned intervention" (Moore et al, 2015, p. 4). It has been argued that fidelity is achieved if the generative mechanisms are essentially the same, even if, for example the contexts in which an intervention (like the pilot) operates and the ways it is implemented, vary somewhat (see e.g. the discussion Moore, et al, 2015). In this context, it means that there is fidelity to the Pilot Programme's theory of change even though different areas have undertaken somewhat different activities, given differences in their context.

- in South East Wales, there have been discussions about what the balance between consultation and training should be; and
- in Ceredigion, a strong partnership model has developed for consultation work with secondary schools, and a three tiered training model is being developed. However, the size and rurality of the area, coupled with limited staff time, have hampered efforts to provide consultations to more than a handful of primary schools.

These differences, together with differences in the baseline position in each area, mean that the impact of the pilot programme is likely to be different in each area.

Although it is too early to robustly assess the impact of the pilot programme, the case for the pilot programme is strong and there is solid support for the pilot programme from most stakeholders interviewed for this study. The investment in the pilot programme provided enough capacity to make a real difference to large numbers of schools and the emerging evidence suggests the pilot programme is making:

- an important contribution to school staff skills and knowledge of mental health difficulties;
- a modest, but still important, contribution to schools' access to specialist advice, liaison and consultancy when they need it (impact here is likely to be constrained, as services are often struggling to cope with a gap between demand and capacity); and
- a modest, but still important, contribution to reducing school staff stress and promoting staff well-being (impact here is likely to be constrained by the range of factors, beyond the pilot's control, that contribute to staff stress and poor well-being).

However, it must also be said that CAMHS In-Reach practitioners have been stretched (given their capacity/time relative to demand), the pilots have generally prioritised work with secondary schools over primary schools, and there are risks that the quality and quantity of support for individual schools will be diluted as increasing numbers of schools engage with the programme.

Moreover, evidence from the evaluation also strongly suggests that, despite widespread support and praise for the pilot (from those who contributed to the study), the pilot programme will contribute to addressing what some see as a 'crisis' in pupils' mental health and well-being, but will not solve this challenge on its own. This reflects the relatively small scale of the pilot programme (relative to the size of the challenge). The achievement of the pilot programme's long term goals, such as ensuring that schools can meet the needs of

pupils, are likely to require more broadly based strategies, such as the development of whole school approaches, which the pilot can contribute to, but is not intended to, nor resourced to, deliver. It will also be important to ensure co-ordination of the pilot programme with other initiatives intended to promote children and young people's mental health and well-being, to avoid unnecessary duplication and maximise synergies, through a whole system approach to promoting mental health and well-being.

Recommendations and emerging learning

Recommendation 1. For the Welsh Government: there is encouraging early evidence of the pilot programme's effectiveness and a robust theory of change, however, the pilot programme's impact is not yet demonstrated. Decisions about the development of the pilot programme, such as its continuation, expansion and/or closure, should be deferred until a more comprehensive assessment of the pilot programme has been undertaken, and its potential contribution to whole school approaches more fully explored. The second round of surveys and interviews with schools and services should provide additional evidence to inform decisions. Although decisions about the development of the pilot programme should not be rushed (and be evidence-based), it will be important to ensure that the pilot programme and other partners are given adequate time to prepare for any future development.

Recommendation 2. For the pilot programme: the professional learning offer to schools should include access to an ongoing programme of training open to all staff in areas where the identification of mental health difficulties might arise; more specialist training for those who need greater expertise, such as ALNCoS/SENCoS and pastoral staff; and responsive and potentially bespoke support and professional learning focusing upon the needs of specific pupils or issues which could, for example, be delivered through consultations.

Recommendation 3. For the pilot programme: evaluation of the effectiveness of professional learning should consider both the numbers of staff engaged and also their roles and responsibilities in schools; for example, increasing the capacity of pastoral staff to assess pupils' needs, may have a greater impact than increasing the capacity of teachers to assess pupils' needs.

Recommendation 4. For the Welsh Government, RPBs, LHBs, LAs, regional educational consortia and the pilot programme: consideration be given to how the mental health difficulties of primary school age pupils who are not in Year 6 can best be met. Extending the pilot and allowing CAMHS In-Reach practitioners to work with younger pupils, is worth

considering. However, the pilot has generally had less engagement with primary schools and any extension risks further stretching the capacity of CAMHS In-Reach practitioners, potentially diluting the pilot programme's impact. Therefore, it is not clear if extending the age range the pilot works with would be a cost-effective option or not.

Recommendation 5. For the pilot programme: the capacity of CAMHS In-Reach teams is carefully monitored to ensure that if, as expected, more schools engage with the pilot programme, the impact of the pilot programme is not unduly diluted and/or staff teams' own workload and well-being compromised.

Recommendations for further research

Recommendation 6. For the pilot programme and Welsh Government: a comparative evaluation of the content, delivery and impact of the different training and professional learning models developed or adopted by each pilot area should be undertaken, in order to inform and maximise sharing of good practice across the three pilot areas. The scope for developing joint or shared models of professional learning across pilot areas should also be explored.

Recommendation 7. For the pilot programme and Welsh Government:: the perceived relevance, value and impact of training and support around staff stress and well-being should be carefully monitored and evaluated and, if necessary, changes made.

Emerging lessons

In addition to the recommendations, the evidence collected to date for this evaluation suggests that:

1. The pilot's professional learning offer needs to be planned and delivered as part of a broader professional learning offer to school staff including, for example, that provided through initial teacher education and by regional education improvement services, and other services such as LA Inclusion, EP services and LHBs.
2. The implications for the pilot and, of both the new school curriculum, and the Joint Ministerial Task Force recommendations on whole-school approaches for school staffs' professional learning requirements, should be identified. Whole-school approaches may create new roles and responsibilities in relation to promoting and supporting pupils' mental health and well-being and therefore new professional learning requirements for some school staff groups.

3. Action is required to assess the extent to which specialist services such as CAMHS, face a demand-capacity gap, and where needed, action to close that gap. This could include, for example, additional investment and reconfiguration of services to better meet the needs of children and young people with mental health difficulties.
4. The scope to increase the capacity of schools to meet the needs of pupils with mental health difficulties without or with less recourse to specialist services, should be explored. This could include, for example, exploring the cost effectiveness of investing in expertise in ALN/SEN and pastoral teams within schools, and providing these teams with easier access to advice and support from specialists (such as consultations the CAMHS In-Reach pilot practitioners provide), rather than requiring referrals to be made to specialist services. The learning from the pilot programme about the cultural and communication gaps between schools and services, and ways in which they can be bridged, is also likely to be relevant here. More work to improve school staff well-being and reduce staff stress is required. The evidence from this study suggests that action here should be part of whole school approaches to promoting mental health and well-being in schools, but detailed recommendations in this area lie beyond this study's remit.

1. Introduction

Context for the CAMHS In-Reach to Schools pilot programme

Pupils' mental health and well-being

- 1.2 Most pupils in Wales have good mental health and well-being. However, around one in eight have a mental health problem and around a quarter of pupils experience periods of feeling low⁷. 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 (Hewitt et al., 2019).
- 1.3 There is evidence that mental health difficulties, such as feeling low, have increased; for example, in Wales:
- the proportion of 15 year old boys reporting feeling low more than once a week increased from less than 10 percent in 2009 to 15 percent in 2014; and
 - the proportion of 15 year old girls reporting feeling low more than once a week increased from less than 22 percent in 2009 to 30 percent in 2014 (PHW, 2016).
- 1.4 There is some evidence that more severe mental health disorders⁸ have also increased, albeit at a slower rate than the rise in mental health difficulties; for example:
- the proportion of 5-15 year olds in England experiencing any mental disorder rose slightly from 9.7 percent in 1999 to 11.2 percent in 2017 (NHS Digital, 2018).
- 1.5 Widespread concerns that pupils' mental health and well-being is worsening and that schools and services like CAMHS 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;

⁷ The latest [Health Behaviour of School Age Children survey](#) identifies that around a quarter of pupils in years 7 to 11 reporting feeling low more than once a week (p.31, Hewitt, et al, 2019).

⁸ '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 Children’s Commissioner, who reported in 2016 that mental health was the issue most commonly raised by children, young people, their parents and carers; 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).

1.6 This has led some people to conclude that there is a ‘crisis’ in mental health (BBC, 2019) and in response to the challenge of improving children’s and young people’s emotional health and well-being, a range of initiatives, including:

- the Together for Children and Young People Programme (T4CYP)⁹ launched in February 2015, in part as a response to the CYPE inquiry into CAMHS;
- the Adverse Childhood Experiences (ACE) informed school movement¹⁰, fuelled by Public Health Wales’s (PHW’s) first 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 by pioneer schools developing the Health and Well-being Area of Learning (AoLE)¹¹ (WG, 2015a);
- The Third Sector Mental Health Grant Scheme, to help prevent mental health problems developing, by improving the information available to pupils, which is funding a range of initiatives delivered by organisations like Action for Children;
- the CAMHS In-Reach to Schools pilot programme announced in 2017, in part in response to the 2014 and 2018 CYP Enquiries 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-being¹², announced in September 2018 (see boxed text).

⁹ 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; early identification and intervention and investment in specialist services (NHS Wales, 2015)

¹⁰ For example, The ACE Support Hub has developed a range of learning materials to support primary schools to develop an ACE-informed approach, [Adverse childhood experiences \(ACE\) awareness – Primary](#)

¹¹ ‘What matters’, the ‘key elements that all learners should experience’ as part of Health and Well-being AoLE are currently being developed (WG, 2015a).

¹² [Joint Ministerial Task and Finish Group on a Whole-School Approach to Mental Health and Well-being](#)

- 1.7 These build upon earlier initiatives such as the Welsh Network of Healthy School Schemes (WNHSS)¹³ launched in 1999: ‘to encourage the development of local healthy school schemes within a national framework’¹⁴.

The Joint Ministerial Task and Finish Group on a Whole-School Approach

The Ministerial Task and Finish Group is intended to bring together all the different activity focused upon improving the mental health and well-being of children and young people. It covers activity initiated by the Welsh Government, and also that initiated by other public bodies such as Local Authorities, Local Health Boards (LHBs), Regional Partnership Boards (RPBs) and regional educational consortia and the voluntary sector. The group aims to identify interdependencies and also gaps in provision in order to inform the development of a whole school approach framework to promote the mental health and well-being of children and young people. The framework is ‘not intended as a one-size-fits all approach, rather a set of common principles all can agree to promote consistency and equity of access.’

The focus upon ‘whole school’ approaches has been complemented by discussions in the group about the need for a ‘whole systems’ approach, encompassing not only schools, but all the services, such as CAMHS, EP, PMHSS and the Youth Service, needed to promote children’s and young people’s mental health and well-being.

Adapted from WG, 2019a

School staff well-being

- 1.8 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 educational professionals in the UK consistently identify high stress levels, with high

¹³ 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’. [Welsh Network of Healthy Schools Scheme](#)

¹⁴ [Welsh Network of Healthy Schools Scheme](#)

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% of respondents agreed or strongly agreed when asked: “are [you] able to effectively manage your existing workload within your agreed working hours?” (p. 54, *ibid.*).

- 1.9 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 with 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.

The English Mental Health Services and Schools Link Project

- 1.10 Similar concerns in England about pupils’ mental health and difficulties accessing services like specialist CAMHS (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 specialist CAMHS 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

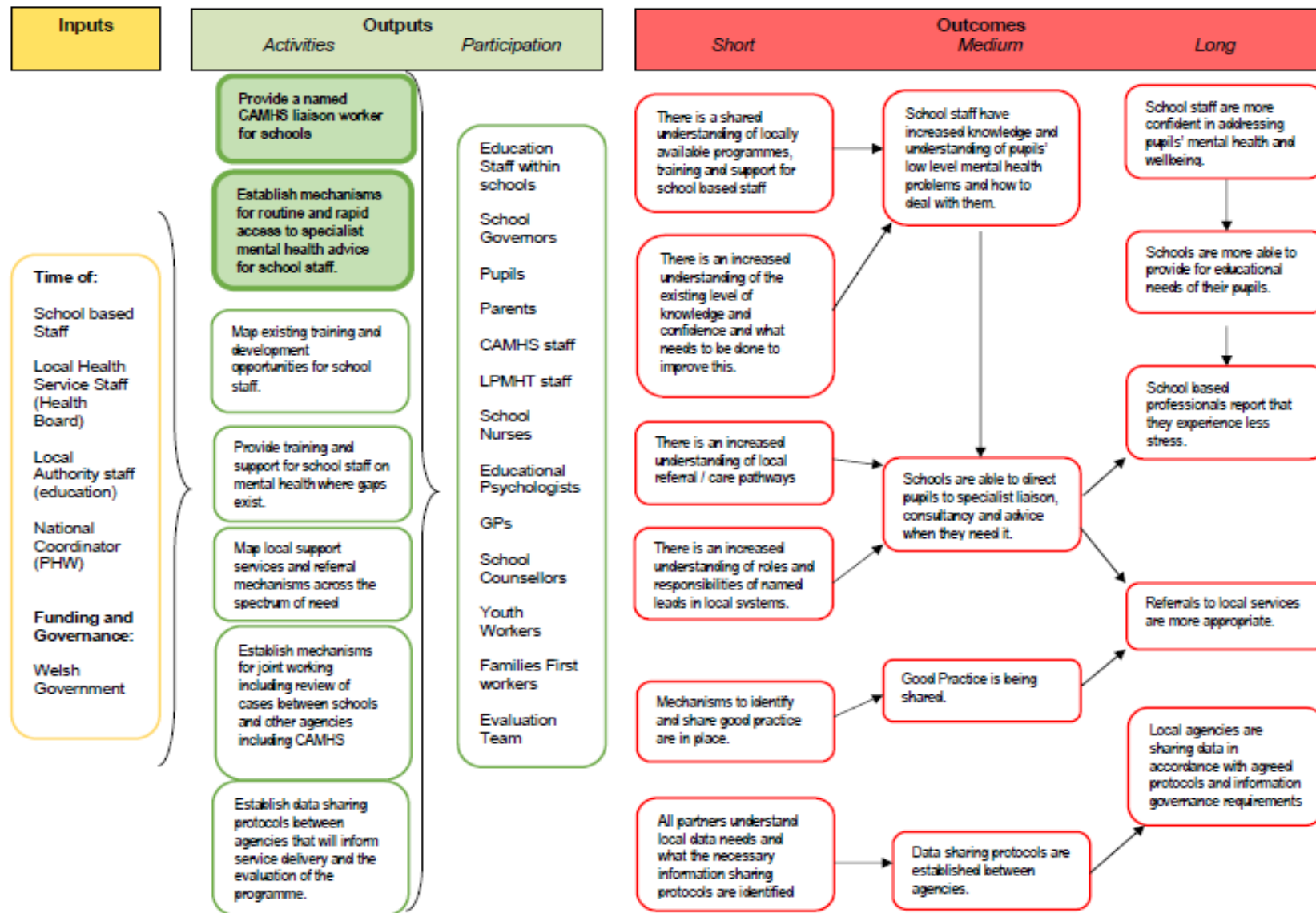
delivered by phone or email and a greater emphasis placed upon improving understanding of referral pathways (DfE, 2017, p.43).

- 1.11 In addition, training, such as mental health awareness, was provided to schools in all areas.
- 1.12 The evaluation of the link project identified that it improved communication and joint working arrangements between schools and CAMHS, and that there was increased understanding of referral pathways and knowledge and awareness of pupils' 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, p12.) 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 CAMHS In-Reach to Schools pilot programme in Wales

- 1.13 As outlined above, The CAMHS In-Reach to Schools pilot programme was announced in 2017 in response to concerns about pupils' mental health and well-being. The pilot focused upon three areas:
- South East Wales (covering Blaenau Gwent and Torfaen / Aneurin Bevan University Health Board and South Powys / Powys Teaching Health Board);
 - West Wales (Ceredigion / Hywel Dda University Health Board); and
 - North Wales (Wrexham and Denbighshire / Betsi Cadwaladr University Health Board).
- 1.14 PHW joined the programme as a partner soon after, with the National Co-ordinator appointed in April 2018, and the programme starting 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.
- 1.15 As figure 1, the pilot programme's logic model, illustrates, the pilot programme aims to build capacity (including skills, knowledge and confidence) in schools, improve pupils' access to specialist liaison, consultancy and advice when needed; reduce school staffs' stress and improve their well-being.

Figure 1: the CAMHS In-Reach to Schools pilot programme's logic model



Source: PHW

- 1.16 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 discussed above. However, there are important differences in terms of:
- scale, as the CAMHS In-Reach pilot programme focuses upon six Local Authority (LA) areas, compared to the 22 English Clinical Commissioning Group (CCG) areas, which tend to be larger than Welsh LAs ¹⁵; and
 - focus, with, for example, the Mental Health Services and Schools Link Project having both a more narrower focus upon providing a lead contact in or for each school to improve access to CAMHS, but also a broader scope, given the aim of transforming systems and services.

Aims and objectives of the evaluation of the CAMHS In-Reach to Schools pilot programme

- 1.17 The aim of the evaluation is to understand how the CAMHS In-Reach pilot programme is working, whether the objectives of the pilot programme are being met and how the pilot programme is understood by stakeholders across the pilot regions.
- 1.18 The objectives of the evaluation are 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 pilots' areas is supporting pre-critical point referrals to CAMHS ¹⁶;
 - 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 and Local Health Board (LHB) [and LA] decisions on the potential of a future roll-out of the CAMHS In-Reach to Schools pilot programme.

¹⁵ [ONS Population Estimates](#)

¹⁶ I.e. timely referrals to CAMHS before mental health difficulties escalate and become critical.

1.19 The research questions¹⁷ for the study are to identify:

- the extent to which the pilot programme has achieved the six short and four medium-term outcomes;
- 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 CAMHS 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 Welsh Government and/or PHW policies;
- issues of relevance and sustainability of these approaches; and
- transferability and generalisability of successful approaches to other contexts.

Structure and content of the report

1.20 This report aims to present the baseline position for schools and services at the start of the pilot programme and also to outline the emerging evidence of effectiveness and likely impacts of the pilot programme, after approximately 15 months of work with schools. A final summative report scheduled for December

¹⁷ 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 logic model outcomes.

2020 will further evaluate the impact of the pilot programme towards the programme's end.

1.21 The remainder of this report is structured as follows:

- section 2 describes the evaluation's approach and methodology and considers its strengths and weakness:
- section 3 discusses the implementation and delivery of the pilot programme;
- section 4 provides additional context for the programme by describing the mental health problems identified by pilot schools and services during qualitative research;
- section 5 assesses the baseline position in relation to school staff skills and confidence in relation to pupils' mental health difficulties, the early evidence of pilot effectiveness and the likely contribution of the pilot to the intended outcomes (i.e. increased staff skills, knowledge and confidence);
- section 6 assesses the baseline position in relation to schools' access to specialist services, the early evidence of pilot effectiveness and the likely contribution of the pilot to the intended outcomes (i.e. improved access to specialist liaison, consultancy and advice when needed);
- section 7 assesses the baseline position in relation to school staff stress and well-being, the early evidence of pilot effectiveness and the likely contribution of the pilot to the intended outcomes (i.e. school staff experience less stress);
- section 8 considers schools' effectiveness in meeting pupils' mental health needs, promoting pupils' and staff well-being and whole school approaches to this;
- section 9 outlines the study's conclusions, in relation to the study's aims, objectives and research questions;
- section 10 outlines the evaluation's recommendations and emerging learning, based upon the study findings.

2. Approach and methodology

Introduction

2.1 In line with HM Treasury Guidance on policy evaluation (HM Treasury, 2011) a theory-based approach to evaluation, focused upon testing the CAMHS In-Reach to Schools pilot programme's logic model (see figure 1) was used. In order to generate data to test the logic model, 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 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), CAMHS and school counselling services; and
- engagement as a critical friend to the national pilot programme team and each pilot project team.

Desk-based research

2.2 Desk-based research focused upon reviewing:

- pilot documentation, including the pilot programme's logic model (figure 1, outlined in section 1) project plans and self-evaluation data collected by each pilot;
- research into pupils' mental health and well-being, including that undertaken by PHW (most notably PHW, 2016), the Schools Health Research Network (SHRN) (such as Hewitt et al., 2019) and the NHS (such as NHS Digital, 2018; Murphy and Fonagy, 2013);
- research into school staff and their well-being, including that commissioned by the Welsh Government and carried out by the EWC; 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

- 2.3 Pilot data provided important additional information on delivery in each pilot area (e.g. on the type and take up of training) and also in some areas, participant self-evaluation data.
- 2.4 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.

Survey of education staff

- 2.5 School staff in pilot areas were surveyed in order to measure:
- the baseline position in relation to school staff knowledge and skills, access to specialist services and experiences of stress when dealing with pupils' mental health difficulties (which are all key outcomes for the pilot programme); and
 - 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.
- 2.6 Further rounds of the survey¹⁸ are planned to measure the mid and end line position.

The questionnaire

- 2.7 The survey used an online self-completion questionnaire. The main areas covered by the questionnaire were:
- staff confidence in:
 - identifying pupils' 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 need advice and support.
 - schools' effectiveness in promoting:
 - pupils' mental health and well-being; and
 - staff mental health and well-being.

¹⁸ These surveys were planned for spring and autumn 2000. At the time of publication of this report, the survey schedule is being revised due to the COVID-19 situation and its disruptive effects upon school staff.

- 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. CAMHS).
- 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.

Administration of the survey

2.8 The survey was open for approximately three months from the end of March 2019 to the end of June 2019. 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 to all the schools by the evaluation team. This was followed by two reminders, sent to schools that had not responded. In addition, 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 Wales¹⁹) and contact with schools by pilot staff and partners, and by the evaluation team, during visits to schools.

Response rates

2.9 Table 2.1 shows that staff from around a third of primary schools and almost 60 percent of secondary schools in the pilot area, responded to the 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.

¹⁹ Hwb is the Welsh Government's strategic digital channel to support the delivery of the curriculum in Wales and provide access to the curriculum, online resources and professional learning information. [Hwb: About Us](#)

Table 2.1. The proportion (and number) of pilot schools that responded to the survey in each LA

	Primary schools		Secondary / middle schools	
	Number of schools invited	Number of schools where staff responded	Number of schools invited	Number of schools where staff responded
Wrexham	55	21	9	6
Denbighshire	46	14	8	4
Ceredigion	37	10	7	2
Torfaen	25	8	7	3
Blaenau Gwent	19	6	4	4
South Powys	11	5	2	2
Total	193	64	37	21

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

2.10 Table 2.2. shows the proportion of staff from primary, secondary and all age (3-16/19) schools in the survey sample who responded. The total number of staff who responded (n=352) is only a small fraction of the total education workforce in the pilot area. There are, for example, 1,991 teachers and 2,350 support staff in Wrexham and Denbighshire, and 585 teachers and 627 support staff in Ceredigion²⁰.

²⁰ Source: StatsWales: [Teachers by local authority, region and category](#), and [Support staff by local authority, region and category](#),

Table 2.2. The proportion (and number) of staff who responded to the survey, who worked in primary, secondary and all age schools.²¹

Primary schools	Secondary schools	All age schools	Total (all staff in the sample)
48% (n=170)	48% (n=170)	4% (n=12)	100% (n=352)

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

2.11 Table 2.3. shows that almost half of the staff who responded had a role as a teacher and around a fifth had a school leader or support staff role. Around 10 percent were part of the pastoral teams or were SENCo/ALNCo.

Table 2.3. The proportion (and number) of staff who responded to the survey, according to their role

Because respondents could choose more than one option, totals may add up to more than 100 percent ²².

Teacher	School leader	Support staff	Pastoral lead/team	SENCo/ALNCo	Other	School counsellor
45% (n= 161)	22% (n=78)	19% (n=67)	9% (n=31)	8% (n=30)	1% (n=5)	0% (n=1)

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

2.12 The number of responses from staff varied in each area. In part, this reflects differences in the numbers of schools in each area (see table 2.1.). However, as table 2.4. illustrates, there was a much larger number of respondents from Denbighshire compared to other areas. Because this could have biased the survey results, the responses from staff from Denbighshire were compared with responses from staff in other areas. As there was little difference in the responses, with the exception of one question²³, the risk of bias was judged to be low.

²¹ Responses from staff in all age schools were included when we report on results for all staff, but are not included when we report on responses from primary and secondary school staff. Theirs responses are not reported in separately given the small number of responses.

²² This is why the total percentage is higher than 100 percent; however, the vast majority of staff only chose one option.

²³ As outlined in section 3, when asked if they were confident that their school was effective in promoting the mental health and well-being of staff, there was marked difference in response from staff in Denbighshire compared to staff in other areas.

Table 2.4. Respondents to the survey by Local Authority area – proportion of all respondents (and number)

	School staff
Denbighshire	42% (n=148)
Wrexham	27% (n=94)
Torfaen	10% (n=34)
Blaenau Gwent	9% (n=33)
Ceredigion	8% (n=27)
South Powys	5% (n=16)
Total	100% (n=352)

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

Analysis of survey data

- 2.13 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. The comments were categorised into themes²⁴ and discussed alongside the quantitative data (i.e. the responses to the closed-ended questions).
- 2.14 Validity of responses to the survey appear good with, for example, consistency in responses and little evidence of respondent fatigue, with a completion rate of 93 percent (of the questions in the questionnaire). In addition, as outlined in sections 5 to 7, findings from the survey were consistent with findings from qualitative research with school staff.
- 2.15 Overall, the survey secured an acceptable response rate from schools given the challenges associated with surveying school staff, and also secured responses from a range of staff groups within schools. However, the response rate in terms of the total number of staff within those schools was disappointing and results from the sample cannot be generalised with confidence to the whole population of school

²⁴ 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).

staff. The modest total number of responses also means that the size of some sub-groups is small, and when making comparisons between groups (such as teachers and pastoral staff), figures need to be treated with caution.

Qualitative case studies

- 2.16 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 a sample of schools and LA, LHB and voluntary sector services working with those schools to support pupils’ mental health and well-being. The first round of case studies was undertaken in summer and early autumn 2019, and they will be updated by two return visits in 2020 (or when fieldwork is possible following the Covid-19 situation), enabling change over time to be explored.

Site selection

- 2.17 The criteria for selecting case study sites were:
- willingness of the secondary school and a sample of its cluster primary schools to commit to the longitudinal study;
 - 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; and
 - a mix of school clusters serving areas of high and low socio-economic deprivation within each pilot area.
- 2.18 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.
- 2.19 In total, 21 schools were visited and 42 school staff (including school leaders, schoolteachers and pastoral staff) were interviewed. Table 2.5 provides a breakdown of school by type and by pilot area.

Table 2.5. Case study schools by pilot area and Local Authority

Pilot area	Local Authority	Primary schools	Secondary / all age schools
West Wales	Ceredigion	2	2
Mid and South	South Powys	2	2
Wales	Blaenau Gwent	1	1
	Torfaen	2	2
North Wales	Denbighshire	2	2
	Wrexham	1	2
Total		10	11

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

Interviews with services

2.20 Key services working with schools to support pupils' mental health were identified through interviews with schools and, as table 2.6. outlines, interviews were conducted with 15 staff from a range of services across the three pilot areas.

Table 2.6. Services interviewed by pilot area

Pilot area	Services included in the study
West Wales	<ul style="list-style-type: none">• The Educational Psychology Service• The School Counselling Service (i.e. Area 43)• The Youth Service
Mid and South Wales	<ul style="list-style-type: none">• The Educational Psychology Service• The Education Welfare Service• Primary Mental Health Service• The School Nursing Service• Specialist CAMHS• The Youth Service.
North Wales	<ul style="list-style-type: none">• Action for Children• The CAMHS Early Intervention Service• The Educational Psychology Service• The School Counselling Service.• Specialist Youth Work Service

Strengths and weakness of the qualitative case studies

2.21 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. 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 the pilots

2.22 Throughout the evaluation, the evaluation team has worked with the pilot programme's National Co-ordinator and each of the pilots as critical friend. This aided engagement with the evaluation by the pilots, enriched the evaluation team's understanding of the pilot programme 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 with key pilot staff and other stakeholders in the Welsh Government.

Assessing the baseline position and emerging evidence of effectiveness

- 2.23 The survey and case studies were intended to help measure the baseline position for schools and services at the start of the pilot programme. However, there were delays; agreeing the questions to be used in the survey, securing permissions from LHB research and development departments, and identifying schools who would be willing to take part in the evaluation as case studies. As a consequence of the delays, by the time the baseline survey was undertaken between March and June 2019 and visits and interviews were undertaken in the summer and early autumn of 2019, the pilot programme had been operational for about six to nine months. Although not ideal, as the chance to measure a pre-intervention baseline was missed, the judgment of the evaluation team is that because, by the time the survey and school visits were undertaken, it is unlikely that the pilot would have had made a large impact upon the outcomes measured by the baseline survey and qualitative research with schools. This reflects the relatively limited programme delivery to schools in the initial period of the pilot programme's work with schools from September 2018 onwards, and reinforces the case for treating the report's findings on impact as tentative.
- 2.24 Conversely, the delays in the baseline survey and qualitative research with schools and services provided greater scope to capture the early engagement of schools and services with the pilot and initial experiences and perception of the impact of pilot activities, like training and consultation.

3. Pilot Programme Implementation

The three pilot areas

- 3.1 The three pilot areas (Ceredigion, North Wales and Mid and South East Wales) were chosen because there was already existing work, and thus relationships, or, as one interviewee put it, ‘foundations’ that the pilots could build upon in each area; for example:
- Betsi Cadwaladr University Health Board (BCUHB) had developed a Self-Harm Referral Pathway and CAMHS were already offering consultations to schools;
 - Powys Teaching Health Board had mental health workers visiting all secondary schools once a month, to support staff²⁵; and
 - within Hywel Dda University Health Board, Ceredigion had been pro-active in engaging across the LHB developing, for example, the Getting the Low Down resource and a Self-Harm Referral Pathway (see case study 1).
- 3.2 The selection of pilot areas in three separate parts of Wales, with different LHBs and education services, also enabled the pilot model to be tested in varying contexts with, for example, different specialist services and different referral pathways.

Case study 1. The North Wales Self- Harm Pathway

Denbighshire LA have worked with CAMHS to develop a self-harm/suicidal thoughts pathway. It is a protocol to follow when a student presents with self-harm or suicidal thoughts. One school described how it has worked well for them, providing a buffer of support and a shared responsibility when making decisions. As a school explained: ‘there is a checklist to go through; if there is an immediate danger there has to be an emergency intervention, otherwise you ring CAMHS and talk it through with them and you jointly decide the level of risk and the response’. This can bring about a quick access to services if appropriate. Those who have done the self-harm pathway training update it each year.

²⁵ The pilot is seen as similar, building on this work, but providing extra capacity to start to work with primary schools as well (which they are currently not doing).

3.3 In addition, as table 3.1. illustrates, the size of each area differs markedly.

Table 3.1. The profile of each pilot area

Pilot area	LA	Number of primary schools	Number of secondary or all age schools	Size (Km ²)
Ceredigion	Ceredigion	39	7	1,783
Mid and South	Blaenau Gwent	19	2	109
East Wales	South Powys	11	2	N/A ²⁶
	Torfaen	25	6	126
North Wales	Denbighshire	45	7	844
	Wrexham	58	9	500

Source: StatsWales School Census ²⁷

3.4 These differences in context both affect the baseline position from which each pilot was starting (e.g. in relation to staff skills and confidence), and have shaped the way the pilot programme has been developed in each area; for example, where in Powys and North Wales CAMHS were already providing consultations in schools, less emphasis was placed upon developing this element of the pilot programme (see case study 2).

Case study 2. Schools’ access to CAMHS in North Wales

CAMHS 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 will often purchase courses such as Seasons for Growth from the third sector.

CAMHS 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, CAMHS in Denbighshire has a link worker system based around the secondary schools that primary schools can access.

²⁶ A size cannot be easily calculated as only part of the county is covered by the pilot.

²⁷ [Schools by local authority, region and type of school](#)

Establishing the programme

- 3.5 All three areas developed in different ways and at different paces; for example, Ceredigion focused initially upon recruitment and building relationship with schools, whilst the other two areas initially focused more upon developing training programmes for schools.
- 3.6 By September 2018, steering groups were well established in each area and staff had been recruited (see below) and started liaising with schools. Information sharing protocols and options for joint working were discussed locally and agreed in North and West Wales (Ceredigion)²⁸, and training needs assessments were undertaken in each area.

Pilot programme staffing and capacity

- 3.7 The pilot has a full time National Co-ordinator supported by senior staff at PHW. Table 3.2. outlines the staffing of the pilot programme in each area.

²⁸ In North Wales, all information/referrals go through the Single Point of Access (SPoAs) and as CAMHS staff were already linked to schools there were no concerns about information sharing. In Ceredigion, an information sharing protocol (ISP) was already in place, with information (such as notes from consultations) stored within the sCAMHS Care Partner recording system.

Table 3.2. Staffing of the pilot in each area

Area	Staff	Role and responsibilities
Ceredigion	Band 7 Schools In-Reach 'SIR' Team Lead. (Full time).	Delivery of consultation and school liaison; training; and staff wellbeing sessions. Leading and managing the team, reporting to Band 8 Pilot Lead and also to CAMHS Service Manager. Reporting on service development.
	Band 6 Schools In-Reach 'SIR' Practitioner. (Part time, 0.8).	Delivery of monthly consultations and school liaison, training and education sessions, networking, and staff wellbeing sessions.
	Band 5 Schools In-Reach 'SIR' Practitioner. (Part time, 0.4).	Carrying out monthly consultations and liaison, training and education sessions, and networking.
	Band 3 Administrative Assistant. (Part time 0.8).	Maintaining correspondence with school links and other professionals within the county to promote the pilot; arranging training venues (if not in school); and providing operational support (letters, agendas, minutes etc).
Mid and South Wales	Two Band 7 Practitioners (Full time)	Delivery of consultations and school liaison ; training and education and staff wellbeing sessions. Reporting on service development. Organising training venues. Project administration and data analysis.

		They report to the Clinical Psychology lead under the general PCMHSS CYP directorate, who provides project management and holds budget responsibilities
	Bank Admin was purchased for 8 days in March but not continued due to the uncertainty about future funding.	Operational support
North Wales	Band 7 CAMHS Senior Mental Health Practitioner (full time)	Project management. Delivery of consultations and school liaison; and training.
	Band 6 CAMHS Mental Health Practitioner (full time)	Delivery of training to whole staff teams and the Youth Mental Health First Aid training.
	Band 3 Project Support Administrator (part time, 0.6)	Operational support (e.g. to coordinate and arrange all the training and purchasing the materials).

Source: Ceredigion, mid and South Wales and North Wales Pilots

Challenges to delivery

- 3.8 Qualitative research with stakeholders identified concerns that the programme was announced and launched before the detail of the programme delivery and objectives had been worked out, and before a national co-ordinator had been appointed. This meant that some of the pilots needed to adjust the balance and emphasis placed upon the different strands (such as training and consultation), but this was not felt to have caused any long-term problems.
- 3.9 Initial staff recruitment went well and the CAMHS In-Reach practitioners appointed have been consistently praised by respondent stakeholders for their skill and commitment. However, staff absence and changes in the staff team have been a challenge in Ceredigion (as they limited the capacity of an already small team, see

table 3.2 for details), and it was difficult for the pilots to recruit new staff at the level desired for a short-term contract, when the pilot was extended to December 2020.

- 3.10 Addressing misconceptions about what the programme is and aims to do has been a key challenge for the pilots. It has been noted by a number of pilot programme staff that the name, the 'CAMHS In-Reach to Schools pilot programme', may be misleading, as improving links to specialist services, like CAMHS, is only a small part of the pilot. More fundamentally, as section 6 outlines, the pilot programme is not, as some schools hoped, a pilot offering dedicated CAMHS workers working with a caseload of pupils within schools (the pilot is not intended, nor is it funded, to enable this).
- 3.11 Unlike the other two areas, in Mid and South Wales, information sharing arrangements are still not resolved and the information governance process was described by pilot staff as "complex". Regional Transformation leads, In-reach Practitioners, and information governance officers from Aneurin Bevan UHB and Blaenau Gwent and Torfaen local authorities agreed that the pilot processes met information governance regulations. In Powys, existing arrangements covering CAMHS work with schools were adopted for the pilot. However, in order to solidify the agreement, an information sharing protocol was developed with the national Wales Accord on the Sharing of Personal Information (WASPI) team. However, there have been delays getting each of the three local authorities²⁹ and the two health boards involved in the pilot to sign off the WASPI. Currently the CAMHS In-Reach practitioners can access CAMHS records, but not General Practitioners' (GP) systems, and there are concerns that if, for example, they notify a school that a pupil is judged to be high risk, this may contravene the General Data Protection Regulations (GDPR).
- 3.12 As sections 1 and 6 outline, the number and range of initiatives focused upon improving pupils' mental health and well-being in schools means the pilot operates in a complex and often rapidly changing service landscape, and has required careful planning to avoid duplicating or negatively impacting upon other initiatives. Steering groups and individual members of steering groups who, for example, have

²⁹ For example, in one area, a senior leader initially asked for an additional appendix explaining the expectations of the WASPI agreement for schools and the commitment from the pilot and later requested a full outline of the consultation process written for schools.

strategic roles in LHBs or LAs, have been important here in ensuring policy coherence at a strategic level. CAMHS In-Reach practitioners have played an important role at an operational level, in building relationships and links with schools and other services. It is notable, though, that despite joint sponsorship by health and education, the pilots have been led by health services in each of the areas. There has been strong engagement from health services, such as CAMHS and, in some areas, school nursing, and also from LA EP services. However, with the exception of North Wales, there has been much less engagement from education services, such as LA inclusion services.

- 3.13 The size and rurality of areas, coupled with the number of schools (see table 3.1.) relative to the resources and staffing, is a particular challenge in North Wales and, to a lesser extent, in Ceredigion and Mid and South East Wales. Staff time spent travelling between schools, the logistics of scheduling sessions in schools, have all been challenging. CAMHS In-Reach practitioners in North Wales and Ceredigion have a base to work from, and can access secure databases from here (e.g. to identify the services working with a young person a school has raised concerns about), but cannot access these remotely, which has been a source of frustration. In contrast, CAMHS In-Reach practitioners in South East and Mid Wales do not have a base to work from, which has complicated their work.
- 3.14 There have been differences of view about the most effective training to offer schools; for example, both North and South East Wales have promoted the YMHFA training³⁰, whilst PHW has expressed some concerns about the appropriateness of this, given its diagnostic focus on mental ill health. The evaluation does not make a judgment on this although, as section 5 outlines, schools' responses to YMHFA training has generally been very positive. The development of different training packages by each pilot area, largely independently from each other, has enabled bespoke and context-specific training to be developed in response to consultation with schools, but raises questions about possible inefficiencies and missed opportunities to share materials and insights.

³⁰ The training aims to teach staff the skills and confidence needed to identify the signs of mental health issues, offer first aid and guide children and young people towards the support they need.

Schools' engagement

3.15 Engagement of schools has been a challenge to varying degrees in all three areas. Qualitative research with the pilots identified a range of responses, from schools very keen to get involved, through to those that needed to be encouraged to get involved and others with whom it has been very hard to engage. A variety of reasons why schools have not engaged have been identified. Most are linked to competing priorities for schools' time and attention, such as Estyn inspections. A strength of the model as a pilot is that all schools in a geographical area have been invited and actively encouraged to engage, so it has not targeted only the most interested schools. However, the amount of work that has been dedicated to engage with some schools has inevitably drawn time, attention and resources away from other aspects of the pilot programme.

Awareness of and engagement with the pilot

3.16 When the baseline survey was conducted in spring 2019, there was an even split (50/50) between staff who were aware of the pilot programme and those who were not. There was little difference between awareness of the pilot amongst primary and secondary school staff (just over half of staff in secondary schools and just under half of staff in primary schools were aware of the pilot). This difference was smaller than expected, because overall the pilot has been more active in secondary schools (i.e. covering all age groups in secondary schools, compared with only Year 6 in primary schools). This may be because most staff in primary schools completing this survey worked with Year 6 pupils (and therefore saw the survey as relevant to them). It may also reflect social desirability bias, with respondents feeling the 'right' answer to the question was to say they were aware of the pilot. It is expected that the proportion of staff who are aware of, and have been supported by, the pilot will have increased since then.

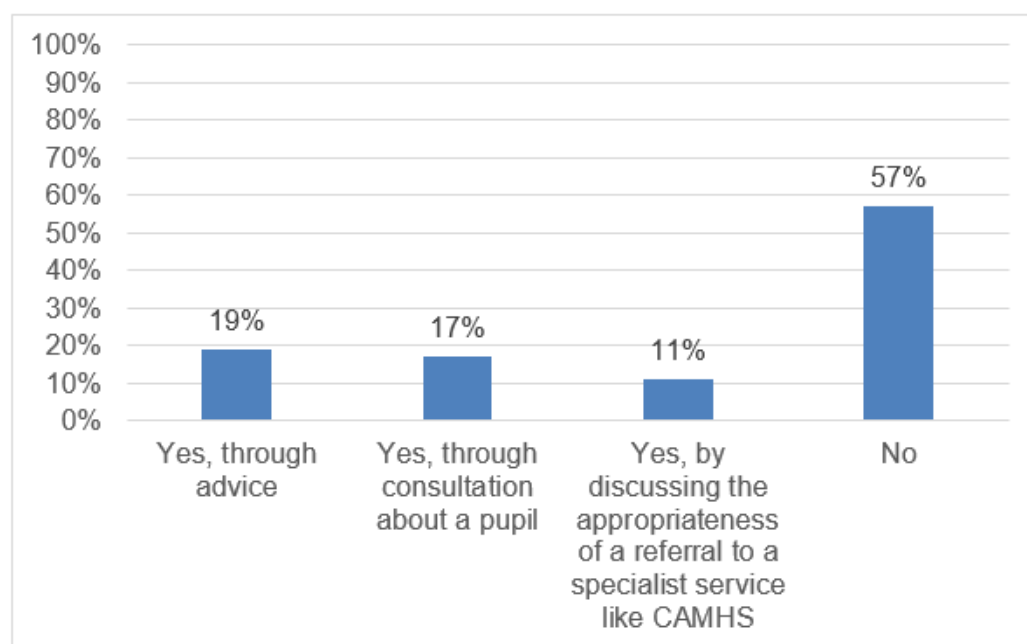
3.17 Of those staff who were aware of the pilot, around two thirds (66 percent) knew who the CAMHS In-Reach practitioner for the school was. As expected, this was higher amongst those who had received training from the pilot (85 percent).

3.18 Graph 3.1. shows that, of those who were aware of the pilot at the time the survey was conducted in late March-June 2019, just over a third (36 percent) had already been supported by a CAMHS In-Reach practitioner through consultation or advice

and around one in ten (11 percent) had discussed the appropriateness of a referral to a specialist service like CAMHS with a CAMHS In-Reach practitioner.

Graph 3.1. Responses of staff who were aware of the pilot when asked whether they been supported by a CAMHS In-Reach practitioner and if so, how

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



Source: People and Work, CAMHS In-Reach baseline survey, 2019 (n=148)

Fidelity to the original logic model

3.19 As outlined in sections 5, 6 and 7, overall there has been good fidelity³¹ to the logic model. However, the emphasis assigned to different elements has varied from pilot area to area and also within pilot areas. Moreover, the pilot has developed new causal pathways, or mechanisms, which do not feature in the original logic model; for example, the contribution of workshops and training on staff well-being to reducing staff stress did not feature in the original logic model. A revised and simplified theory of change is therefore proposed in the conclusions.

³¹ Fidelity describes “the consistency of what is implemented with the planned intervention” (Moore et al, 2015, p. 4). It has been argued that fidelity is achieved if the generative mechanisms are essentially the same, even if, for example the contexts in which an intervention (like the pilot) operates and the ways it is implemented, vary somewhat (see e.g. the discussion Moore, et al, 2015). In this context, it means that there is fidelity to the Pilot Programme’s theory of change even though different areas have undertaken somewhat different activities, given differences in their context.

4. The mental health difficulties reported by pilot schools and services

4.1 As part of the qualitative research, schools were asked to describe the types of mental health difficulties that pupils in their school experienced. 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 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’.

4.2 The rise was therefore thought to reflect both an increase in mental ill health (and, to lesser extent, neurodevelopmental disorders) and also greater recognition of previously hidden or misunderstood difficulties³²; for example, 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’. 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

³² 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.

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'.

- 4.3 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 also, for example, the new curriculum, was therefore welcomed.

Primary schools

- 4.4 Primary school staff described the earlier onset, and also increasing severity, of pupils' mental health difficulties. As one teacher described it: 'ten years ago, working in primary, we weren't used to dealing with these sort 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.'
- 4.5 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'.
- 4.6 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 also the greater knowledge that primary school staff may have of children's home lives, compared to secondary schools.
- 4.7 A number of schools linked ACEs to attachment (as ACEs could undermine emotional bonds between children and their parents), and as one SENCo explained it: '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 schools

- 4.8 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; for example, as a pastoral lead described it: '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' by a member of one secondary school's pastoral team. 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.
- 4.9 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 sometimes linked to a discussion about 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.
- 4.10 The perceived negative impact of social media upon pupils' mental health and well-being was a key concern for secondary schools, and was a much greater concern for secondary schools than it was for primary schools, presumably as social media use increases with age. Some schools also described how, in certain years they had groups of pupils who would communicate with each other through social media in a very negative way, which they thought could increase the risks of self-harm and suicide. This was seen as particularly difficult for schools to manage, due to the large number of pupils who could be involved or affected and the risk of escalation (where, for example, a discussion about self-harming led to action, with young people actually harming themselves). 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 notes 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).

- 4.11 Some schools highlighted pressure to succeed, particularly for 'high flyer' young people who put undue pressure upon themselves to succeed, and the period around exam time was described by some schools as particularly worrying. To a lesser extent than primary schools, schools also talked about the impact of ACEs, such as family breakdown.

Services' experiences

- 4.12 Services' descriptions of pupils' mental health difficulties 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), 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 pupils' gender identities.

5. Staff skills and confidence in pilot areas

Introduction

- 5.1 As figure 5.1. illustrates, the model widely used by schools for addressing pupils' mental health difficulties involves early identification that a pupil may have mental health difficulties, assessment to determine if they do, what their needs might be and what support is required, delivery of that support and review of the effectiveness of that support. This model is based upon the approach used to identify, assess and provide for pupils' Special Educational Needs (SEN) / Additional Learning Needs (ALN) (see e.g. WAG, 2004). This cycle is underpinned by the SEN / ALN model of a 'graduated response'. Here, expertise (e.g. in assessing needs) and additional support within (e.g. from ALN/SEN and/or pastoral teams) and beyond the school (e.g. from LA and LHB services like EP and CAMHS) is drawn upon when needed (ibid.). This model means that increasing numbers of staff and services can become involved, as the complexity and severity of needs increases or becomes apparent, and staff and services need to work together to meet those needs. This model also means that although all staff need a basic awareness and understanding of mental health and well-being for pupils, only some staff, such as ALNCos and pastoral teams, need more "advanced" or "specialist" skills and knowledge of mental health and well-being (cf. WG, 2015b).

Figure 5.1. The Intervention and Support Cycle



5.2 This model means that:

- all staff need to be able to identify that a pupil may have mental health difficulties (and therefore to be aware of their role and responsibilities); for example, some schools reported that the training around ACEs and mental health meant that staff thought about, and better understood, the causes of challenging behaviour. This meant that instead of getting frustrated with the child, they will think ‘what do we need to be doing to help?’;
- the extent to which staff also need the skills and knowledge to be able to assess a pupil who has been identified as potentially having mental health difficulties, will depend upon: (i) the complexity and/or severity of the presentation (with mild to moderate needs assessed by the school and more severe and/or complex presentations referred to specialist services like CAMHS) and (ii) their school’s approach to assessment and their role in the school (e.g. pastoral or ALN leads/teams will often have responsibilities for assessment of mild to moderate difficulties);

- similarly, the extent to which staff need additional and sometimes more specialist skills and knowledge³³ to be able to support pupils with mental health difficulties will depend upon: (i) the complexity and/or severity of the presentation (with more complex needs often requiring more specialist support) and (ii) their school's approach to support and their role (e.g. pastoral or ALN leads/teams will often have responsibilities for organising support, like nurture groups, for pupils with mild to moderate difficulties).

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, for example, take on the diagnostic and therapeutic roles played by specialist services like CAMHS. As a primary school pastoral lead described it:

‘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 This model means that simply measuring average levels of staff confidence, skills and knowledge may under-estimate the capacity of schools to assess and support pupils with mental health difficulties. Instead, measuring the confidence, skills and knowledge of those responsible for assessing and supporting mental health difficulties would be a more precise measure of schools' capacity if (and only if) schools' systems to identify and refer pupils for assessment and support work well. Equally, whole school approaches, discussed in section 7, may require more broadly based staff skills and knowledge.

5.5 For this model of distributed expertise to work, the evaluation team's analysis based upon the data collected for this study, is that schools need:

- a flexible and responsive model of collaboration and professional learning to ensure that expertise is shared and deployed so that, for example, following an assessment, those teaching and supporting the child or young person have the

³³ I.e. over and above the skills and knowledge expected of, for example, teachers or support staff, in supporting pupils.

skills and knowledge needed to implement the plan³⁴, and that staff can access timely support (e.g. when they face challenges beyond their competence), which we discuss in this section; and

- clear pathways for assessment within schools (e.g. to those staff within schools with more expertise, like ALNCOs and pastoral teams) and beyond schools (e.g. CAMHS), which we discuss in section 6.

The pilot programme's theory of change

- 5.6 The pilot programme's original theory of change (described earlier) identified: 'provid[ing] support for school staff on mental health issues where gaps exist' as the main mechanism for ensuring that: 'school staff have increased knowledge and understanding of pupils' low level mental health problems and how to deal with them' and that: 'school staff are more confident in addressing pupils' mental health and well-being'.

The baseline position in pilot areas

Identifying mental health difficulties

- 5.7 Qualitative research with schools identified that school staff most commonly described identifying pupils' mental health difficulties on the basis of pupils' behaviour. Some staff highlighted the importance of personal relationships in knowing a pupil's emotional state and identifying that something was not right. As one interviewee explained: 'we know our pupils' and this was seen as a key strength. Support staff who, as the assistant head of one school commented, were the 'front line', were often seen as playing a key role here. This is consistent with Estyn's findings (in their recent review of well-being) that, in schools that are effective at promoting well-being: 'staff are proactively positive with pupils in their early interactions, greeting pupils by name, smiling, providing a reassuring presence

³⁴ Given the large numbers of pupils with mental health difficulties (outlined in the introduction) it is highly likely that all teachers and most support staff will be teaching and supporting pupils with mental health difficulties. They will need to understand the difficulties and any additional learning provision and/or changes to their practice or classroom environment required. These types of skills and knowledge could be acquired when needed (e.g. following an assessment and plan which identified a pupil's strengths, underlying causes of their difficulties, and the support needed).

and quickly identifying anyone who may benefit from additional support' (Estyn, 2019, p.14).

- 5.8 Some secondary schools in particular also identified mental health difficulties through analysis of data or surveys of pupils such as Pupil Attitudes to School and Self (PASS). The approach, rooted in systematic data analysis was, typically, based upon 'symptoms' or 'red flags' (such as poor attendance or behavioural problems) or identification of ACEs, and would complement identification through pastoral systems. A number of secondary schools also described how weekly team meetings brought together different staff (most notably pastoral staff), and in some cases other services, such as youth services, and the Education Welfare Officer (EWO), to discuss children whom they were concerned about.

Case study 3 - Identifying pupils at risk of developing, or who have, mental health difficulties – one school's experience

Through the qualitative research, one school described how it sends staff into feeder primary schools to collect information in liaison with ALNCoS, so: 'we are usually primed about children we might be concerned about'. The head of year 7 collates the information from primary schools, which includes friendship groups and pupils' strengths as well as any concerns and it is shared with staff on a need to know basis.

The head teacher described how the school had developed an ACEs survey for year 7 to try to identify how many ACEs a pupil has. They piloted it last year and will do it again this year and use it to inform the levels of support provided. This was seen as important, because as the school described it, sometimes needs are really obvious but the survey helps them in identifying the withdrawn - 'the hidden children'.

Within the school, there is a well-being centre and all staff meet once a week to discuss needs. Staff have all had safeguarding training and look for changes in behaviour or low mood, and will then send the details to the well-being centre, which holds a list of agencies and parents. The response depends on what level they think is appropriate; if very concerned the school will ring the parent, the GP or their CAMHS link. Other ways of identifying potential issues come from

information from the pupil, from their friends, and/or staff raising concerns. Staff also are sometimes made aware of social media posts that can alert them to problems.

In order to support pupils, the school is developing a provisions policy looking at all the things that they can provide, at 3 levels:

- tier 1. low level support, with nurture programmes, young carer support;
- tier 2. involving CAMHS, youth service and other support bodies; and
- tier 3. greatest concern, involving the educational psychologist and EWO and involving the highest level of reporting and modified timetables.

The school have identified pupils in each year group at each level and are developing a toolkit for each pupil and the aim is to ensure that each pupil is supported at the right level, with scope to move up and down levels as their needs, or the school's understanding of their needs, changes.

5.9 Although the school in the case study (3) found this approach to screening valuable, the approach was questioned by PHW. Neither PHW nor the ACEs Hub in Wales support the use of screening tools and the counting of ACEs for individual pupils. This reflects concerns that screening in this way risks labelling, and stigmatising individual children, and may cause harm for pupils, as it highlights the difficulties they have experienced.³⁵

5.10 As case study 3 illustrates, qualitative research with schools shows how combining a focus upon pastoral relationships and data increases schools' (and staff) confidence that pupils with mental health difficulties are identified. This is consistent with Estyn's findings that "good schools...use information about pupils' well-being to improve pupils' school experience" (Estyn, 2019, p.17).

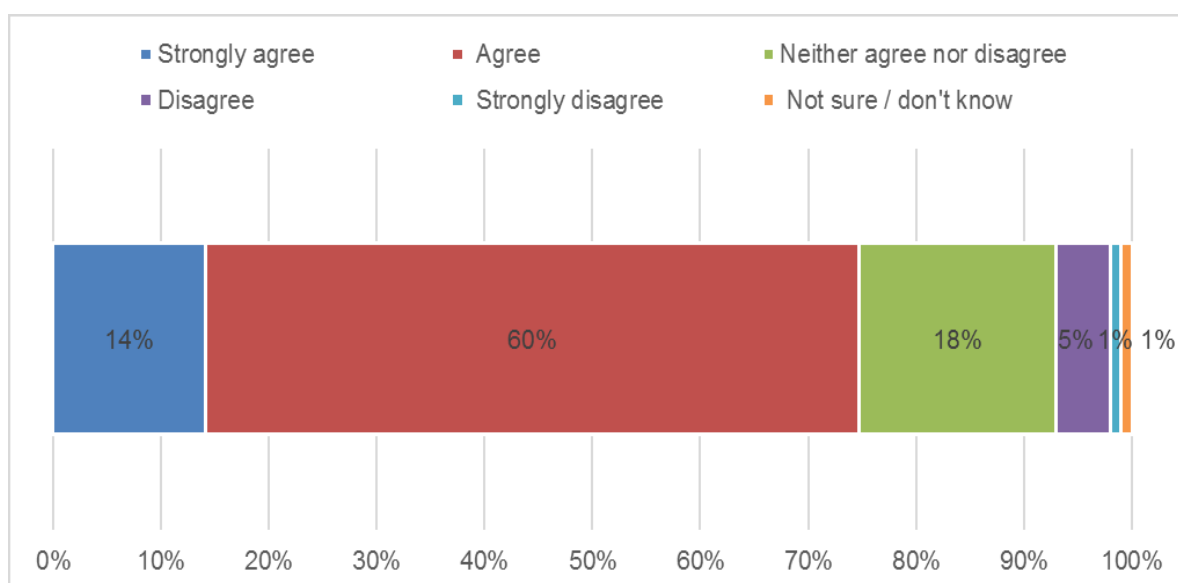
³⁵ Given these challenges, PHW are increasingly proposing 'trauma informed' approaches, to help move education staff away from counting ACEs and categorising and targeting individual pupils, to developing a more universal approach to the way in which they relate to all pupils and recognise and respond to their needs. When used consistently, this type of approach aims to ensure that all children benefit, whether they have experienced trauma or not.

5.11 In addition, in a few cases schools reported that:

- young people self-refer, or their parents and, in some cases, friends, raise concerns; and
- information was passed to schools, most commonly through transition planning with primary schools, or in the case of primary schools, through home visits to children before they started school.

5.12 Many staff in the pilot areas were fairly or very confident that they could identify pupils with mental health difficulties. As graph 5.1. illustrates, the survey identified that around three quarters (74 percent) of all school staff either strongly agreed or agreed that they felt confident that they could identify that a pupil may have unmet mental health needs. The proportion that strongly agreed was lower, at 14 percent.

Graph 5.1. Staff responses to the question: 'I am confident that I can identify that a pupil may have unmet mental health needs'



Source: *People and Work, CAMHS In-Reach baseline survey 2019 (n=351)*

5.13 Qualitative research with schools supported the survey findings that the majority of staff were confident, but confirmed that a minority were not. Qualitative research with schools also provided one explanation for the survey findings that staff in primary schools tended to be more confident than staff in secondary schools³⁶; staff

³⁶ Primary school staff were more confident than secondary school staff, with 19 percent of primary school staff strongly agreeing, and 61 agreeing, when asked if they were confident that they could identify that a pupil

in primary schools reported generally having a closer pastoral relationship with pupils (meaning they knew them better) than staff in secondary schools.

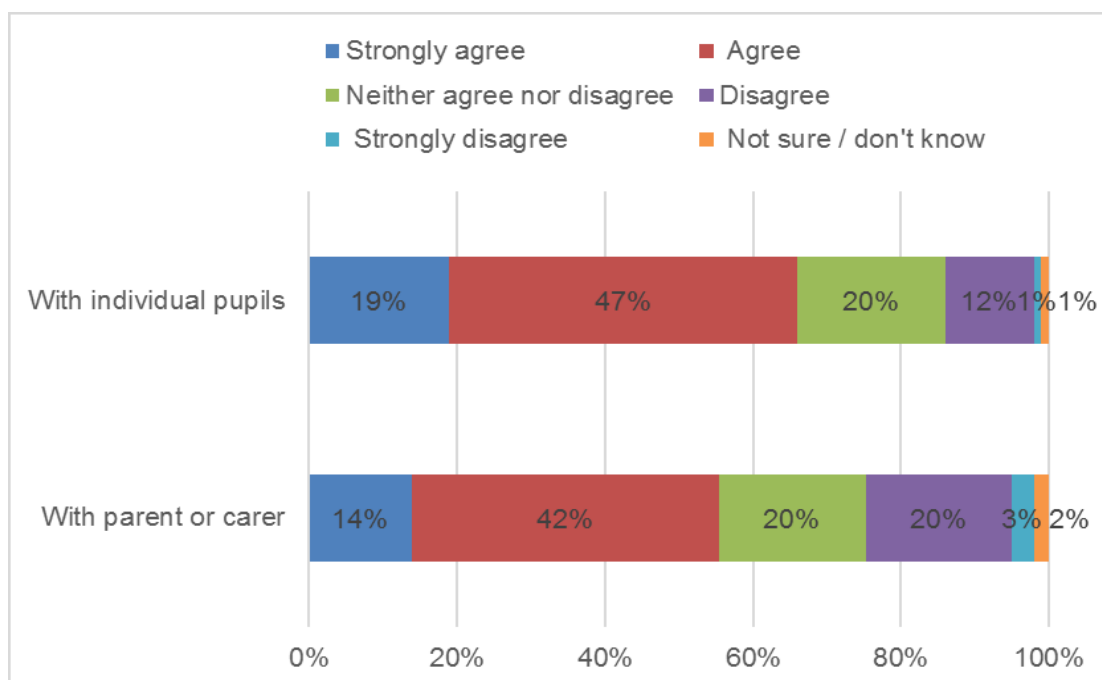
- 5.14 However, qualitative research with both primary and secondary schools also highlighted how despite schools' efforts, some pupils with mental health difficulties could be missed. These included so called 'swans', pupils who looked fine but were frantically paddling below the surface. This was generally considered more likely in secondary schools, where the number of pupils was larger and relationships with staff generally less close and where staff were less confident in identifying pupils with mental health difficulties. It was also noted that difficulties might not be identified until they had escalated (and manifested themselves in behaviour). In addition, in schools that had experienced suicides, there had been reflection and concern that signs might have been missed, but also reassurance from services that (in these cases) schools had done all that they could.
- 5.15 There was also some suggestion from some of the schools visited that pupils with mental health difficulties outside of mainstream education might also be missed. Schools' links to pupil referral units where many pupils with behavioural problems (and who could also have mental health difficulties) were referred, were described as *ad hoc*. An educational psychologist described how even though they can visit young people at home, they did not get referrals of school refusers because: 'these are not causing [schools] a problem'.

Assessing needs

- 5.16 Staff confidence in their own abilities to assess pupils' mental health difficulties was more mixed. As Graph 5.2. shows, around two thirds (66 percent) of all staff either agreed or strongly agreed that they felt confident in discussing mental health and well-being needs with individual pupils. However, markedly fewer said they felt confident when speaking to parents or carers about these needs, with a little over half (56 percent) agreeing or strongly agreeing. The proportion that strongly agreed was again lower in response to both questions.

may have unmet mental health needs, compared with 10 percent of secondary school staff strongly agreeing, and 58 percent agreeing.

Graph 5.2. Staff confidence in communicating with pupils and parents or carers



Source: *People and Work, CAMHS In-Reach baseline survey 2019 (n=350-351)*

- 5.17 As outlined above, not all staff would be expected to assess pupils needs, and nine out of ten staff surveyed (90 percent) agreed or strongly agreed when asked if they were confident in identifying when they needed advice or support to better understand or address a pupil’s mental health difficulty. Qualitative research with school staff suggested that few teachers, especially in secondary schools, would attempt to assess a pupil’s difficulties. Both school staff and support agencies reported that some secondary school staff struggled to have difficult conversations with pupils and therefore avoided the issue. Instead, once a concern was identified, it was usually referred straight away to the school’s pastoral team or lead.
- 5.18 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 pastoral staff and

ALNCoS/SENCoS were more confident than other staff groups in assessing needs³⁷.

- 5.19 Qualitative research with schools confirmed the survey findings that staff were generally more confident discussing mental health and well-being with pupils themselves than they were discussing pupils' mental health and well-being with parents or carers. The confidence gap was particularly pronounced for secondary school staff³⁸.
- 5.20 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.'

- 5.21 Qualitative research suggested that, given the numbers of pupils identified as potentially having mental health difficulties, coupled with difficulties in accessing some specialist support services like educational psychologists (the subject of the next section), pastoral and/or ALN teams were forced to triage pupils, and decide which pupils to prioritise for access to specialist services. Some services expressed concerns that this could mean schools prioritised access for the most disruptive pupils, rather than prioritising pupils who might have greater needs, but who were less disruptive.

³⁷ 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 percent respectively agreed or strongly agreed) compared to 45 percent of other staff groups who agreed or strongly agreed.

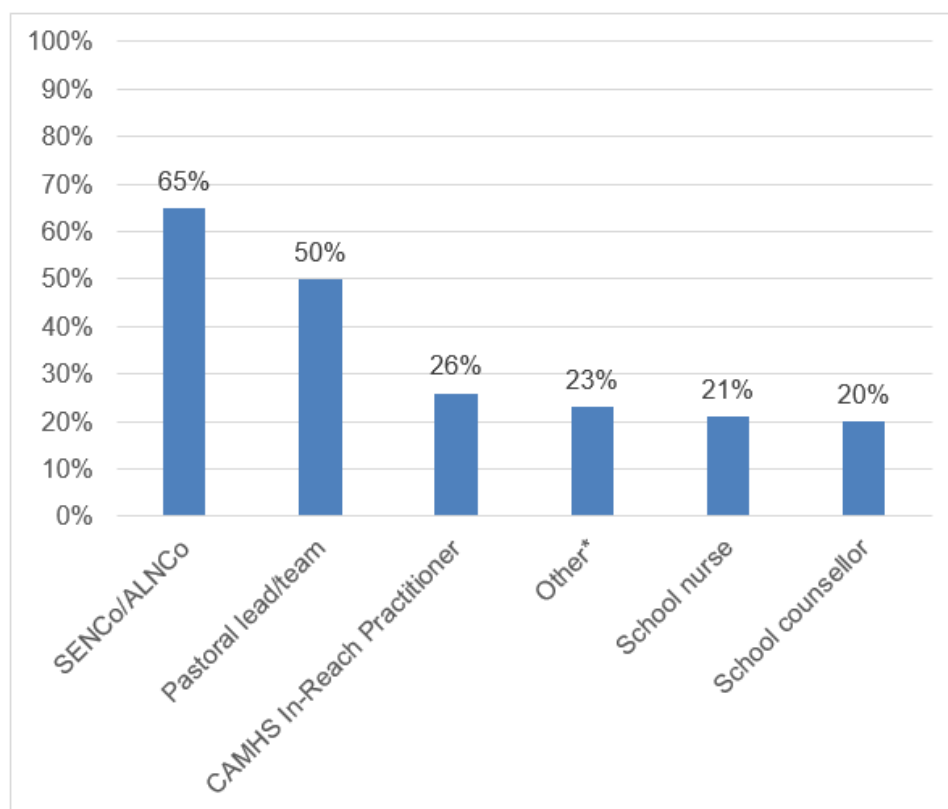
³⁸ 65 percent of primary staff either agreed or strongly agreed that they were confident doing this, compared with 44 percent of secondary school staff.

Accessing additional advice and support when needed

5.22 Most staff surveyed (around 90 percent) agreed or strongly agreed when asked if they were confident that, when needed, they knew how to access advice or support if they identified a pupil who may have mental health difficulties. Graph 5.3 outlines the services staff identified they would go to for further advice or support within the school; around two thirds (65 percent) chose a SENCo/ALNCo and half (50 percent) chose a member of the pastoral team.

Graph 5.3 Who staff would go to for further advice and support when they identify that a pupil may have mental health difficulties

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



*Examples mainly included Head or Deputy Head-teacher, Child Protection Officer, Educational Psychologist, Safeguarding Officer and Families First staff member.

Source: *People and Work, CAMHS In-Reach baseline survey 2019 (n=348)*

5.23 Qualitative research with schools and services illustrated how, in line with the 'graduated response' model, in order to support pupils' mental health difficulties,

schools drew upon both in-house support (such as the services listed above), and external support (such as support from educational psychologists and/or CAMHS, discussed in section 5; for example, the assistant head of a secondary school described how:

‘we’re creating a “Hwb Bugeiliol” – Pastoral Hub in September. It will have four rooms, one for staff, one for group work and two smaller ones for one-to-one work and it will host myself, the heads of year and the Cynnal worker, a teaching assistant at level three and the youth worker who will have increased hours to three days a week. It will be good to have the pastoral team all in one place’.

- 5.24 With few exceptions, pastoral staff interviewed for this study were confident in their ability to address pupils’ mental health difficulties. Qualitative research highlighted how staff confidence was linked to experience in dealing with mental health difficulties. As a pupil support manager in a secondary school described it: ‘our pastoral team have got better over time, we’ve had training and are experienced. We’ve got quite good at working with pupils with eating disorders, unfortunately’. There was no direct question in the survey on staff confidence supporting pupils with mental health difficulties, and it may be worth considering adding one to the mid and end line surveys.
- 5.25 However, qualitative research with schools also highlighted how, despite the confidence in SEN and pastoral teams, the rise in mental health difficulties (i.e. mental health problems that may fall short of mental illness³⁹), had challenged schools. This meant that even when staff were confident, as one 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.’ Moreover, a small number of staff in a few schools, interviewed during visits to schools, were struggling to cope with increasing demand and lacked confidence and were, as one deputy head put it: ‘flying blind’. Given the small numbers of staff interviewed, and likelihood of sampling bias (with, for example, those most interested and engaged in supporting pupils’ mental health

³⁹ “Mental health problems” describe “experiences that interfere with day to day functioning. This can be at a level to be clinically diagnosable but may also be sub-clinical.” In contrast “mental health illness” is used to “describe those more severe and often enduring mental health problems that are more likely to receive a clinical diagnosis and require treatment by specialist mental health services.” (pp. 12-13, PHW, 2016).

and well-being, most likely to take part in interviews) it is not possible to judge how widespread this problem is.

- 5.26 The qualitative research also identified the costs for schools that invest in in-house support and expertise; for example, in addition to the costs of training, as one primary school head teacher explained: ‘we’ve changed two teaching assistants’ roles to being well-being focussed and this is great in terms of providing for pupils’ mental health and well-being, but it does impact on teaching as we can’t replace that teaching assistance (they used to provide)’. Similarly, for some schools and services, the model of multi-agency meetings to help co-ordinate support was seen as a luxury, something that was valuable, but which school staff and some services could not find time to attend.

Pilot approaches and activity

- 5.27 As table 5.1 illustrates, the three pilot areas have sought to increase staff skills and knowledge of mental health difficulties through a mix of training and consultation.

Table 5.1 Pilot approaches to increasing staff skills and confidence

Area	Training	Consultation, advice and liaison with CAMHS In-Reach practitioners
Blaenau Gwent	Yes	Yes
Ceredigion	Yes	Yes
Powys	Yes	Some*
Torfaen	Yes	Yes
Wrexham and Denbighshire	Yes	Not initially, although this is now being developed

* In Powys, CAMHS provides support and consultation to the two secondary schools through a monthly visit from a CAMHS support worker, so this element was initially less developed⁴⁰. However, CAMHS In-Reach practitioners have now started to visit schools to provide consultations.

Source: interviews with project staff

⁴⁰ There were already established consultations with Powys Community Mental Health Service (PCMHS) practitioners in the secondary schools.

Ceredigion

5.28 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 is due to be rolled out in January 2020;
- tier 2, delivered face to face, through courses typically lasting 30-60 minutes, providing training in areas like mindfulness, stress and anxiety relief⁴¹; and
- tier 3 is 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 intervention⁴².

5.29 As tables 5.2 illustrates, there have been 517 participants on Tier 2 training and 41 participants on Tier 3 training courses. To provide some context for this, there are 585 teachers and around 537 support staff in Ceredigion⁴³. 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.

Table 5.2. The number of participants who attended Tier 2 and Tier 3 training in the Ceredigion area

Staff group	Tier 2	Tier 3
Primary school staff	173	0
Secondary school staff	344	29
School nurses	0	12
School Counsellors	3	0
Total	520	41

⁴¹ The full list is: the CAMHS Service; Mindfulness; Stress; Anxiety; Low Mood & Depression; Self-esteem; Eating Disorders; Gender Identity; Self-harm & Suicidal Ideation; and Five Ways to Well-being.

⁴² 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.

⁴³ Source: StatsWales: [teachers by local authority, region and category](#), and [Support staff by local authority, region and category](#). The numbers of support staff include 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.

South East and Mid Wales

- 5.30 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 Well-being and Everyone Matters workshops⁴⁴). In addition, modular training covering areas like childhood psychological development and understanding and responding to distress was developed by a psychology-led team and then piloted in spring and summer 2019. The intention is that the modular courses will be available to schools free, or at very low cost, and can be delivered in twilight slots.
- 5.31 As tables 5.3. and 5.4. illustrate, a total of 112 people have completed the 2 day YMHFA training course⁴⁵ in the 2018-19 academic year and 693 people attended the 60-75 minute Five Ways to Well-being workshop (which is primarily focused on staff well-being, but which is also relevant for relevant for pupils). To provide some context for this, there are 755 teachers and around 490 support staff in Torfaen and 506 teachers and around 620 support staff in Blaenau Gwent⁴⁶. Figures for South Powys are harder to quantify, as only part of the LA is included in the pilot programme. This means that around four percent of school staff in the region have completed YMHFA training and if we assume each participant is unique (so e.g. the numbers do not include individual staff, completing several courses) around a quarter of school staff have engaged with the well-being sessions (the lack of data for South Powys complicates the calculations)⁴⁷.

⁴⁴ These included tasters in areas like mindfulness, well-being and giving and taking care.

⁴⁵ Most of the training has been delivered over two consecutive days, with the exception of one school where the course was run as four three-and-a-half hour twilight sessions over a period of five weeks.

⁴⁶ Source: StatsWales: [teachers by local authority, region and category](#), and [Support staff by local authority, region and category](#). The numbers of support staff include 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.

⁴⁷ There are 93 schools in Powys. If we assume the same average number of staff in all primary and all secondary schools in Powys, this would suggest that the 13 schools in South Powys account for approximately 14% of all staff in Powys. There are 1,059 teachers and 858 support staff in Powys, which suggests approximately 150 teachers and 120 support staff in south Powys.

Table 5.3 The number of participants who completed the YMHFA training in the 2018-19 academic year in Blaenau Gwent, Torfaen and South Powys

Staff group	Number of participants
School Staff (Teachers, TAs etc.)	87
School Nurses (Gwent)	12
Youth Service (Blaenau Gwent)	5
EWOs (Torfaen)	3
Healthy Schools Coordinators (Blaenau Gwent & Torfaen)	3
Other (Assistant Psychologist; Student Nurse)	2
Total	112

Source: Mid and South Wales pilot

Table 5.4 The number of participants who attended the Five Ways to Well-being Workshop in the 2018-19 academic year in Blaenau Gwent, Torfaen and South Powys

Setting	Number of Schools who have run the workshop	Number of School Staff who have participated in the workshop
Primary	33	507
Secondary	5	168
Health Schools Network	N/A	18
Total	38	693

Source: Mid and South Wales pilot

North Wales

5.32 In North Wales, the training model covers four areas:

- whole school policy;
- school management review – school self-evaluation;
- Stress in the Workplace and Five Ways to Well-being; and
- YMHFA

5.33 The Stress in the Workplace and Five Ways to Well-being sessions and YMHFA training have had the most take up from schools. Table 5.5 shows the total number of staff trained over the last year. 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 a third of school staff in the region have engaged with the training. 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.

Table 5.5 Total number of schools engaged and staff trained - September 2018- November 2019 in North Wales

Setting	Number of Schools engaged	Number of School Staff engaged
Primary	66	396
Secondary	21	956
Total	87	1352

Source: North Wales pilot

Consultation, advice and liaison with CAMHS In-Reach practitioners

5.34 As Table 5.1 illustrates, consultation, advice and liaison with CAMHS In-Reach practitioners was a part of education and training strategies in Blaenau Gwent, Powys, Ceredigion and Torfaen. In North Wales, which had stronger links between CAMHS and schools before the pilot, they are about to start a consultation service to a cluster of schools. Consultations have enabled pilot practitioners to provide targeted and concrete advice on and support for individual pupils or groups of pupils. The consultation model is discussed in more detail in section 6.

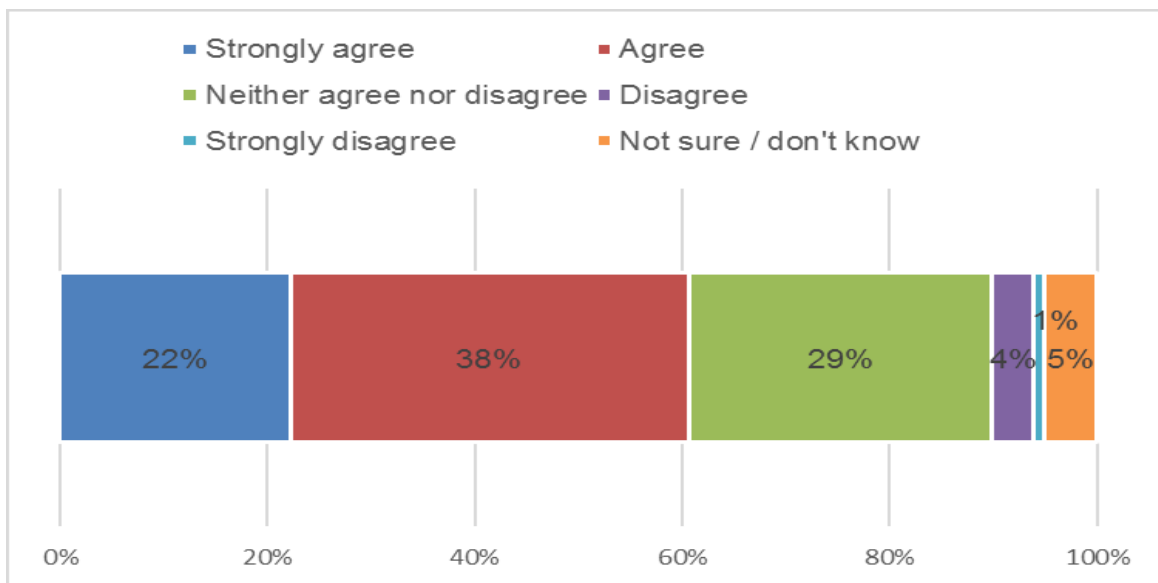
Emerging evidence of effectiveness

5.35 When surveyed in spring 2019, around a fifth (18 percent) of all staff in the survey had received training. As outlined above, the evidence from the Mid and South Wales and North Wales pilots (which covers a longer time period than the baseline survey) suggests roughly between a quarter and third of school staff have engaged with at least some training, which covers both pupils mental health difficulties and also staff stress and well-being (discussed further in section 7). Given differences in the duration of training, and also size, number of schools and geography of each

pilot area, direct comparisons of the numbers trained in each pilot area should not be made.

5.36 Graph 5.4 shows that three fifths (60 percent) of the staff surveyed who had received training either agreed or strongly agreed that the training delivered by the pilot had increased their knowledge and understanding of pupils' mental health problems and how to deal with them. Around a third (30 percent) were inconclusive in that they neither agreed nor disagreed. It is possible that this reflects other types of training (e.g. training on staff well-being) delivered by the pilot and the differing views on the effectiveness of training will be explored further in follow up surveys and visits to schools⁴⁸. Participant evaluation data provided by pilots is generally very positive about the training, although responses to training or sessions focused upon staff stress and well-being were sometimes less positive, with some staff finding this less relevant.

Graph 5.4 Responses from staff who received training delivered by the pilot when asked if it had had increased their knowledge and understanding of pupils' mental health problems and how to deal with them.



Source: *People and Work, CAMHS In-Reach baseline survey 2019 (n=78)*

⁴⁸ Training on staff stress and well-being was not part of the pilot programme's logic model and was therefore not considered in the baseline survey.

5.37 The qualitative research with schools identified a generally positive or very positive response from staff to the training; for example, interviewees contrasted their experience of training through the pilot programme, which they felt had empowered them, with previous training on mental health (delivered by others before the pilot) where they had come out feeling de-skilled and very worried; as a member of secondary school pastoral team put it:

‘[name of CAMHS In-Reach practitioner] makes you feel that you are doing your best with the tools you have and what you know. I often go to conferences where you feel inadequate but you come out of training with [CAMHS In-Reach practitioner] feeling uplifted’.

5.38 This interviewee contrasted the YMHFA training they had done before (by another party), with the same course run by CAMHS In-Reach practitioners who, it was reported, could expand on the training and link it to their work (which markedly increased its value and impact). The quality of delivery was therefore important and when well delivered the content of the YMHFA course was valued. For example as a head of year in a secondary school commented:

‘the [youth] mental health first aid course was excellent – it gives you reassurance that what you are doing it right – and it gives you a lot more confidence ...when you are constantly talking to pupils you see the issues covered in the course coming up and you have some idea on how far to push it, what questions to ask’.

Qualitative research suggested that training delivered by the pilot programme was particularly valued where LA training for school staff had been cut.

5.39 Qualitative research identified that, in line with the model of distributed expertise and responsibilities outlined above, schools generally targeted training at particular staff who specialised in mental health and well-being within the school, such as pastoral roles. This could be particularly valuable for staff involved in assessing risk and deciding which pupils needed to be prioritised for access to specialist services. Qualitative research also identified that, in a few schools, training was also extended to staff working with parents, because, as a secondary school assistant head described it: ‘a child with a mental health problem often has a family with mental health problems’, and to administrative staff, who were described as being on the ‘front line’ when parents come into school.

- 5.40 Qualitative research with schools and with staff from the pilots identified that linking the training to consultations was valuable; for example, advice and consultations could be used to model practice and give reassurance that what teachers were doing (which could have been informed by training) was the right thing to do. As a primary school SENCO commented: ‘sometimes it is a good thing to have someone experienced to say that you are doing well’. As the SENCO described it, it helps having someone to signpost services where they exist and: ‘provide us with good resources’.
- 5.41 It was observed by one interviewee from the pilots that because the pilots worked with the adults who supported pupils, rather than directly with pupils, this helped to ensure that schools took responsibility. This was felt to increase staff skill and confidence as they could not simply ‘hand on’ the pupil to specialist services, as they believed to have happened in the English Mental Health Services and Schools Link Pilot (discussed in section 1). Similarly, qualitative research with schools identified that the strong emphasis in Blaenau Gwent, Ceredigion and Torfaen upon facilitating a ‘formulation’ of the problems by school staff and other professionals, rather than simply providing advice on what to do, was felt to enhance the impact of advice and consultations upon school staffs’ confidence and skills ⁴⁹.
- 5.42 It was also reported that by helping CAMHS In-Reach practitioners better understand school staff knowledge, confidence and also their concerns, consultations could also be used to help identify schools’ training needs.
- 5.43 However, there were also examples of schools across each of the pilot areas where the staff felt so experienced and confident that the impact of the pilot was felt to be limited. There were also occasional criticisms of the training, including a complaint from one primary school interviewee that, in their view, much of the content of the YMHFA course was aimed at secondary schools. There were also a small number (n=3) of written comments in the survey criticising the training.
- 5.44 Moreover, engagement by schools in the training has been mixed. Qualitative research suggested that some schools where engagement has not been possible

⁴⁹ This could involve, for example, discussing and identifying what were thought to be the underlying causes of symptoms like low mood or anxiety (e.g. a family breakdown), in order to identify the most appropriate response (e.g. referral to Team around the Family (TAF) for support).

are supporting pupil well-being very well and do not see the need for training. However, some low engagement schools are thought by pilot staff to have weaknesses in the way they identify and support pupils, but do not see the need for training. Other schools value and want the training, but have sometimes struggled to release staff for training given the costs of, for example, supply cover, and other competing demands upon training and professional learning, such as the new curriculum.

Assessing the likely contribution of the pilots to intended outcomes

5.45 There is a clear demand from schools to enhance some staff skills and knowledge (e.g. those such as ALN/SENCOs and pastoral staff who are identified by schools as needing more “advanced” or “specialist” skills and knowledge (cf. WG, 2015b)) and training and consultations are valued as ways of upskilling these staff. In contrast there is much less evidence of a desire for whole school training, given both the logistical challenge of releasing staff this would pose and the cost implications (e.g. of supply cover). This reflects the current model in which only those staff who need to, develop “advanced” and “specialist” skills and knowledge. Although it would be premature to judge the value and impact of the training and consultations at this early stage, the evidence suggests that impact will depend on both:

- the quality and relevance of training (which appears to be high) and advice delivered through consultations (which appears to be valued); and
- schools choosing to engage, selecting the right staff to be trained depending on the level and type of training offered (e.g. identifying those who need more advanced or specialist skills and knowledge to go on higher level courses), being able to release them for training, and staff then cascading or sharing learning with others in the schools, as appropriate, where the picture is somewhat more mixed.

5.46 Qualitative research for this study, and other research in this area also highlights the need for:

- a ‘mixed economy’ in which training is complemented by other models of professional learning, such as initial teacher education, coaching (which consultations may be analogous to), mentoring and taking part in professional

learning communities (which are somewhat analogous to special interest groups – see case study 4) (Hill, 2013); and

- training and other types of professional learning being responsive, so that staff can develop and refresh skills and knowledge when they need them (e.g. when staff move on, change roles and/or new mental health difficulties emerge) (WG, 2015b).

Case study 4. Special Interest Groups

In Torfaen, special interest groups have been established by the CAMHS In-Reach to Schools practitioner in all but one of the secondary schools to share and support school staff going through modular training. These groups provide an opportunity for staff to come together, discuss the learning they have done, and provide peer support. The groups are reported to have started well, but after two or three modules staff participation has tended to drop off, and it is felt that school leaders are not really 'buying in' to the idea and ensuring people can prioritise attendance. However, it is reported that when people do come, the quality of discussion and the range of ideas and approaches shared are very strong.

- 5.47 This suggests that the pilot's professional learning offer needs to be planned and delivered as part of a broader professional learning offer to school staff including, that provided by regional education improvement services and other services such as LA Inclusion, EP services and LHBs. This reflects both the volume of professional learning likely to be required (which is beyond the capacity of the pilots) and the case for a mixed economy, with professional learning delivered in different ways through different channels (see e.g. Hill 2013). It also suggests that for the pilots themselves, providing access to an ongoing programme of training (e.g. to train new staff and refresh skills) alongside consultations, which can be more responsive and targeted to specific pupils or issues, is likely to be particularly important.

6. Access to specialist services

Introduction

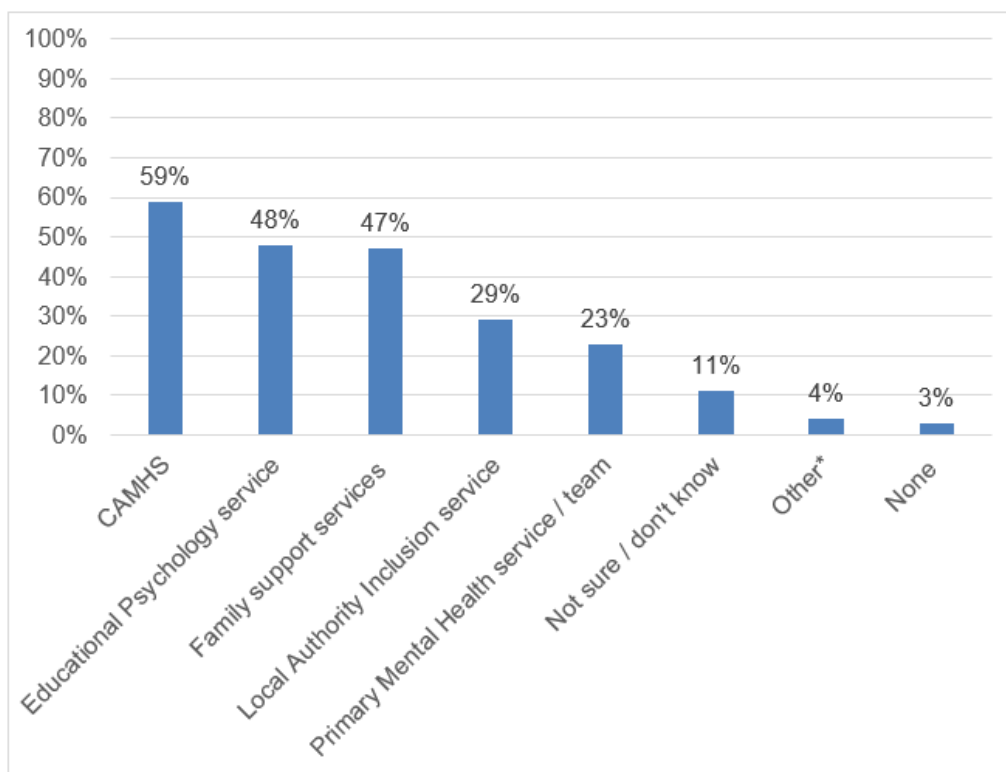
- 6.1 As outlined in section 5, while schools can, should and do, assess pupils' mental health difficulties, they are not trained mental health experts, and they should not seek to diagnose conditions. Instead, assessment of severe and complex mental health difficulties should be undertaken by specialist services such as EP and CAMHS.
- 6.2 As outlined in the introduction, concerns have been raised about access to specialist services (see e.g. NAFW, 2018; WG, 2015c). In response, the pilot programme's original theory of change (see figure 1) identified improving schools' understanding of roles, responsibilities and referral pathways as the main mechanism for ensuring that schools are (as the pilot programme's theory of change puts it): 'able to direct pupils to specialist liaison and consultancy and advice when they need it' (as an outcome of the pilot programme).

The baseline position

- 6.3 As seen above, schools report relying on 'in-house' expertise and external services to assess and support pupils with mental health difficulties. This section now turns to the latter of these (i.e. external services). Graph 6.1 shows that advice or support from CAMHS was the most common service, chosen by just under three fifths (59 percent of respondents), followed by EP services and family support services, which were both chosen by just under half (48 and 47 percent) of respondents, when asked which services they would go to for further advice or support.

Graph 6.1. The services school staff identified they would go to for advice and support

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



*Written comments mainly provided examples of staff within the school, as listed in graph 4.1 above.

Source: *People and Work, CAMHS In-Reach baseline survey 2019 (n=348)*

Access to specialist services

6.4 Qualitative research with schools identified that in some cases they have had pupils with emotional distress and not known what their options were, because:

- they did not know about services; for example, as one primary school head teacher expressed it: 'it would be great if schools could have up-to-date information. You can hear, by chance almost, about services that you had no idea were available locally';
- they could not get parental consent; for example, one primary school head teacher described how a family is refusing to go to TAF (Team Around the Family) but needs to (in their view). They explained that they have not had contact with TAF for several years now, as they can only contact TAF if parents agree and they reported

that in their area, parents will not agree. Other schools reported parents were often more willing to work with TAF than they were with social services; and/or

- there was no service that pupils were eligible to access, which this section focuses on in particular.

6.5 Qualitative research with schools and services and, as noted above, other literature reviewed for this study (such as WG, 2015c), 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’.

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.

6.6 A number of schools described lengthy waiting lists or waiting times for accessing services; for example, a primary school head teacher reported:

‘waiting lists for CAMHS and Neurodevelopment aren’t helpful and CAMHS and Social Services will often not offer support as the pupils don’t meet thresholds or criteria. 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’.

6.7 As another 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’.

6.8 The survey of school staff included a specific question on support from CAMHS. Fewer than half (46 percent) of staff surveyed who had accessed CAMHS, either agreed or strongly agreed that they felt supported by CAMHS. Access to CAMHS was also the most frequently highlighted issue in written comments. These focused in particular upon difficulties with referral to and support from CAMHS. This was of

great concern to staff as they felt they were not able to adequately support their pupils in a timely and effective manner; for example:

‘When we have concerns about a child and relevant paperwork has been completed there is a very long waiting list for the child to be supported. I feel that we are letting the children down even though we have done as much as we can do and implemented all relevant paperwork’. (Member of support staff in a secondary school).

‘Although I understand the role of CAMHS the waiting times mean that it is not easy to access support’. (Secondary school leader).

6.9 However, in contrast, a small number of staff praised CAMHS in their written comments, albeit sometimes with caveats. As one respondent put it:

‘CAMHS offer great advice and support for many of our pupils but when identifying pupils in the Foundation Phase there is understandably a long waiting list but this often leads to the pupils leaving Foundation Phase without support in place for them’. (Primary school teacher).

6.10 Qualitative research with schools also identified problems in accessing EP services in some areas; for example, a primary school head teacher commented: ‘there is no EP really – there is one in [name of area omitted] but he can only see children for statementing, he has to come down and although he does what he can, he is limited’.

6.11 Qualitative research with services confirmed the impact of increasing demand and cuts in funding on services’ capacity to meet need. Some services also highlighted how cuts in other services and/or a raising of thresholds in those services, had increased the demand for their own service (a phenomenon sometimes known as cost shunting’).⁵⁰ Many interviewees reported that they had been forced to raise their thresholds as a result and some talked about a so-called ‘missing middle’ caused by the hollowing out of services between schools and increasingly specialist services with high thresholds. As case study 5 illustrates, there were also concerns about the ways in which eligibility criteria limited access, meaning some pupils could

⁵⁰ Cost shunting describes how costs previously borne by one services can be transferred to ‘shunted’ to one or more other services, as a result of cuts to the first service. So for example, cuts in educational psychology services may increase the demand for and costs experienced by CAMHS services.

fall through the gaps between services. Some schools and services described how preventative or early intervention work, by services such as social services, had also been cut. Moreover, some felt that partnership working between health and social care services and schools had also reduced, as services increasingly turned inwards and focused upon their own organisational priorities and targets.

Case study 5. Falling through the gaps

One of the CAMHS In-Reach practitioners described how pupils with complex issues, and very poor well-being, but who do not have a mental illness, 'keep her awake at night'. She described, for example, Kate (not her real name) a teenager who has been excluded from school, but who still "hangs around the school" causing problems. Kate has been very offensive to staff (swearing at them) and has damaged school property. Kate is in care (i.e. she is 'looked after') but the LA social care service is reported to be unable to help her, as she will not cooperate. She is self-harming, albeit at a low level, and Primary Mental Health Support Services (PMHSS) say it is not appropriate for them to work with Kate, whilst CAMHS say she is not mentally ill and have been reluctant to engage further.

The CAMHS In-Reach practitioner explained that PMHSS work with young people with 'mild to moderate difficulties', but what they mean by this in practice is a child or young person who cannot sleep at night, has negative thoughts, is worried – and who will respond to a six-week intervention (by PMHSS) and then be able to move on. As they explained, in their view, the children and young people that PMHSS accept are: 'ready to do a piece of work [i.e. to engage with PMHSS]' – but if like Kate, the young person is not ready (and falls short of the eligibility criteria for services like CAMHS), there is no service for them.

The CAMHS In-Reach practitioner's vision is for an assertive outreach model in CAMHS backed up by specialist provision in schools, with more upskilled staff, that would be better able to support pupils like Kate. However, developing this sort of service model is beyond the pilot's remit.

- 6.12 As case study 5 illustrates, PMHSS potentially have a role here in filling this gap. However, they can only work with young people who are ready to engage and, as outlined above, relatively few schools identify them as source of support. This may be because they are generally accessed via GPs (rather than referral from schools) and because of criticism of what is perceived to be the adult orientation of PMHSS (NAfW, 2018).
- 6.13 In some areas, like Gwent, there were also a plethora of new, often time limited initiatives established by education, youth, health and voluntary sector services supporting children and young people with mental health difficulties. The aim is system-wide change, by accelerating and scaling up existing initiatives, improving access to expertise, without requiring referrals to a specialist service like CAMHS, in order to better meet the needs of children and young people⁵¹.
- 6.14 Although the development of new services in each of the three pilot areas has been welcomed, it has contributed to a complex service landscape for schools and the pilot programme to navigate, particularly where services are targeted at specific groups, conditions and/or geographical areas, and consequently have constrained eligibility criteria. It is too early to judge what impact the new services are having upon overall capacity (and this is a question beyond this evaluation's remit) and consequently, on the demand that individual services, like CAMHS, face; for example, establishing new services may increase demand (as well as increasing capacity), particularly where the new service configuration addresses a previously unmet need.

Islands of access

- 6.15 In contrast to the general picture outlined above, the qualitative research with schools also identified a small number of examples of schools that described having good relationships with, and access to, external services; for example, a secondary school head teacher described a multi-layered support system:

‘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

⁵¹ The aim is similar to the CAMHS In-Reach pilots in that it aims to enable and empower services to ‘hold onto’ children and young people (by providing access to expertise when needed), rather than referring them onto other services.

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’.

- 6.16 Similarly, as outlined below, the survey identified that amongst those staff accessing CAMHS, just under half (46 percent) agreed or strongly agreed that they were supported by CAMHS, and qualitative research with services identified examples of what were felt to be strong and effective working relations with schools.

The impact of difficulties in accessing specialist services

Differences in access to services appeared in part to reflect differences in service provision in separate pilot areas. Some services in North Wales and Ceredigion described good working relationships between schools and CAMHS. However, the views of schools themselves were more mixed. There appeared to be more engagement between schools and CAMHS in North Wales, but also problems with delays, high thresholds and problems communicating with CAMHS, and an understanding that CAMHS was stretched.

Case Study 6. SPACE-Wellbeing

SPACE-Wellbeing, (the Single Point of Access for Children’s Emotional Wellbeing and Mental Health) 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 CAMHS go via SPACE Wellbeing.

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

- 6.17 There were also examples of well-received regional initiatives, like the Self-Harm Referral Pathway in North Wales noted earlier, and SPACE Wellbeing in Gwent (Case study 6). Qualitative research suggested whilst stakeholders were often supportive of the principles, at this stage relatively few of the pilot schools had asked for support via SPACE-Wellbeing. It was also reported that there is no consistent involvement of education services in SPACE-Wellbeing, except sometimes an educational psychologist. This may be illustrative of a broader finding about the lack of integration of some health and education initiatives intended to support children and young people's mental health.
- 6.18 Differences in service provision and pathways did not appear to explain or account for all the variations in engagement with services. It appeared that local factors, including staff sickness, and also the relationships between schools and services were also important factors; for example, a primary school well-being lead reported: '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 that we have a history of previous working experience'.
- 6.19 It was also observed by schools that services would often change over time, with a number of projects and services supported by time-limited funding, such as youth workers who provide counselling funded through the European Social Fund (ESF), an Action for Children project funded by Royal Mail, and more local projects and groups which were often funded by charities. Further exploring the reasons for the variation in access to services will be an important line of inquiry in the next round of qualitative research with schools and services.

Pilot approaches and activity

- 6.20 As table 6.1 illustrates, the three pilot areas have sought to help ensure that schools are able to direct pupils to specialist liaison and consultancy and advice when they need it, through three main strategies:
- providing Information and advice (e.g. on services, referral pathways);
 - brokering access to / acting as an intermediary between schools and services; and
 - offering consultation, advice and liaison with CAMHS In-Reach practitioners.

Table 6.1: Pilot approaches to improving schools' access to specialist advice and support

Area	Information and advice (e.g. on services, referral pathways)	Brokering access to / acting as an intermediary between schools and services	Consultation, advice and liaison with CAMHS In-Reach practitioners
Blaenau Gwent	Yes	Yes	Yes
Ceredigion	Yes	Yes	Yes
Powys	Yes	Some	Yes with primary schools and some secondary school pupils*
Torfaen	Yes	Yes	Yes
Wrexham and Denbighshire	Yes	No	Not initially, although this is now being developed

Source: interviews with project staff

* It was agreed that Powys Primary Care Mental Health Support Services would continue to provide routine consultation to pupils from Powys in Brecon and Crickhowell High Schools, while the CAMHS In-Reach practitioner would cover pupils from Gwent in those schools (they make up approximately 45% of the Crickhowell High School's population).

Emerging evidence of impact

Providing information and advice

6.21 As seen in the previous section, most staff surveyed were confident that they knew how to access specialist services when needed. However, the qualitative research with schools showed a lack of knowledge of services was reported to be a barrier to access. The research identified a small number of cases where the pilot was felt to have made an important contribution to school staffs' knowledge of services, and crucially, which services to refer to and when. As a senior leader in a primary school described it: '[name of CAMHS in reach Practitioner] 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'. The pilot programme staff were described as

knowledgeable about other services, and schools talked about them referring pupils to services they did not know existed.

Brokering access to / acting as an intermediary between schools and services

- 6.22 Qualitative research with schools and services suggested that the CAMHS In-Reach practitioner's role as an intermediary between services was particularly valued. Some schools described how the project had helped them improve relationships with other services. For example, as a secondary school well-being lead explained: 'prior to [CAMHS] In-Reach we didn't have anything. Working with [name omitted] has been good. Before that CAMHS was very detached from us. Communication wasn't free flowing'. Similarly, an interviewee (role omitted to protect their anonymity) describing their practice as a CAMHS worker described how she could count on two hands the number of times she liaised with, or even contacted, a school. They recounted that the only time CAMHS contacted a school was to hand over and give schools a list of what they should be doing.
- 6.23 Because CAMHS In-Reach practitioners are trusted by both health and education staff, they have helped improve communication between services and schools. As the boxed text illustrates, the CAMHS In-Reach practitioners have helped provide a bridge between settings that keeps communication open; for example, in Ceredigion, CAMHS In-Reach practitioners attend TAF meetings to help facilitate information sharing and communication between between mental health services, education and voluntary sector services.
- 6.24 Across the three pilot areas, CAMHS In-Reach practitioners are raising awareness of mental health services in schools and, to a lesser extent, raising awareness of schools' experiences to services. Bridging the divide between schools and services, by enhancing understanding, is important because schools and many specialist services operate in very different cultural and organisational contexts. The pilot programme's contribution to raising awareness in health settings about the constraints schools face in supporting pupils, the differences between therapeutic and busy school settings, and the importance of communicating with schools were all described by stakeholders from the pilots and services as important.

Case study 7. Ceredigion's Consultation Pathway

In Ceredigion, pilot practitioners identified that CAMHS were sometimes not aware that they (CAMHS) were working with pupils who the CAMHS In-Reach Practitioners were also working with schools to support. The CAMHS In-Reach pilot practitioners also identified that CAMHS 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 CAMHS 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 CAMHS and schools.

- 6.25 In Ceredigion, it was also reported that most referrals to CAMHS still come via GPs. Across all areas, schools sometimes ask parents to ask their GP to make a referral to services, with generally mixed results. This sometimes worked, but could also lead to the referral being bounced back by GPs, who felt schools had better links to services than they did. There were also concerns that GPs may not be fully aware of the work that is being done with a pupil in school, and are likely to not know or understand a pupil as well as a school (and therefore make a less informed referral). In response, in Ceredigion they are looking to develop a system of placing correspondence, with a summary of the plan in place to support a pupil, on to GP data systems. It is hoped this could reduce the number of referrals to CAMHS via the Single Point of Access.
- 6.26 Arrangements to improve communication between schools and services like CAMHS differ in each area; for example:
- in Blaenau Gwent and Torfaen, the new SPACE-Wellbeing panel is intended to improve the exchange of information between services and appropriateness and speed of referrals to specialist services; and

- in North Wales and Powys, visits to schools by CAMHS contribute to the sharing of information between schools and CAMHS.

Consultation, advice and liaison with CAMHS In-Reach practitioners

6.27 There is no single or uniform approach to consultations; for example:

- In Ceredigion, CAMHS In-Reach practitioners typically attend TAF meetings, and then provide consultation sessions to schools on a monthly basis;
- in Mid and South East Wales, the two CAMHS In-Reach practitioners have different ways of arranging consultations, with one booking the whole year in advance and the other taking a more flexible and reactive approach. Qualitative research with schools and the pilot suggested that the more flexible and responsive model was harder for the pilot to plan and manage but had been more successful in encouraging staff to use the consultation sessions; and
- in North Wales (which had stronger links between CAMHS and schools before the pilot) the initial focus was upon training, but they are about to start a consultation service to a cluster of schools.

6.28 As case study 8 illustrates, consultations in Ceredigion, can focus upon the CAMHS In-Reach practitioner discussing with school staff the difficulties groups of pupils with similar needs experience, or those of an individual pupil. This is also the case in Mid and South Wales. The discussions can involve one member of staff through to a multi-disciplinary meeting with multiple staff from the school and services working with the pupils. It is important to note that the discussions are with staff and do not involve direct assessments of, or work with, pupils themselves. Qualitative research with schools and the pilot suggested that this flexible and responsive model was important.

Case study 8. Ceredigion's consultation models

In Ceredigion, consultations are taking different forms. They 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 will provide advice and/or recommendations, including, for example, advice on the appropriateness of a referral to CAMHS or signposting to another service. However, as outlined in section 4, CAMHS In-Reach practitioners also aim to get the staff attending the consultation to come up with the solutions themselves, in order to upskill them and increase their confidence.

6.29 Data from the pilot indicates;

- In Ceredigion, over the period December 2018 – December 2019, 69 pupils were discussed (and two were re-discussed), of these just under half (n=31) were known to CAMHS and around 10% (n=7) were signposted to CAMHS;
- In Powys, over the period September 2018 - July 2019, around 19 pupils were discussed⁵² ;
- In Blaenau Gwent, over the period September 2018 - July 2019, 60 pupils were discussed; and
- In Torfaen, over the period September 2018 - July 2019, around 87 pupils were discussed⁵³ .

6.30 Although consultations have been valued by schools, the total number of pupils supported through consultations is therefore relatively small in absolute terms, compared to the total numbers of pupils likely to have mental health difficulties in the pilot area. As outlined in section 1, around one in eight pupils are thought to

⁵² Figures are described as 'approximate' because some sessions were jointly held with Primary Care Mental Health Services and some consultations sessions were discussions around general problems effecting a class, rather than specific to an individual pupils.

⁵³ Figures are described as 'approximate' because they include pupils discussed during multi-agency meetings with other services or during case discussion with primary and specialist CAMHS.

have a mental health problem, and if this rate is applied, it suggests that in 2018/19⁵⁴:

- in Blaenau Gwent, around 530 pupils in years 6 to 11 will have mental health difficulties⁵⁵;
- in Ceredigion, around 450 pupils in years 6 to 11 will have mental health difficulties⁵⁶; and
- In Torfaen, around 820 pupils in years 6 to 11 will have mental health difficulties.⁵⁷

6.31 Qualitative research with schools suggests the difficulties accessing CAMHS outlined above, meant that the consultation, advice and liaison offered by CAMHS In-Reach practitioners in Ceredigion and Mid and South Wales were particularly valued; for example, as a secondary school well-being officer put it:

[name of CAMHS In-Reach practitioner omitted] is one of the best I have met – she offers open meetings ...and will do an anonymous consultation with ...[pupils]. The good thing is that I can ring her and she gives me more confidence’.

6.32 As such, the 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 1) it does not provide a ‘full’ CAMHS offer to schools; for example:

- CAMHS In-Reach practitioners will only work with and advise staff (they do not see, assess and/or work directly with the child or young person); and
- they only advise on mental health issues, and would, for example, signpost concerns about neurodevelopmental issues to the ND service (which is generally part of CAMHS).

6.33 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

⁵⁴ Source, StatsWales, [Pupils by local authority and year group](#),

⁵⁵ This is based upon the numbers of pupils in Year 6 (n=810) and Years 7-11 (n=2,935).

⁵⁶ This is based upon the numbers of pupils in Year 6 (n=650) and Years 7-11 (n=3,600).

⁵⁷ This is based upon the numbers of pupils in Year 6 (n=1,100) and Years 7-11 (n=5,495).

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 CAMHS service might). However, in practice the model can be difficult to sustain, particularly when, as is often the case, the focus of a consultation is on an individual pupil. In addition, in some cases CAMHS In-Reach practitioners have been asked to liaise between school and health services about a specific pupil and/or been sent notes about individual pupils by other services. Some schools have also brought parents or carers into discussions. Although this has been seen to be very helpful in developing strategies with the school and parents and in improving partnership work with services, it has created tensions for the programme in trying to define and protect the boundaries of the CAMHS In-Reach practitioner role.

The likely contribution of the pilots to intended outcomes

- 6.34 As outlined above, schools often struggle to access specialist liaison and consultancy and advice when needed, and there was a clear need for action here. However, the problem schools faced was not only their understanding of available referral pathways (which the pilot programme focused upon); it was also the constrained capacity of services relative to demand.
- 6.35 As outlined in this section and in the introduction, the numbers of pupils with mental health difficulties has increased and services have struggled to cope with the consequently increased demand. The pilot may contribute to addressing this demand-capacity gap through two key mechanisms:
- increasing capacity in schools to address low level mental health difficulties by upskilling staff and increasing their confidence, may help ensure that pupils with low-level difficulties are identified, assessed and supported by schools, rather than being referred to a specialist service (outlined in section 5); and
 - by enabling earlier and more effective intervention in schools, capacity building in schools (such as upskilling staff), may help prevent mental health difficulties escalating and reaching the complexity or severity where specialist services are needed. However, even if this were to happen, it would take time before these changes in school practice impacted upon the number of pupils with more severe or complex mental health difficulties who needed to be referred to specialist services like CAMHS.

- 6.36 In addition, the pilot programme aimed to improve understanding of referral pathways and ensure that referrals were made at the right level, to the right service. There was some evidence of the pilot programme improving staff knowledge of services, and this may have diverted some referrals away from CAMHS to other services. However, the impact is likely to be modest, given evidence from the survey and qualitative research with schools that the problem was primarily about accessing existing services (given high thresholds and waiting lists) rather than knowing which service to refer to, and closing the demand-capacity gap that specialist services face lies beyond the pilot programme's goals.
- 6.37 Given the difficulties in accessing services, providing additional capacity by extending CAMHS services to schools primarily through consultation and advice was therefore particularly valued in areas like Blaenau Gwent, Ceredigion and Torfaen, where CAMHS lacked the capacity to do this themselves. Nevertheless, as acknowledged above, the pilot programme is not extending the full CAMHS offer to schools (as sometimes happened in the English pilot) and is not a substitute for access to CAMHS for those pupils with more severe or complex needs.
- 6.38 The constrained offer to schools appears to have contributed to views amongst some services interviewed for the study that the pilot programme lacked the capacity (given the size of the pilot programme teams relative to the number of schools) to really make a difference to schools' ability to meet needs; as one interviewee from a SEN specialist service put it: 'to make a difference you need regular contact and conversations with schools and have the presence to follow-up'. In part this may reflect misunderstanding about the pilot, fuelled by the pilot programme's name, the 'CAMHS In-Reach to Schools pilot programme'.
- 6.39 The qualitative research with schools and the pilots suggested that, despite the small size of teams, the pilot was reaching out to, and making a difference to, secondary schools through advice and consultation. This was an important achievement, as the model of a single worker covering a whole LA sometimes dilutes impact too much. However, the pilot had generally struggled to reach out to primary schools, particularly in large rural areas like Ceredigion, where only two of the 39 primary schools regularly request consultations.

6.40 Qualitative research with services also identified concerns about:

- the lack of a more strategic approach to meeting the needs of pupils' mental health difficulties, given the range of LA, LHB and voluntary sector services involved (such as school nurses, school counselling services, the youth service, EP, CAMHS and the voluntary sector) and a plethora of new initiatives in some areas like Gwent (and affecting the pilot in Blaenau Gwent and Torfaen). This strategic role is largely beyond the pilot's remit, although, as seen earlier, it is sometime addressed by pilot steering groups and individual members of pilot steering groups.
- what some described as the 'missing middle' tier of services between schools and specialist services like CAMHS, as the result of cuts in services, but also service configurations which not all pupils' needs comfortably fit into, which had led to the closure of some services and a raising of thresholds for others; and
- the impact of the pilot programme being much greater for secondary (and all age) schools. The pilot programme only works with pupils in the final year of primary school (Year 6) and primary schools frequently expressed frustration that the pilot could not work with younger children. This reflected the earlier onset of mental health difficulties amongst primary school age children, , and also the lack of services for young children (for example, school counselling services only work with children in Year 6 and above). Moreover, as outlined in section 3, the pilot has generally prioritised work with secondary schools and has sometimes found it harder to engage primary schools; it is also more costly to support the primary schools that have engaged (given the greater number of primary schools and the smaller number of pupils in each school in need of support, compared to secondary schools).

6.41 Given these limitations, it appears likely that the impact of the pilot upon schools' access to specialist liaison and consultancy and advice when they need it will be more modest than its impact upon schools' capacity to deal with pupils' low level mental health difficulties.

7. Staff stress and well-being in pilot areas

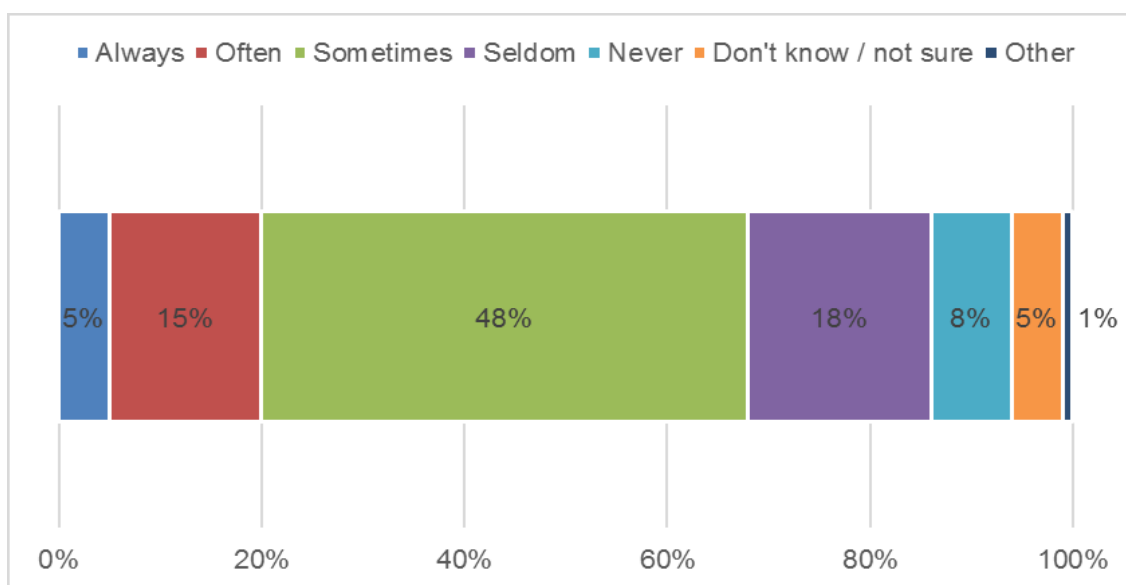
Introduction

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.

The baseline position

7.2 Graph 7.1 shows that a fifth (20 percent) of staff surveyed reported that they 'often' or 'always' experienced increased levels of stress when dealing with pupils' mental health difficulties.

Graph 7.1 Responses of staff when asked if they experienced increased levels of stress when dealing with pupils' mental health difficulties



Source: *People and Work, CAMHS In-Reach baseline survey 2019 (n=344)*

7.3 Qualitative research with schools confirmed the stress that school staff often experienced when dealing with mental health difficulties. Weaknesses in staff confidence and also competence in dealing with mental health were seen as having a negative impact upon staffs' own mental health and well-being. It was also observed that:

- pupil well-being is linked to staff well-being, as education staff cannot support pupils if they do not have good mental health themselves. Similarly, as another primary school interviewee described it: ‘if you are not in a good place you can’t deal with a child’; and
- staff well-being improves when there is a calm environment (and that improvements in pupils’ well-being and behaviour would also improve staff well-being).

7.4 Knowing what to do, but not having time and/or problems accessing specialist services (discussed in sections 6 and 7) were 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. It’s 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’.

7.5 However, the qualitative research with schools also made it clear that staff confidence (or competence) and/or problems accessing specialist services when needed were not the only cause of staff stress and poor well-being. Other factors included:

- workload, and as one school leader expressed it: ‘I would say workload is the main cause of stress’;
- the pressure upon schools as a result of inspection and accountability regimes and budgetary cuts, which meant several schools were planning or consulting on redundancies; and

- the ALN transformation programme⁵⁸ and the new curriculum for Wales⁵⁹, which were welcomed, but seen as increasing demands upon schools' and staff's time, attention and resources.

7.6 This is broadly consistent with other research discussed in the introduction, which highlights workload as a key cause of stress for teachers.

7.7 Qualitative research with schools also identified that 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 pupils' 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'.

Access to support

7.8 Almost three quarters (74 percent) of all staff surveyed agreed that they knew who to go to if they needed support with their own well-being. However, a small number 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:

'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 their job adequately'. (ALNCo)

'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).

⁵⁸ [Additional Learning Needs \(ALN\) Transformation Programme](#)
⁵⁹ [Curriculum for Wales](#)

7.9 The qualitative research with schools suggested that support from schools was mixed, with some schools highlighting a range of actions taken to promote staff well-being. Equally, in other schools, staff well-being was described as being on the 'to do' list (by the head of a well-being team in a secondary school). A number of interviewees, including school leaders in both primary and secondary schools, pointed out that there is no professional supervision for teachers, unlike for health professionals. One school described how they wanted to do more cluster well-being work, particularly around support for pastoral staff and how they had discussed a peer support system at cluster level, but stressed that was not the same as individual supervision. Similarly, as seen earlier (in section 5) in Torfaen, special interest groups have been established to both aid professional learning but also provide peer support.

Pilot approaches and activity

7.10 As table 7.1 illustrates, the three pilot areas have addressed the challenge of reducing staff stress and improving well-being through a mix of four key approaches:

- training in stress management and promoting well-being;
- training in recognising and meeting pupils' mental health needs (increasing staff skills and confidence);
- consultation, advice and liaison with CAMHS In-Reach practitioners (increasing skills and confidence, which contributes to reducing stress); and
- improving access to specialist services (reducing stress linked to difficulties in accessing services).

Table 7.1 Pilot approaches to reducing staff stress and improving staff well-being

Area	Training in stress management and promoting well-being	Training in recognising and meeting pupils' mental health needs (increasing confidence)	Consultation, advice and liaison with CAMHS In-Reach practitioners (increasing confidence, providing reassurance)	Improving access to specialist services (reducing stress linked to difficulties accessing support)
Blaenau Gwent	Yes	Yes	Yes	Yes
Ceredigion	Yes	Yes	Yes	Yes
Powys	Yes	Yes	Yes in part*	In part*
Torfaen	Yes	Yes	Yes	Yes
Wrexham and Denbighshire	Yes	Yes	Not initially, although this is now being developed	No

Source: interviews with project staff

* In Powys, PMHSSS continue to provide consultation to pupils from Powys, while CAMHS in Reach practitioners support pupils from Gwent in South Powys' two high schools.

7.11 The models of training in, for example, promoting the Five Ways to Well-being; consultation, advice and liaison and access to specialist services, developed by the pilots, are discussed in earlier sections.

Emerging evidence of effectiveness

7.12 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'.

7.13 Qualitative research with schools highlighted the contribution made to their own well-being by:

- training, like the Five Ways to Well-being course, which has been taken up by large numbers of staff, and was seen as of value (applicable) to both staff and pupils;
- the reassurance offered by advice and consultations with CAMHS In-Reach practitioners; and
- improved communication with support services.

7.14 Nevertheless, although as outlined above, the overall response to training was positive, there were a couple of written comments in the survey saying that the CAMHS In-Reach training had not been good enough. Most of these critical comments focused upon the well-being training and workshops, which appeared to be less positively received than training on pupils' mental health difficulties; for example, written comments in the survey included:

'the training we received in Feb 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 pupils' 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 Qualitative research with the pilots, and also some of the participant self-evaluation data collected by pilots, also indicated that the training directly on staff stress and well-being has been more contentious than training on pupils' mental health and well-being, with some staff engaging strongly and others questioning its value, relevance and/or delivery.

Assessing the likely contribution of the pilots to intended outcomes

7.16 As outlined above, high levels of staff stress and low levels of staff well-being are a key concern. As the next section outlines, there is increasing recognition that

promoting staff well-being is an integral part of whole school approaches to promoting pupils' mental health and well-being; as one study identifies:

'staff within many schools are themselves highly stressed and this will be impacting on the emotional climate within schools and undermines ability to provide positive support to children and young people' (Stirling and Emery, n.d.).

7.17 Levels of staff well-being and stress depend upon multiple factors, including those factors the pilot aims to change, such as confidence and competence and access to specialist services. However, levels of staff well-being and stress also depend, to a large degree, upon wider factors including staff workloads, accountability and ALN and curriculum reforms, which the pilot does not address. The pilot's contribution is therefore likely to be one of reducing (but not eliminating) sources of stress, raising awareness of and the profile of the issue and legitimating conversations; and also helping staff cope better (e.g. through a focus on the Five Ways to Well-being). These latter contributions (raising awareness, reducing stigma and helping staff cope) may help mitigate the impact of sources of stress, which the pilot does not address (like heavy workloads). However, it is important to bear in mind the scale of the challenge here, 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.

8. Schools' effectiveness in meeting pupils' needs and promoting pupils' and staffs' mental health and well-being

Introduction

- 8.1 As outlined in the logic model (figure 1), by upskilling staff the pilot aims to ensure that: 'schools are more able to provide for [the] educational needs of their pupils'. This section considers schools' effectiveness in meeting pupils' needs, and also wider questions about schools' effectiveness in promoting pupils' and staff mental health and well-being.

Schools' effectiveness in meeting pupils' and staff needs

- 8.2 Staff confidence in their schools' effectiveness in supporting pupils was comparable to their confidence in their own skills and knowledge. As graph 8.1 illustrates, around three quarters (74 percent) of all staff surveyed either agreed or strongly agreed they were confident that their school was effective in promoting the mental health and well-being of pupils. It is therefore possible that judgments about their own ability influenced their judgments about the school as a whole.
- 8.3 The evidence suggests that primary schools are more effective than secondary schools at promoting pupils' health and well-being. Confidence amongst primary school staff surveyed with over four out of five (84 percent) agreeing that their school was effective, was higher than confidence amongst secondary school staff where just over three out of five (63 percent) agreed that their school was effective. The results are broadly comparable with Estyn's judgment that: 'nine-in-ten primary schools and three-quarters of secondary schools have several strong aspects to their support for pupils' health and well-being'. 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. Nevertheless, they both suggest that primary schools are more effective than secondary schools at promoting pupils' mental health and well-being. In this context it is worth bearing in mind that Estyn also conclude that: 'around two-thirds of primary schools and a third

of secondary schools in Wales have an inclusive whole-school approach [see boxed text] to supporting pupils' health and well-being.' (Estyn, 2019, p. 8).

Whole School Approaches

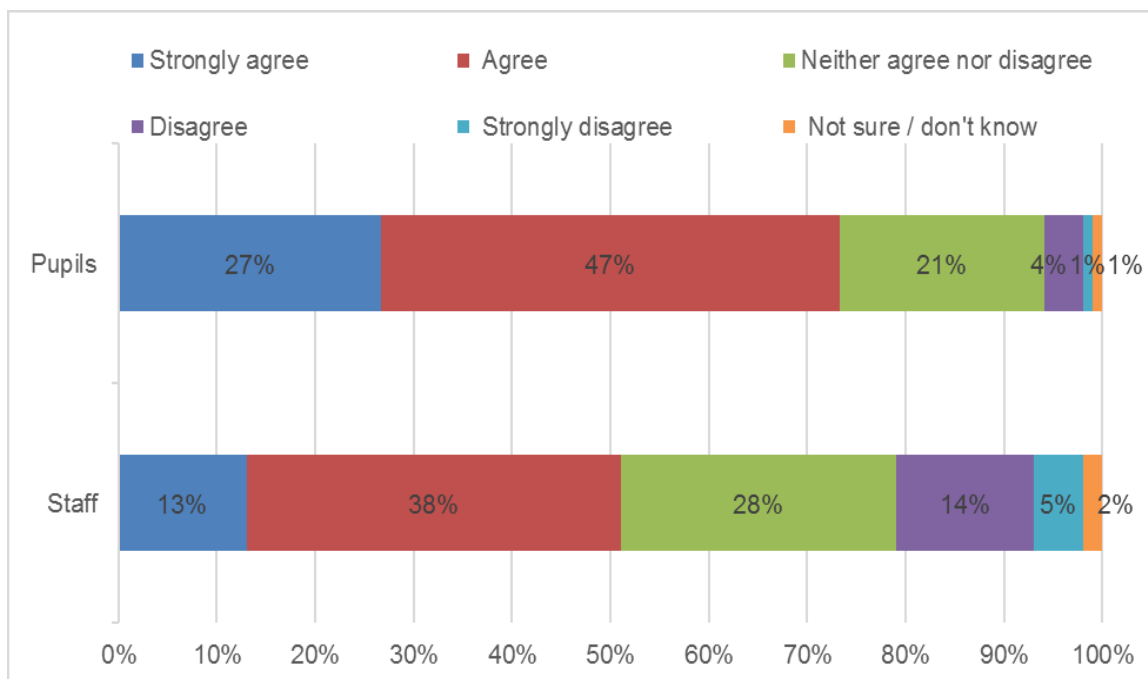
Estyn defines schools with: 'an inclusive whole-school approach to supporting pupils' health and well-being' as having:

- 'policies and practices that ensure pupils make good progress in their learning
- leaders who 'walk the talk' about supporting pupils' health and well-being
- a nurturing culture, where positive relationships enable pupils to thrive
- an inclusive community and ethos
- detailed knowledge about pupils' health and well-being that influences policies and actions and policy
- environment and facilities that promote good health and well-being, such as space to play, socialise and relax at break times
- a broad and balanced curriculum, that includes discrete, evidence-based learning experiences that promote health and well-being
- supportive pastoral care and targeted interventions for pupils that need additional support
- effective links with external agencies
- close partnerships with parents and carers
- continuing professional learning for all staff that enables them to support pupils' health and well-being'.

Adapted from Estyn, 2019

8.4 However, as graph 8.1 also illustrates, staff who were surveyed were markedly less confident that their school was effective in promoting the mental health and well-being of staff (around half (51 percent))⁶⁰ (than they were that their school was effective at promoting pupils' mental health and well-being (around three quarters (74 per cent))).

Graph 8.1 Staff confidence in schools' effectiveness promoting pupils' and school staffs' mental health and well-being



Source: *People and Work, CAMHS In-Reach baseline survey 2019 (n=350 and n= 320)*

Emerging evidence of effectiveness and assessing the likely contribution of the pilots to intended outcomes

8.5 The emerging evidence of the impact of the pilot upon staff skills and confidence is encouraging, and suggests that the pilot will contribute to helping ensure that (as the pilot's theory of change puts it): 'schools are more able to provide for [the] educational needs of their pupils'. However schools' ability to meet pupils' needs, such as their ability to access and mobilise expertise and support within (e.g. from ALN and/or pastoral teams) and beyond the schools (e.g. from specialist services like CAMHS), are areas where the pilot's contribution is likely to be more modest

⁶⁰ On this question, responses from staff in schools in Denbighshire were different to staff in other areas: 47% of staff in Denbighshire agreed or strongly agreed that their school was effective in promoting the mental health and well-being of staff, compared to 60% of staff in other areas. The responses from staff in Denbighshire may therefore be biasing the sample somewhat in relation to this question.

than the impact upon staff skills. More broadly, as the next subsection outlines, ensuring that schools can provide for the educational needs of their pupils may require whole school approaches.

Whole school approaches

- 8.6 As outlined in the introduction, the Welsh Government is committed to developing a whole school approach to promoting pupil well-being and mental health. The pilot programme could make an important contribution to this, but as the report has discussed, the whole school agenda is much broader than the pilot's aims in relation to increasing staff skills and confidence, access to specialist advice and liaison and staff well-being. In particular, the focus (in whole school approaches) upon promoting pupils' well-being and helping prevent mental health difficulties emerging or escalating through, for example, changes to the school's culture (e.g. fostering a safe and calm environment), the curriculum and teaching, and partnerships with the wider community and families, is a whole school responsibility (see e.g. Sterling and Emery, n.d.; Estyn, 2019). Implementing whole school approaches will require more than training and consultation for/with individual staff members, which has generally been the focus of the pilot⁶¹. As outlined in section 3, developing whole school approaches does not feature in the pilot's logic model) and is seen as beyond the pilot programme's capacity; and instead the pilot can be seen as part of a whole approach.

Schools' commitment to mental health and well-being

- 8.7 As the name suggests, whole school approaches require commitment from the whole school. Qualitative research with services highlighted the perceived importance of raising the priority attached to mental health and well-being in some schools. Interviewees from some services reported that there are still schools and teachers that do not see their role as being to promote good mental health; for example, as an interviewee from the youth service described it, in their view:

⁶¹ North Wales's work on whole school approaches stands out as an exception here but, as outlined in section 5, take up of this has been slower than other elements of the training.

'some [teachers] are just 'old school' and think it is not their job to be concerned or people should just 'pull themselves together' as they described it. A lot of teachers want to teach maths not give emotional support'.

8.8 This attitude was generally felt to be declining, but one service reported that in their view almost half of teachers did not see supporting pupils' mental health and well-being as part of their role. It was not clear how they had come to this conclusion and there may have been a degree of hyperbole. Nevertheless, interviewees from services also talked about schools which were 'good' at supporting well-being, and poorer schools which were not felt to be, with some (such as an interviewee from the youth service) saying: 'it is always the same schools you hear about' (where there were concerns about how pupils' health and well-being was understood and supported).

8.9 During the qualitative research (with schools, with a few exceptions, school staff only raised the low priority schools and staff gave to pupils' mental health and well-being, when they reported that in the past, well-being had had a lower priority in their schools (i.e. this was no longer the case now). This is likely to reflect sampling bias, as schools and staff within those schools agreeing to be involved in the evaluation, and also those schools actively engaging with the pilot programme, were more likely to have an interest and commitment to improving pupils' (and staffs') mental health and well-being. The difficulties the pilot programme itself had in engaging all schools in their area also suggests that some schools have not prioritised pupils' mental health and well-being, although it is also important to bear in mind that precisely because some schools have prioritised this area, they have not felt they have needed the pilot's help (and have not therefore engaged). Other factors such as time and resources may also have influenced schools' engagement. By working to engage all schools in each area, the pilot is likely to help raise the priority attached to mental health by schools, but cannot be expected to ensure this in isolation.

9. Conclusions

Pilot implementation and delivery

- 9.1 Qualitative research with stakeholders, a review of project documents and analysis of progress against the pilot programme's logic model indicate that the pilot programme's implementation and delivery has been generally effective. Recruiting highly skilled workers has been critical to the pilot programme's success. Research with schools identified that the quality of the training delivery has been crucial (and in making this point, interviewees often unfavourably contrasted experiences of training delivered by others to that delivered by the pilot programme). The skill and ability of the CAMHS In-Reach practitioner to link (and embed) training with the consultations, following up by linking to real examples, was also very much valued. However, sustaining the quality of work is likely to be a future challenge. As engagement with schools strengthens (which is a success of the pilot programme), the same-sized staffing teams are delivering to, and working with, increasing numbers of schools, which risks diluting impact.
- 9.2 Fidelity to the pilot programme's theory of change has been strong overall. Whilst using the same mechanisms, different areas have emphasised or prioritised different aspects of the pilot model, given differences in context; for example:
- in North Wales, there has been a strong emphasis on promoting staff well-being and upon training, and less around consultation and access to specialist services;
 - in South East Wales, there have been discussions about what the balance between consultation and training should be, with some pushing for an emphasis upon training, and others for more emphasis upon a responsive consultation model and a group-based model of professional learning and support to underpin the training; and
 - in Ceredigion, a strong partnership model has developed for consultation work with secondary schools, together with a three-tiered training model. However, the size and rurality of the area, coupled with limited staff time, have hampered efforts to provide consultations to more than a handful of primary schools.

9.3 Qualitative research highlighted how these differences in emphasis reflect a number of different factors, including:

- differences in context, most notably in terms of access to specialist services and the relative need to prioritise this area;
- differences in the interest and engagement of schools in each area; and
- differences in the skills and strengths of individual CAMHS In-Reach practitioners and capacity of each pilot area's team.

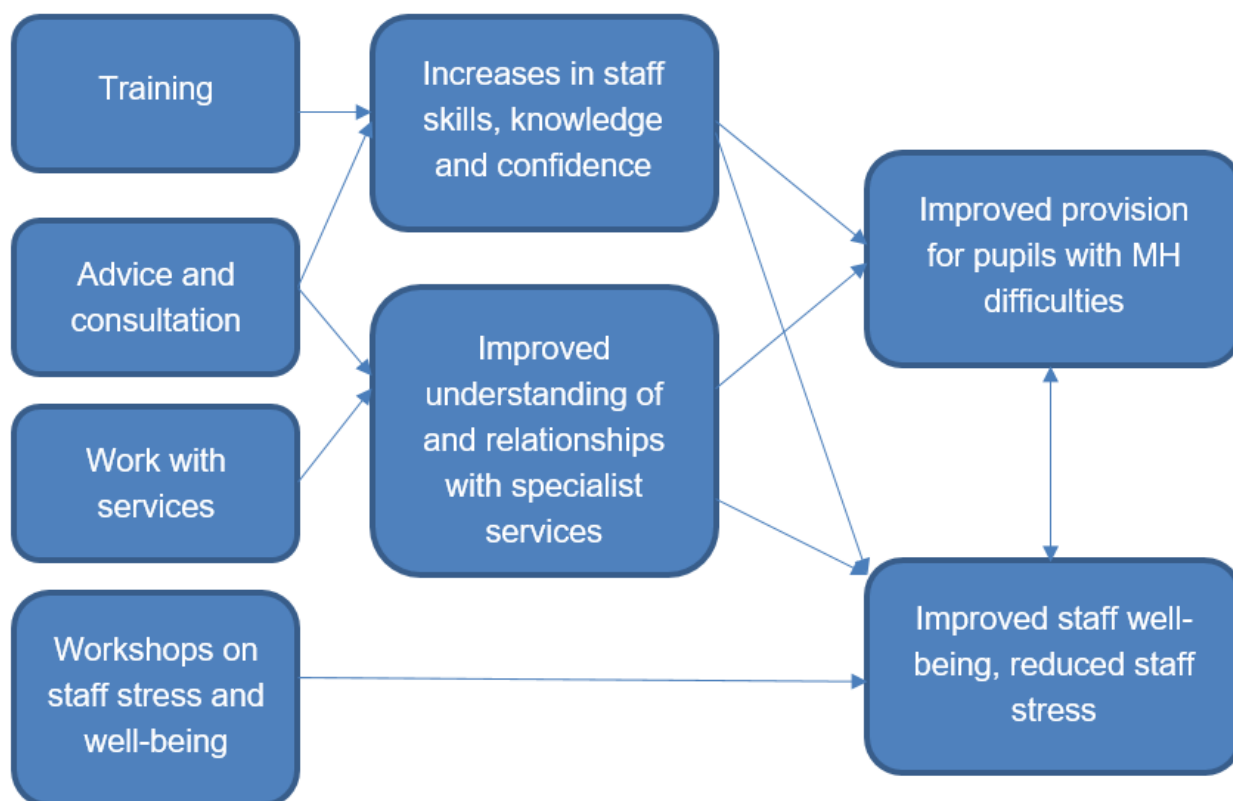
These differences, together with differences in the baseline position in each area, mean that the impact of the pilot programme is likely to be different in each area.

9.4 The evolution of the pilot means, as figure 9.1 illustrates, two key and mutually reinforcing mechanisms for generating change have developed, in which:

- training, advice and consultation increases staff skills, knowledge and confidence;
- advice and consultation and work with services improves relationships with specialist services like CAMHS, even if not necessarily increasing access; and this in turn improves provision for pupils with mental health difficulties, and contributes to improved staff well-being; and
- training in reducing stress and improving well-being, together with increases in staff confidence and improved relationships with specialist services, and improved provision for pupils' mental health, contributes to improvements in staff well-being, which also contributes to improved provision for pupils' mental health.

9.5 These mechanisms are consistent with the pilot programme's theory of change, but were not fully articulated as causal mechanisms in the pilot's original logic model.

Figure 9.1 Pilot mechanisms for generating change



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

9.6 Qualitative research with schools identified that concerns about mental health and well-being were felt to be ‘huge issues’ for schools. The evidence from the survey of staff and interviews with school staff suggests that most are confident in identifying if pupils have mental health difficulties, but overall, staff are much less confident in assessing pupils’ needs or supporting their needs. The generally positive response to the training offered also provides indirect evidence of skill gaps (addressed through the training and consultation). Other research suggests gaps in staff knowledge in areas like childhood development (Estyn, 2019). In their latest report on school impact on pupils’ health and well-being, Estyn reports that:

‘few teachers enter the profession with substantial background training in child or adolescent development, or how best to support children’s health and well-being. Only a minority of staff in schools think that the training or guidance they have

received initially or in-service has helped them to support pupils with their well-being and mental health' (p. 33, *ibid.*).

- 9.7 Although the source for this finding appears to be an online survey (NAFW, 2017) rather than findings from Estyn inspections, and therefore will have some important limitations (as it is drawn from a self-selected and relatively small sample), it highlights similar concerns about staff skills and confidence raised by a number of stakeholders interviewed for this study.
- 9.8 Equally, as section 5 outlines, the current model for assessing, planning and supporting pupils with mental health difficulties means expertise is unevenly distributed across schools and services. When the model works well, this expertise is drawn on as and when it is needed. This means that not all staff are responsible for assessing or planning for pupils with mental health difficulties and consequently, not all staff need the same level of skills, knowledge and expertise in relation to pupils' mental health and well-being. This model also means that the effectiveness of training and consultation depends not only upon the quality and relevance of the training and advice offered by the pilot programme, but also upon schools choosing to engage with the pilot programme, selecting the 'right' staff to be trained (given schools' current model of meeting pupils mental health needs) and being able to release them.
- 9.9 However, shifts to whole school approaches, such as those outlined in section 8, and the greater emphasis upon well-being in the new school curriculum, may mean more staff need skills and knowledge than in the current model. 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 models of training and consultation developed by the pilot, are likely to be needed to meet staff professional learning needs.

The effectiveness of the pilot in facilitating access to specialist support

- 9.10 The evidence gathered so far for this study highlights the ways in which increasing demand for specialist services and cuts in funding, have forced services to ration access through waiting times and higher thresholds. This has left many schools struggling to access specialist support for those pupils who need it.

- 9.11 The pilot programme does not increase the capacity of specialist services, and therefore it can only improve access to specialist services by reducing demand for those specialist services, by, for example:
- helping prevent pupils' mental health difficulties escalating;
 - 'holding onto' and supporting more pupils without recourse to support from specialist services; and
 - ensuring that only those pupils who need assessment and support from specialist services are referred to those services.
- 9.12 The pilot can contribute to each of these by, for example, training and supporting staff, offering direct access to some aspects of the CAMHS offer, through advice and consultations, and by acting as an intermediary or bridge between schools and services, improving communication and mutual understanding. However, unlike the English Mental Health Services and School Links pilot, the CAMHS In-Reach pilot programme has not offered (or provided funding to enable) schools to have direct access to CAMHS. As a consequence, the impact of the CAMHS In-Reach pilot programme upon the capacity of CAMHS and schools' access to specialist services, has been more modest than the pilot programme's impact upon staff skills or confidence, or the English pilot's impact upon schools' access to CAMHS. This raises questions about how the capacity of specialist services like CAMHS can be increased and/or the capacity of schools increased, so that they can 'hold onto' (and continue to work with, rather than refer on) more pupils and deal with more complex mental health difficulties without, or with less, recourse to specialist services.
- 9.13 The pilot's impact upon schools' access to services is also likely to be much greater for secondary schools compared to primary schools. The pilot programme only works with pupils in the final year of primary school (Year 6) and during our interviews, primary schools frequently expressed frustration that the pilot could not work with younger children. Moreover, the pilot has generally prioritised work with secondary schools and has sometimes found it harder to engage and support primary schools.

The effectiveness of the pilot in reducing staff stress and promoting staff well-being

- 9.14 Improving staff well-being and reducing staff stress is important for both staff and pupils, as staff mental health difficulties are a cause for concern in and of themselves and because they are also likely to undermine schools' efforts to address pupils' mental health difficulties and to promote pupil well-being.
- 9.15 The evidence from the survey of staff, interviews with schools and services, and the literature reviewed for this study, all highlight the high levels of stress and low levels of well-being that some staff experience. Staff confidence and difficulties in accessing specialist services, which the pilot seeks to address, contribute to this. However, many of the other causes of high levels of stress and low levels of well-being, such as heavy workloads, accountability regimes and school reforms, are not directly addressed by the pilot. Training and workshops to promote well-being and cope with stress may help mitigate the impact of these factors upon staff, but do not address the root causes.

The case for the pilot

- 9.16 Although it is too early to robustly assess the impact of the pilots, the case for the pilot is strong. Based on the evidence we have gathered and the views of various stakeholders we find that:
- the pilot programme's theory of change is sound;
 - delivery has been good overall;
 - most stakeholders are supportive of both the pilot programme's ambitions and its impact to date; and
 - the emerging evidence (from the pilots themselves, survey of staff and qualitative research) of the pilot programme's impact, upon staff skills and confidence in particular, is encouraging.
- 9.17 However, at this stage, there is less evidence of, and less reason to expect, as big an impact on:
- schools' access to specialist services, as services are often struggling to cope with a gap between demand and capacity (a gap the pilot cannot close); and

- school staff stress and well-being, given the range of factors beyond the pilot's control, that contribute to staff stress and poor well-being.

Potential risks and challenges

- 9.18 The total initial investment in the pilot (£1.4m) was fairly modest relative to the impact on schools. The investment in the pilot provided enough capacity to make a real difference to large numbers of schools. However, as noted above, CAMHS In-Reach practitioners have been stretched given the numbers of schools and staff they work with, the pilots have generally prioritised work with secondary schools over primary schools, and there are risks that the quality and quantity of support for individual schools will be diluted as increasing numbers of schools engage with the programme.
- 9.19 The evidence gathered so far also strongly suggests that, despite widespread support for and praise for the pilot (amongst those who contributed to the study), the pilot programme will not be a panacea for what some see as a 'crisis' in pupils' mental health and well-being. The pilot is not intended nor resourced to do this. This reflects the modest scale of the pilot programme (relative to the size of the challenge) and the factors discussed above are likely to limit its impact in areas such as access to specialist services. However, some members of the pilots have felt as if at times, the programme has been presented as if it is a panacea. It is therefore important to be realistic and pragmatic about what the pilot programme can and should do and what it cannot and/or should not try to do; for example, while the pilot can make an important contribution to the whole school agenda, it is neither resourced nor positioned (given PHW's and LHBs' leadership of the pilot programme) to deliver the cultural and organisational changes required in perhaps a third of primary schools and two thirds of secondary schools (Estyn, 2019). Instead, the pilot programme is better thought of as a potential part of a wider strategy to promote whole school approaches. It will also be important to ensure 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 mental health and well-being.

10. Recommendations for the pilot programme, further research and emerging learning

Recommendations for the pilot programme

Recommendation 1. For the Welsh Government: there is encouraging early evidence of the pilot programme's effectiveness and a robust theory of change, however, the pilot programme's impact is not yet demonstrated. Decisions about the development of the pilot programme, such as its continuation, expansion and/or closure, should be deferred until a more comprehensive assessment of the pilot programme has been undertaken, and its potential contribution to whole school approaches more fully explored. The second round of surveys and interviews with schools and services should provide additional evidence to inform decisions. Although decisions about the development of the pilot programme should not be rushed (and be evidence-based), it will be important to ensure that the pilot programme and other partners are given adequate time to prepare for any future development.

Recommendation 2. For the pilot programme: the professional learning offer to schools should include access to an ongoing programme of training open to all staff in areas where the identification of mental health difficulties might arise; more specialist training for those who need greater expertise, such as ALNCoS/SENCoS and pastoral staff; and responsive and potentially bespoke support and professional learning targeted at specific pupils or issues which could, for example, be delivered through consultations.

Recommendation 3. For the pilot programme: evaluation of the effectiveness of professional learning should consider both the numbers of staff engaged and also their roles and responsibilities in schools; for example, increasing the capacity of pastoral staff to assess pupils' needs, may have a greater impact than increasing the capacity of teachers to assess pupils' needs.

Recommendation 4. For the Welsh Government, RPBs, LHBs, LAs, regional educational consortia and the pilot programme: consideration be given to how the mental health difficulties of primary school age pupils who are not in Year 6 can best be met. Extending the pilot and allowing CAMHS In-Reach practitioners to work with younger pupils, is worth considering. However, the pilot has generally had less engagement with primary schools and any extension risks further stretching the capacity of CAMHS In-Reach practitioners

and potentially diluting the pilot programme's impact. Therefore, it is not clear if extending the age range the pilot works with would be a cost effective option or not.

Recommendation 5. For the pilot programme: the capacity of CAMHS In-Reach teams is carefully monitored to ensure that if, as expected, more schools engage with the pilot programme, the impact of the pilot programme is not unduly diluted and/or staff teams' own workload and well-being compromised.

Recommendations for further research

Recommendation 6. For the pilot programme and the Welsh Government: a comparative evaluation of the content, delivery and impact of the different training and professional learning models developed or adopted by each pilot area should be undertaken, in order to inform and maximise sharing of good practice across the three pilot areas. The scope for developing joint or shared models of professional learning across pilot areas should also be explored.

Recommendation 7. For the pilot programme and the Welsh Government: the perceived relevance, value and impact of training and support around staff stress and well-being should be carefully monitored and evaluated and, if necessary, changes made.

Emerging learning

The evidence collected to date for this evaluation suggests that:

1. The pilot's professional learning offer needs to be planned and delivered as part of a broader professional learning offer to school staff including, for example, that provided through initial teacher education and by regional education improvement services, and other services such as LA Inclusion, EP services and LHBs.
2. The implications for the pilot of both the new school curriculum, and the Joint Ministerial Task Force recommendations on whole school approaches for school staffs' professional learning requirements, should be identified. Whole school approaches may create new roles and responsibilities in relation to promoting and supporting pupils' mental health and well-being and therefore new professional learning requirements for some school staff groups.
3. Action is required to assess the extent to which specialist services such as CAMHS, face a demand-capacity gap, and where needed, action to close that gap. This could

include, for example, additional investment and reconfiguration of services to better meet the needs of children and young people with mental health difficulties.

4. The scope to increase the capacity of schools to meet the needs of pupils with mental health difficulties without or with less recourse to specialist services should be explored. This could include, for example, exploring the cost effectiveness of investing in expertise in ALN/SEN and pastoral teams within schools, and providing these teams with easier access to advice and support from specialists (such as consultations the CAMHS In-Reach pilot practitioners provide), rather than requiring referrals to be made to specialist services. The learning from the pilot programme about the cultural and communication gaps between schools and services, and ways in which they can be bridged, is also likely to be relevant here. More work to improve school staff well-being and reduce staff stress is required. The evidence from this study suggests that action here should be part of whole school approaches to promoting mental health and well-being in schools, but detailed recommendations in this area lie beyond this study's remit.

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Annex A. Copy of Baseline Questionnaire

Evaluation of the CAMHS In-reach to schools pilot programme: baseline questionnaire

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

4. What language medium school do you work in?

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

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

- | | |
|---|---|
| <input type="checkbox"/> Teacher | <input type="checkbox"/> School Leader / member of the senior management team |
| <input type="checkbox"/> Support Staff | <input type="checkbox"/> School nurse |
| <input type="checkbox"/> SENCo or ALNCo | <input type="checkbox"/> School counsellor |
| <input type="checkbox"/> Pastoral lead / team | |
| <input type="checkbox"/> Other (please specify) | |

Evaluation of the CAMHS In-reach to schools pilot programme: baseline questionnaire

Confidence and support

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 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)

- SENCo/ALNCo
- School nurse
- Pastoral lead/team
- CAMHS In-Reach Practitioner
- School counsellor
- Other (please specify)

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

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

Evaluation of the CAMHS In-reach to schools pilot programme: baseline questionnaire

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

Evaluation of the CAMHS In-reach to schools pilot programme: baseline questionnaire

The CAMHS In-reach pilot programme

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

- Yes
- No

Evaluation of the CAMHS In-reach to schools pilot programme: baseline questionnaire

CAMHS In-reach pilot programme

14. I know who the CAMHS In-Reach Practitioner for our school is

- Yes
- No

15. 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? (please select all that apply)

- Yes, through advice
- Yes, through consultation about a pupil
- Yes, by discussing the appropriateness of a referral to a specialist service like CAMHS
- No
- Other (please specify)

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

- Yes
- No

If you have, can you please briefly describe what training you had

Evaluation of the CAMHS In-reach to schools pilot programme: baseline questionnaire

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

Evaluation of the CAMHS In-reach to schools pilot programme: baseline questionnaire

Comments

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