Evaluating the Impact of the Whole School and College Approach

to Mental Health and Wellbeing:

The Development and Pilot of the WSCA Outcome Self-Assessment Tool

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Background

Promoting emotional and mental wellbeing in the school and college years is vital for supporting the longer-term functioning of children and young people (CYP). Evidence suggests that young people who experience emotional problems are at greater risk of long-term negative outcomes, such as poorer educational outcomes, social withdrawal, and poor psychosocial functioning (Clarke & Lovewell, 2021; Johnson et al. 2018; Ogundele, 2018). Schools and colleges are increasingly considered important in promoting mental and wellbeing for CYP, largely due to the amount of time that CYP spend in school and college, but also because the structure of school and college lends itself to the implementation of interventions and provisions due to existing structures (Patalay et al. 2016). There has been a growing body of literature that supports the role of schools in identifying young people who are at risk of mental disorders and providing them with the right support early on (Humphrey & Wigelsworth, 2016). Moreover, the 2017 Green Paper "Transforming Children and Young People's Mental Health Provision" (DfE, 2017) recognised schools as pivotal in a universal approach to mental health and wellbeing, whereby all CYP can access opportunities that promote emotional wellbeing and those at risk of significant mental health difficulties and distress can be identified early on and receive timely support.

One of the aims of the Green Paper was to focus support in local areas and schools, notably by increasing mental health leadership and infrastructure through recruiting and training staff to undertake the role of Senior Mental Health Leads in schools, so that schools can have a designated staff member to coordinate this work. This complemented the introduction of Mental Health Support Teams (MHSTs) to work with schools. These MHSTs are involved in three core functions:

- the delivery of evidence-based interventions for mild to moderate mental health issues;
- supporting the implementation of a whole school and college approach to mental health and wellbeing; and
- offering advice to schools and liaise with external specialist services to signpost CYP to the appropriate support.

These teams were introduced in 2018 with the selection of 25 'Trailblazer' sites, with subsequent waves rolling out across the country in the years since then, with 35% coverage of children and young people achieved by 2023.

For the purposes of this paper, we will be focusing on the second function of the MHSTs: the Whole School and College Approach (WSCA) to mental health and wellbeing. This is a coordinated and committed approach across an educational setting to provide universal promotion of wellbeing, identify emotional and mental health difficulties early on and provide timely support to CYP. Public Health England (2021) outlined eight key principles to this work:

- an ethos and environment that promotes respect and values diversity;
- leadership and management;

- curriculum, teaching and learning;
- enabling student voice;
- staff development to support their own wellbeing and that of students;
- identifying need and monitoring impact of interventions;
- working with parents/carers; and
- targeted support and referral.

All of these components work together with the aim of embedding positive social and emotional development into daily school practices (Goldberg et al., 2019), thereby contributing to the development of a positive culture where everyone feels welcome. Given that the WSCA is complex and involves multiple components, it requires commitment from all staff and is an ongoing iterative process. Evaluation of this approach is therefore crucial to understand where changes in school's approaches to wellbeing are benefitting the students, and specifically to ensure that the needs of the CYP and families are being identified and addressed by the WSCA. It is recommended good practice to regularly evaluate whether the approaches are making an impact and review interventions so that it can inform planning and next steps (Anna Freud, nd[1]).

There are existing examples of measures for pupil wellbeing and WSCA activities. For example, Anna Freud have developed a wellbeing measurement framework for schools and colleges, which includes a suite of validated questionnaires for pupils that assess concepts such as positive wellbeing, resilience, emotional difficulties, and perceptions of mental health support (Anna Freud, nd[2]). Numerous providers also offer digital frameworks for administering surveys on the topic and for recording, tracking, and analysing data from those surveys. However, despite these efforts, there is evidence to suggest that there is a lack of or inconsistencies in the evaluation of the impact of the WSCA. For example, exploration of this in Wales suggests there are barriers to measuring WSCA work, such as a lack of long-term follow-up data and the different timescales of implementation across schools (Brown et al., 2023). In that particular study, the impact measures were only completed by pupils and not staff, and thus only incorporated one perspective in the school context. It has also been found that there is a wide variation in evaluation approaches being used and, in many cases, impacts on different aspects of the WSCA such as school ethos, leadership, and teaching and learning practices have not been consistently addressed (see Wignall et al., 2022).

Recently, we undertook a Best Practice Review and Evaluation of the WSCA in the East and South East of England (Procter et al., 2021), which incorporated:

- a literature review concerning the way in which WSCA was linked with emotional wellbeing and mental health;
- a process mapping of the ways in which the WSCA was developed and rolled out by MHSTs in the selected regions;
- a programme of work to gather pupil voices to help us understand how the WSCA could link with children's practical help-seeking;
- self-assessments from MHSTs and schools of the WSCA activities being implemented; and

- in-depth interviews with school and MHST staff about this work.

Our Best Practice Review highlighted numerous dimensions of effective implementation, and identified key factors that appeared to be contributing to these. These have been presented in Procter et al.'s (2021) publicly-available report, which has received considerable attention. Importantly, the work also highlighted a number of limitations that MHSTs and educational settings felt were holding back progress. One of the key concerns was that measurement of impact of WSCA was seen as tenuous, with priority being given to the evaluations of the one-to-one interventions, rather than assessing and tracking the outcomes associated with WSCA. This view was also supported by a recent national evaluation of MHSTs (Ellins et al. 2023). This was highlighted as problematic in that a limited measurement of this area could lead to a limited prioritisation of WSCA activities. As a result of these findings, and in line with previous work, a key recommendation from that review was to initiate a programme of work to develop and pilot an outcomes toolkit to encourage the systematic collection of evidence from the WSCA at multiple time points, with a standardised protocol that schools can adopt, drawing upon the input of multiple informants.

The exploration of the WSCA and insights from staff highlight the need for standardised methodology to evaluate work in this area. Ideally, this would be built into school development plans to support both implementation and measurement of impact. Evaluation of the work would provide MHSTs with an opportunity to showcase their WSCA work and report on its effectiveness, alongside the work with individual pupils. This need has also been identified by both local and national teams.

In light of current practice, the limited evidence, the challenges of consistency of approach, and key recommendations concerning the need of a WSCA outcome measure, this project had two key aims: (1) to work in partnership with staff and pupils to develop a standardised impact outcome tool, using pupil and education and MHST staff input; and (2) to pilot this tool with a sample of schools and gain feedback on its feasibility and acceptability. In this paper we will outline the two key phases of the project, in line with these aims. Phase 1 includes the development of the tool, whereby staff and pupil voice activities were completed in schools in the South and South East of England. Phase 2 outlines the pilot process, whereby schools from South, South East of England and North East and Yorkshire trialled and provided feedback on the tool.

Phase 1: Development of the WSCA Outcome Self-Assessment Tool

The aim of Phase 1 was to develop an outcome tool to be used by schools and MHSTs, using pupil and staff input. Our aim was to gather information from pupils and staff on what was important in relation to mental health and wellbeing in schools, namely the key indicators of positive change and impact and what this would look like in their school community context. We also wanted to assess pupil and staff views on the different kinds of approaches that could be taken to gathering information relating to mental health and wellbeing within the school community. The underlying goal of the outcomes tool that was developed as a result of this work was to provide schools and colleges with a way of self-assessing how effective their approaches are, considering both the nature and strength of evidence they are using. This encourages a deeper understanding of how changes are being made in their setting, beyond simply measuring and recording a range of activities without considering how effective they truly are.

Methodology

The process for engaging MHSTs and schools in our project took place between January and February 2023. The research team used existing communication channels and local MHST networks to connect with MHSTs in the South and South-East of England. Those who expressed interest reached out to MHST schools in their local area and asked consent to participate in the development project. If consent was gained, MHST leads communicated this to the research team and volunteered for participation on behalf of schools. Consent was gained from a member of senior management within each school to participate.

We invited schools to run our pupil voice activity with Years 4 or 5 (8-10 years old) in primary schools and Years 7 or 8 (11-13 years old) in secondary schools, minimising disruption to other year groups who we knew were likely to be taking part in key assessment activities at the time of data collection. The participants included 138 primary school pupils and 90 secondary school pupils, from five primary and five secondary schools. With regard to the staff voice activity, we asked for input from a small-cross section of staff in each educational setting (approx. 4-6 members, ideally including the Senior Mental Health Lead, other wellbeing specialists, teaching staff, and support staff). We received a summary of key points from the staff voice discussions in six primary and four secondary schools, drawing upon the contributions of 29 and 17 staff members respectively in these settings. Participants represented six different local areas in the South and South East of England.

Pupil Voice and Staff Voice Activities

The materials for our pupil voice and staff voice activities were shared to the participating MHST leads to be distributed to the schools. This included an information pack for each activity with a school consent form contained within it. To maximize the input from pupils and staff and reduce the time burden on schools, two activities were devised that could be self-

completed by participants in a group setting. The pupil voice activity included a 20-45-minute class-based session and the staff voice activity was a structured 30-40-minute informal group discussion.

Pupil voice. In line with previous work (Procter et al, 2021) and best practice guidance (PSHE Association, 2021) a simple class-based activity was developed to gain the views of children and young people on how they are currently asked for views on their wellbeing. This was considered important to inform not only the content of the outcomes tool, but also how that information would be presented to pupils and collected.

For example, we know that common current practice includes the use of both written and computer-based surveys, as promoted in the Anna Freud framework among others. However, we also know that children and young people who may have additional needs or be neurodivergent for example, may find some of these methods challenging. This can result in the views and experiences of these groups being poorly collated and represented, meaning pupils who could benefit most from whole school and college approaches are not supported to have their voice heard effectively (Ford et al., 2021).

With this evidence and practice in mind, a more interactive body map activity was devised, based on the success of this approach previously (Procter et al, 2021), incorporating distancing techniques to help encourage a safe environment to discuss issues and potentially personal experiences around topics like mental health (PSHE Association, 2021). As part of this, pupils were asked not about their own personal experiences in a direct way, but rather through a fictional classmate to create that distance in discussions. This meant they could apply their own experiences to this case study, rather than discussing or sharing their own experiences directly. In small groups, pupils were asked to discuss and share feedback on:

- how their setting currently asks pupils about their mental health and wellbeing, and how well that works;
- what things about their setting's current approach may make them feel a little nervous or uneasy, and also what things help them feel more relaxed;
- suggestions for things which would help them feel more 'heard' in their setting; and
- if time permitted, more direct feedback on specific methods of data collection, including surveys, creative activities, tools such as worry boxes, and group discussion

The discussion activity was designed to be run for around 30 minutes, to help minimise time commitment and disruption to settings, and to make it easier to fit into current school structures (e.g., tutor times in secondary school where PSHE is often delivered). Each PowerPoint file contained extensive teacher notes to help direct the activity, with contact details for the project team provided if there were any specific queries.

Staff voice. The staff voice activity consisted of a group discussion of key questions presented on an accompanying PowerPoint presentation. One member of the group was asked to participate as a scribe and note down the discussions on the Staff Voice Response Template provided. The key questions to discuss were split into the following categories:

1. questions surrounding current approaches;
2. the impact of mental health work using a whole school and college approach;
3. how to access pupil views on mental health at school;
4. feedback on the use of surveys; and
5. any other comments from the discussion.

Schools were asked to take photographs of the pupil voice activity outputs for analysis by the project team. They were also asked to summarise the key points from the staff voice discussions on the templates and return this to their MHST lead. The MHSTs then anonymised the outputs by removing any identifiable information and returned them via email to the research team for analysis.

Findings

Pupil Voice

The pupils produced a large set of qualitative data, which was reviewed with an inductive and deductive approach. The following summary highlights key points emerging from the data for primary and secondary school aged children.

<u>Primary schools</u>

1. How does your school currently ask about your wellbeing?

Primary school responses tended to focus on more positive practices. Worry boxes were very popular with pupils – these are boxes placed in prominent places in classrooms or corridors where pupils can anonymously give feedback, offload their worries, or ask for support. They are sometimes physical boxes, but were sometimes reported to be characters like worry monsters that 'eat' their concerns.

2. What makes you nervous when asked about your wellbeing?

A common issue here was being asked to talk in front of the class. Pupils also returned to the role of wider friendships – with a lack of friends or peers being unkind contributing to feelings of nervousness within school. Bullying was also a common theme, and while this may not relate specifically to how pupils are being asked about their wellbeing *per se*, this strongly focused on how pupils are feeling generally, with multiple groups reporting this.

3. What makes you relaxed when asked about your wellbeing?

Pupils reported being asked open and supportive questions, with one group referring to a Disney film to explain this.

> *"Use the Baymax phrase 'How can I assist you?'"*

This reflects a positive school ethos in terms of pupils being given opportunity to give general feedback and help-seeking behaviours, as promoted by whole school and college approaches.

4. Things that would make you feel heard

In this question pupils expressed a range of suggestions ranging from general issues like increased break time to give them space to relieve worries, being able to talk to a teacher or worry monsters, to more specific comments such as:

> *"asking us about our passions and then help us to express it, ask some children but miss out on others needs to be everyone"*

As above, this can be seen as a positive outcome of a school adopting a whole school and college approach to mental health and wellbeing.

<u>Secondary schools</u>

1. How does your school currently ask about your wellbeing?

Unlike primary schools, secondary school pupils tended to focus on more unhelpful practices. Talking to teachers was a common positive tool, but where pupils talked about personal experiences this was more focused on the roles of specific staff within a school supporting wellbeing needs:

> *"You can ask teachers but they are not as good as wellbeing teachers. The people with passes can sort out problems while you just will become worse"*

2. What makes you nervous when asked about your wellbeing?

There was a lot of congruence across all groups and schools on the role of school staff in this question:

> *"They just automatically assume they know what you need and what's wrong, without letting you finish or talk and sometimes you just want to talk"*

Some pupils reported lack of patience and trust from teachers, which made it harder to be heard or access support. This also aligns with concerns about meeting new people and new teachers. Issues with lack of understanding was also reported, both around wellbeing issues and also with general school work. More specific feedback on how pupils were asked about their own wellbeing was also interesting:

> *"Hands up (embarrassing), survey on computer might not be accessible, too big/small group"*

These comments indicate a need for well-trained and supported staff who feel able to respond to student concerns in a safe way. It also points to the role of staff wellbeing and workload being a central element to this – with overwhelmed and unsupported staff more likely to demonstrate negative behaviours reported by pupils like being shouted at or dismissed

3. What makes you relaxed when asked about your wellbeing?

For secondary schools, this question was associated more strongly with fostering peer relationships, with staff relationships needing to be softened or "less strict" or "smiling at you".

This chimes with our previous work (Procter et al, 2021) where peer relationships were perceived as more prominent in relation to wellbeing support by secondary aged pupils, and adult relationships more prominent in responses from primary aged pupils. Despite this distinction it is important to recognise where these experiences will crossover according to the individual needs and experiences of each pupil.

4. Things that would make you feel heard

Pupils expressed a variety of suggestions ranging from knowing who can help, and use of buddy systems, to specific pressures felt around homework. While some of these may reflect wider issues within school rather than specifically how they can feel heard, there are also common issues around the school environment such as listening to music and having more quiet spots around the school. This section is therefore strongly associated with the *ethos and environment* section of the WSCA.

Staff Voice

Staff from both primary and secondary school responded to the request to contribute to the development of the impact measures. Their views on how they would know that that the WSCA was working effectively, what approaches could be adopted and how to successfully systemically gathered this data was captured. The staff provided a wealth of qualitative data which was reviewed undertaking both a deductive and inductive approach.

With regard to indicators of wellbeing, the participating staff members thought that evidence of the WSCA to wellbeing would be observed if the young people were actively seeking out adults within the school for support, and also if attendance record of pupils improved. It was felt that support for pupils could come from academic, pastoral or other staff in the school system, e.g., dinner personnel. Staff also commented that positive changes would be witnessed in terms of how the pupils interacted with one another, for example, having more positive interpersonal connections and fewer disruptive incidents.

The staff considered it important that multiple perspectives were gathered to help understand whether the impact of any changes were embedded within the entire school. There was a view that the perspectives of school staff leads for health and wellbeing needed to be sought, but also that it would be important to gather views from all staff members, including Learning Support Assistants, as well as from parents and carers.

Staff across both primary and secondary schools identified the challenge of capturing the data. They recognised that if they wished to gain a comprehensive understanding of the impact then surveys were likely to be helpful, but they emphasised that these would need to be easily understood and be of a reasonable length. There was also a concern about how the young people may present themselves in surveys, as their subjective responses were sometimes observed to be unconnected to their behaviour. Each method of survey delivery had benefits and costs: it was felt that paper copies provided better access to all but were harder to collate, whilst online surveys were felt to be easier to collate but not as accessible. An

alternative approach offered was the use of group discussions, as these experiences offered opportunities to hear the various points of view. Other barriers reported were time constraints within the timetable, and the additional extracurricular activities this data gathering would have to compete with. It was also noted that pupils could be hesitant to share their experiences, and that parents and carer surveys typically yielded lower response rates, resulting in a more constrained perspective of the impact of any changes. Finally, and importantly, it was noted that many schools (or clusters of schools within local authorities and/or multi-academy trusts) already had existing practices for gathering pupil and staff perspectives on mental health.

Translation of key themes into the WSCA Outcome Self-Assessment Tool

The insights arising from the pupil and staff voice activities were analysed and discussed across a number of working groups consisting of multi-disciplinary teams (including professionals from education settings, Child and Adolescent Mental Health services and researchers in the field).

Based on the input from pupils and staff, it was decided that, rather than mandating a specific pupil or staff survey of wellbeing, we would take a different approach whereby schools would be able to more holistically look at the full range of indicators available to them and self-assess their settings against 12 key criteria that were generated based on the pupil and staff voice input as important for tracking the impact of the WSCA. The purpose of this WSCA Outcome Self-Assessment Tool is to enable reflection from the educational settings on the impact of the WSCA on pupil and staff emotional wellbeing. The 12 criteria are listed below:

1. Early identification of mental health difficulties

This category highlights how the WSCA has provided strategies to quickly and effectively identify pupils in need of support for mental health difficulties.

2. Effective intervention for mental health difficulties

This category outlines how and to what extent, having identified pupils in need, schools provide effective and timely support for mental health difficulties for those who need it.

3. Pupil help-seeking

This category includes how educational settings ensure pupils have access to and an ability to access support if they need it. Pupils should feel confident and willing to seek help and the resources should be provided for them to do so.

4. Pupil relationships with peers: Social inclusion

This category encourages a reflection on how educational settings ensure pupils feel included in the school environment and have a sense of belonging. This includes how pupils interact with one another in the school environment.

5. Pupil relationships with peers: Bullying

This category asks settings to reflect on prevalence of bullying and the context that surrounds these incidents.

6. Pupil relationships with staff

This category encourages reflection on the relationships between pupils and staff, particularly whether pupils feel safe, supported, and listened to by all staff members.

7. Pupil wellbeing and mental health: Social behaviour

This category reflects the first of two sections around pupil wellbeing and mental health. It encourages settings to assess distressed and dysregulated behaviours, as well as the extent to which pupils display positive, well-regulated, and socially adaptive behaviours

8. Pupil wellbeing and mental health: Emotional functioning

The second section on pupil wellbeing and mental health includes emotional functioning. This involves consideration of how the pupil population exhibits different levels of emotional wellbeing.

9. Pupil participation and engagement in school community

Another key element includes the level of pupil engagement and participation in the school community. This relates to how effective the setting is in cultivating pupil participation at school, and in ensuring that pupils feel heard, involved, and empowered in relation to the issues that concern them.

10. Staff confidence in addressing pupil mental health

This category reflects the confidence of all members of staff in the educational setting in addressing pupil mental health and supporting pupil wellbeing. Where strategies are in place to support and guide staff with this, settings may be expecting to see improved outcomes in terms of the confidence of their staff members.

11. Staff wellbeing

In addition to the previous category, we have also included a category to ensure there are systems in place to support staff members' own levels of wellbeing, by addressing individual needs, assessing how these are accessed by all members of staff.

12. Partnership with parents in wellbeing at school

Finally, the setting is also to reflect on the level of participation of parents and carers in the strategies used to promote wellbeing and address mental health issues within the school community.

Appendix A provides the list of items and response options.

The 12 criteria were developed based on the input from the staff and pupils, whilst also factoring in the eight core elements of the WSCA from Public Health England. For each outcome dimension, educational settings are able to rate themselves on a scale of 0 (little or no positive indicator) to 3 (the strongest indicator of positive outcomes), with qualitative descriptions of each point on the scale. Additionally, for each of these Outcome Ratings, schools are asked to provide a rating for the strength of the evidence used to make the judgement. This Evidence Rating ranged from 1 (only very limited evidence) to 3 (strong evidence is provided), again with a qualitative description for each point on the scale. Therefore, once the tool is complete, each criterion had an overall rating made up by multiplying the scores from the relevant Outcome Rating and associated Evidence Rating.

The research team developed iterations of the tool, with input from the data from Phase 1 and the Best Practice Review of the WSCA. Iterations of the tool were also reviewed by MHST, NHSE and DfE colleagues. The project team aimed to marry up what was drawn from the pupil and staff data with existing concepts and ideas, such as the Public Health England wheel. There was commitment to developing a tool that could be easily and digitally accessed as well as the need to use strength-based, non-pathologising language. The tool was brought to the project steering group for final sign-off. The steering group included colleagues from MHSTs in the South and South East of England, NHS England and Department for Education.

Phase 2: Pilot of the WSCA Outcome Self-Assessment Tool

The aim of this phase of work was to pilot the WSCA Outcome Self-Assessment Tool that we had developed in Phase 1 in a selection of educational settings (covering both primary and secondary phases), and to gather feedback on the usability and feasibility of the self-assessment approach. We also aimed to provide preliminary empirical data on links between schools' implementation of WSCA activities and their observation of outcomes that could be linked to these.

Methodology

We worked with school staff and MHSTs in the South, South East of England and North East and Yorkshire. MHSTs are in place to deliver evidence-based interventions, support the Senior Mental Health Lead (SMHL), and give advice to school staff. We therefore invited MHSTs to take part in our pilot, and to pass on the self-assessment tools to their respective schools for testing. The final sample for the pilot work consisted of 26 schools, from seven MHSTs. The appropriate staff leads in each school were invited to completed measures that were intended to evaluate the implementation and impact of the WSCA:

Outcome Self-Assessment Tool (OSAT). This is the self-assessment questionnaire that was developed using the input from the pupil and staff voice activities in Phase 1, as described above. Local settings rated the 12 outcome dimensions from 0 (little or no positive indicator) to 3 (the strongest indicator of positive outcomes). The ratings were made in an Excel spreadsheet provided for this purpose.

Implementation Self-Assessment Tool (ISAT). We also invited each setting to complete a self-assessment of WSCA implementation, using the questionnaire developed in our previous Best Practice Review (Procter et al., 2021). Local settings rated the 17 implementation dimensions from 0 (little or no whole-school work in that area) to 3 (the most embedded and integrated approach to whole-school work). The ratings were made in an Excel spreadsheet provided for this purpose.

Feedback survey. An online survey was distributed with the aim of gaining additional feedback on the acceptability and feasibility of using the OSAT in the school context. The survey contained multiple-choice, rating-scale, and open-ended questions relating to the experience of completing the tool, the 12 criteria, the response options for the ratings, the self-assessment of evidence quality, and any other general feedback. A list of the questions can be found in Appendix B.

Procedure

The pilot took place in July 2023. The current study gained ethical approval from the Cross-School Sciences and Technology Research Ethics Committee of the University of Sussex, reference ER/ROBINB/34. The pilot package included the WSCA Outcome Self-Assessment Tool, the WSCA Implementation Self-Assessment Tool, guidance on completing the tools, and a link to the feedback survey. The pilot package was sent to MHSTs, who were invited to send this out to the schools in their networks and local areas. Self-assessments were then completed by schools using the Excel spreadsheets, and these were sent back to the MHST colleagues, who were asked to remove any information that could identify a person or school. The anonymised self-assessments were then returned to the researchers via email and stored on a secure network drive.

Planned data analysis

With regard to the outcome and implementation tools, we conducted three stages of quantitative analysis. First, we calculated descriptive statistics for the Outcome and Implementation scores, including the means and standard deviations for each Implementation dimension and Outcome criterion. Next, we explored these scores by assessing whether internally consistent total scores could be derived from the self-assessment tools, and by looking at the relationships between these. In particular, we assessed the correlations between the overall level of WSCA Implementation and WSCA Outcomes (both when weighted and when unweighted by Evidence). We then provided a preliminary regression analysis of which Implementation dimensions were most strongly predictive of each Outcome criterion, using the Forward method for entering variables given the very limited statistical power within this pilot work. Finally, the responses from each item on the feedback survey were collated. We report the frequencies and percentages of responses for each item and summarise qualitative responses to free text questions.

Findings

Overall, 7 MHSTs and 26 schools completed the WSCA OSAT, with 19 of those also completing the WSCA ISAT. A further breakdown of schools is provided in Table 1.

Table 1: Outcome and Implementation measure responses by region and type of school

	Type of School		
	Junior	Primary	Secondary
Mid and South Essex	0	8	4
West Sussex	2	3	2
Kent and Medway	0	1	1
Reading	0	1	0
Bradford and Craven	0	2	0
Basingstoke	0	1	0
Cambridge	0	1	0

Outcome and Implementation tool

The project team first conducted a descriptive analysis on the scores provided for the outcome and implementation tool.

When looking at the Outcome Ratings on their own, we see quite a spread of mean scores from 1.56 (*SD* = .71; staff confidence) to 2.56 (*SD* = .58; pupil relationships with staff), as shown in Table 2. When staff used the Evidence Ratings to report on the perceived quality of evidence for arriving at each outcome criterion judgement, there was less of a spread, with most of the means falling closer to the midpoint of 2.

Table 2: Mean scores for the WSCA Outcomes Self-Assessment Tool

	Outcome (possible range 0-3)		Evidence (possible range 1-3)		Outcome x Evidence (possible range 0-9)	
	Mean	SD	Mean	SD	Mean	SD
Pupil relationships with staff	2.56	.58	2.25	.68	5.81	2.64
Antibullying	2.33	.70	2.16	.83	5.33	3.03
Pupil participation	2.00	.65	2.19	.66	4.50	2.31
Pupil help-seeking	1.96	.75	1.94	.54	4.17	2.09
Effective intervention	1.96	.71	2.00	.61	4.18	2.07
Social inclusion	1.88	.83	2.06	.80	3.72	2.30
Early identification	1.88	.67	2.21	.71	4.26	2.38
Emotional functioning	1.80	.65	2.11	.58	3.78	1.59
Social behaviour	1.70	.93	2.11	.58	3.59	2.45
Staff wellbeing	1.68	.75	1.94	.68	3.50	2.31
Parent engagement	1.58	.58	1.89	.76	3.24	1.99
Staff confidence	1.56	.71	1.78	.65	2.94	2.26

Note: Ns range from 23 to 25 schools for Outcome Ratings, and 16 to 18 schools for Evidence Ratings and Outcome x Evidence Ratings

The WSCA ISAT ratings show a large spread of scores, broadly consistent with findings reported in our previous Best Practice Review (Procter et al., 2021). The lowest rated dimension was governor engagement, and activities around staff wellbeing were also among the lowest scores. The highest rated implementation dimensions were senior leadership and ethos.

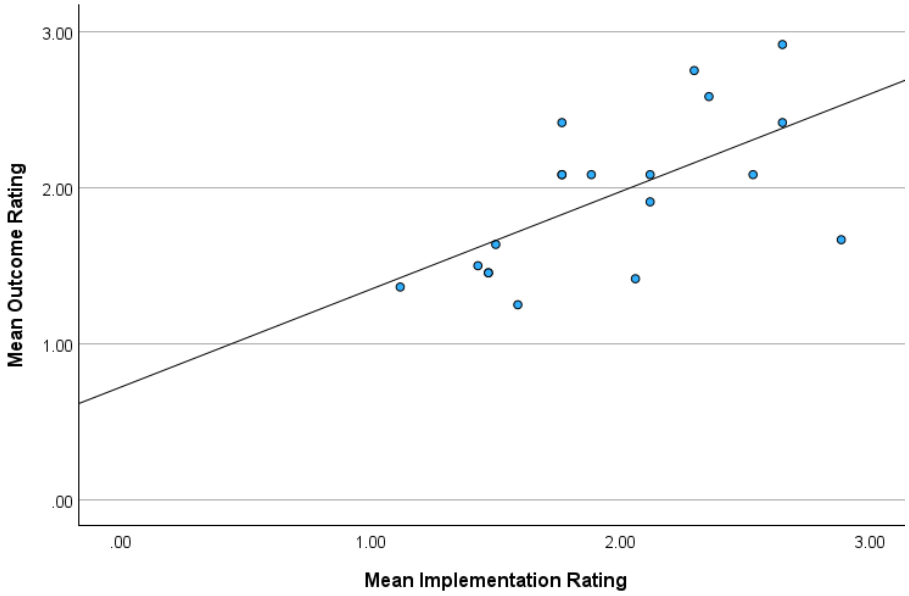
Table 3: Mean scores for the implementation measure

	Mean	SD
Senior leadership	2.53	.77
Ethos	2.45	.76
Universal mental health work	2.40	.60
Targeted mental health work	2.35	.75
Staff engagement	2.25	.72
Integration with other approaches	2.21	.79
Delegation	2.20	.77
Staff development	2.00	1.00
Parent engagement	2.00	.65
Integration with other services	1.85	.99
Governance and leadership of MHST	1.85	1.09
Student voice	1.84	.69
Use of data	1.80	.70
Data collection	1.80	.70
Integration with curriculum	1.80	.77
Staff wellbeing	1.75	.97
Governor engagement	1.25	.55

Note: Ns range from 19 to 20 schools

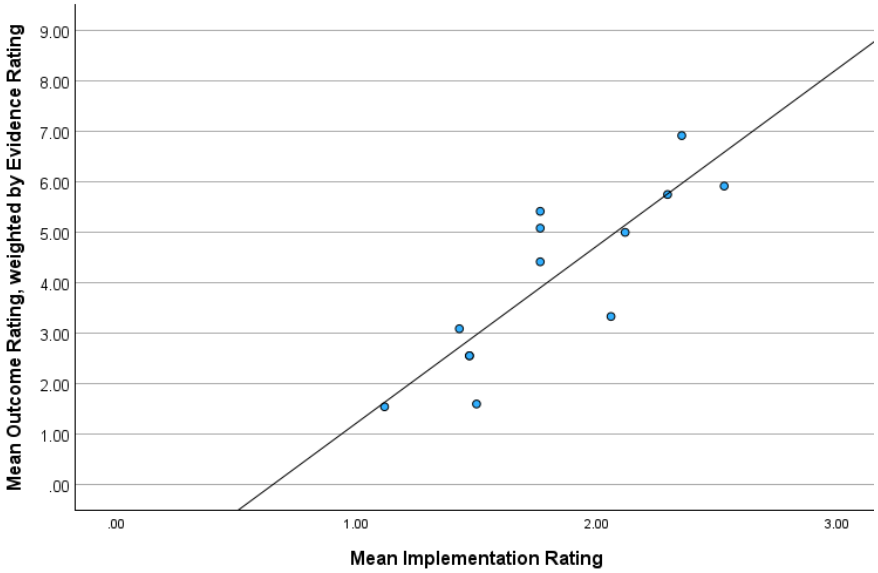
We computed total scores across implementation dimensions and across outcome criteria, by taking the mean across all items for each educational setting. This was supported by analysis of internal consistency, which showed excellent reliability (α = .89 for unweighted Outcome Ratings, .86 for Outcome Ratings weighted by Evidence Ratings, and .91 for Implementation Ratings). Across the 19 schools with calculated total scores, there was a strong positive relationship between implementation and outcomes, r (17) = .62, p = .005, see Figure 1.

Figure 1: Association between Implementation Ratings and Outcome Ratings



As shown in Figure 2, when outcome measures are weighted by the perceived quality of evidence available, the relation was even stronger, r (11) = .85, p < .001. It should be noted that this relationship remained just as strong even when we removed the Implementation dimensions relating to data collection and use of data from the total score for Implementation, r (11) = .87, p < .001.

Figure 2: Association between Implementation Ratings and Outcome Ratings weighted by Evidence Ratings



We next conducted a regression analysis for each individual Outcome Rating, with the various Implementation Ratings included as predictors. It should be noted that because we have a very small sample of schools, the statistical power is extremely limited. However, given the strength of evidence of associations shown above, we expected large effect sizes on at least some variables. Therefore, we undertook the regression analyses using the Forward method, and thereby identified the most significant Implementation predictor for each Outcome criterion. Table 4 shows the Implementation dimensions that mostly significantly predicted each Outcome criterion (using the Outcome Ratings weighted by Evidence Rating).

Table 4: The most significant Implementation predictors for each Outcome criterion

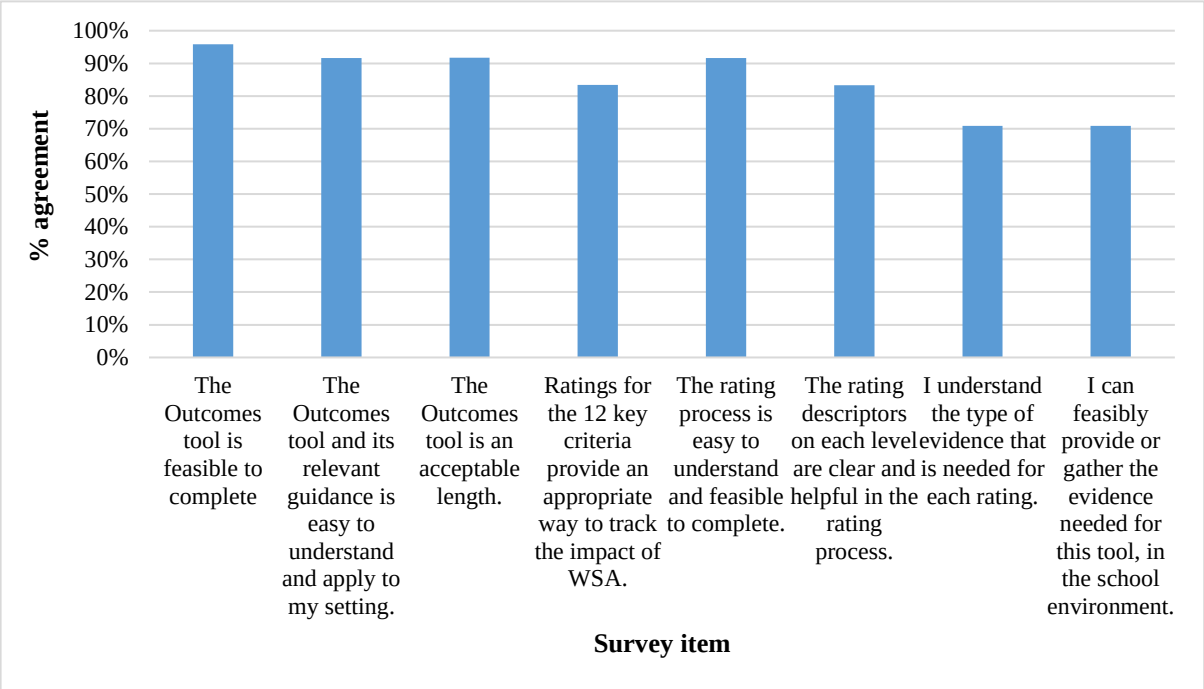
Outcome Rating (weighted by Evidence Rating)	**Implementation Rating** (significant predictors)	**Standardised beta**
Early identification	Governance and leadership of MHST	.70**
Effective intervention	Governance and leadership of MHST	.81**
Pupil help-seeking	Delegation across all staff	.66*
Social inclusion	Delegation across all staff	.66*
Antibullying	Delegation across all staff	.85***
Pupil relationships with staff	Integration of WSCA with other approaches	.71*
Social behaviour	Delegation across all staff	.90***
Emotional functioning	Ethos	.82**
Pupil participation	Student voice	.63*
Staff confidence	Staff development	.72*
Staff wellbeing	Integration of WSCA with curriculum	.75*
Parent/carer engagement	Integration of WSCA with other approaches	.78**

* $p < .05$ ** $p < .01$ *** $p < .001$

Feedback survey

Here we report on the findings from the feedback survey, which relate to the WSCA OSAT only. Eight of the items in the feedback survey asked respondents to indicate their level of agreement with statements relating to the acceptability and feasibility of aspects of the outcome tool. The percentages of those in agreement with the statements for these items are shown in Figure 3.

Figure 3: A bar chart to show respondents agreement with feasibility statements



Results from these items indicate that respondents largely agreed the tool was acceptable and feasible to complete in the school environment, as shown by the agreement exceeding 80% on these items. However, the aspect of the tool which showed lower agreement relates to the evidence needed for the tool. Respondents indicated that it was less clear what evidence was needed for each rating and that it was not as feasible to gather this evidence in the school environment, shown by the agreement rate of just above 70%.

The other items were either dichotomous or open ended and asked the respondent to enter free text to expand on their answers. When asked if they had any problems with the tool, only four respondents raised issues. These respondents indicated that the tool was not visually appealing, highlighted that the ratings were not "clearly progressive" and the statements which accompanied these ratings were "too loose" and indicated they were subjective:

"What I might judge as a three could be very different to someone else."

With regard to the criteria, two respondents indicated that the criteria were confusing or unsuitable (based on a response to a dichotomous yes/no question). When asked which criteria were unsuitable, they selected the pupil help-seeking, bullying, pupil relationships with staff and emotional functioning criteria from a drop-down list. Furthermore, when we asked respondents if they believe there were criteria they wanted to see in the tool, four respondents said yes. Only one respondent went on to elaborate on what they would like to see and stated *"collaborative working with outside agencies/support".*

Finally, we asked for more general feedback. One respondent indicated that a *"digital format would be good and easy to use"*. Another individual also expressed a need for more guidance on the evidence required and how to collate it and stated that completing the tool multiple times would make it easier to collate evidence:

> *"A bit more guidance on the types of evidence and the best way to collate it would be helpful and save time. Completing this a second time should be easier as we can gather evidence as we go along."*

There was also some concern from a respondent that this tool was replicating previous auditing work, rather than developing a novel outcome tool, but it was less easy to use than previous versions:

> *"This doesn't look like an outcome measurement, it looks like another auditing tool and schools already have lots of versions of these that has better functioning and easier to use than this one."*

It should be noted that the concerns raised above came from a very small number of individual respondents, but the identified issues deserve attention in further development of this work.

Conclusions and next steps

The aim of this project was to work in partnership with staff and pupils to develop and pilot an outcome self-assessment tool to assist with tracking and assessing the impact of the WSCA in schools. This project therefore involved two key phases: 1) a development project in partnership with pupils and school staff from the South and South East of England; and 2) a small-scale pilot of the tool to investigate its acceptability and feasibility with schools. As a result of these strands of work, we developed a WSCA OSAT, which complemented the WSCA ISAT developed and used in our previous work (Procter et al., 2021) to track the various dimensions of WSCA activity being put in in educational settings. The new WSCA OSAT was piloted in a sample of approximately 20 schools.

Overall, this tool was shown to be feasible and acceptable to complete, based on the high level of agreement given by participating schools. Regarding the criteria, respondents tended to agree that the criteria were appropriate for tracking, and the majority also agreed they could feasibly gather the evidence required to complete the tool. Overall, more detail and guidance can be developed alongside this tool to ensure schools are comfortable using the tool and are using it in line with its original purpose. Further suggestions included transforming the tool into a digital format that is easier to access and navigate.

We also gained some preliminary indications of patterns in the rated outcomes associated with WSCA activity, although it must be stressed that these are based on a small sample of self-selected educational settings. Nonetheless, the findings do reveal some intriguing tendencies. We conducted a simple analysis of descriptive statistics relating to the rated outcome criteria. Staff confidence was among the lowest rated outcome criteria among the participating schools, which must be seen in the context of growing evidence from the literature concerning staff confidence about their ability to identify and address children's mental health needs. Qualitative studies with school staff regularly find that there is a need for the expansion of training to support staff in helping pupils (Moon et al. 2017; Pryjmachuk et al. 2011; Askell-Williams & Lawson, 2013). Items such as social inclusion and early identification also tended to be rated lower. Social inclusion is an important factor to improve in schools as evidence suggests that a sense of belonging in school could be a protective factor for young people, especially in secondary school (Bonnell et al. 2019).

On the other hand, anti-bullying initiatives were rated highly in the outcome ratings, and therefore it would appear as though schools are taking an active approach to reduce problems as they occur. Anti-bullying work is a topic that has had increasing traction in recent years, and therefore increasing resources focused on it (see Department for Education, 2022). Therefore, the evidence of more positive outcomes from schools could be partly explained by this increased support and resources with which schools have been able to engage over a significant period of time.

Importantly, we also found that overall ratings of outcomes were strongly associated with ratings of WSCA implementation. Again, these results should be interpreted with caution

given the small sample size, and given that the same informants were providing data at the same time.

Strengths and limitations

A strength of this project is the inclusion of multiple perspectives in the development and refinement of the tool, ranging from pupils and staff to colleagues in MHSTs and NHS England. This project built on findings from previous work which also contained valuable insights from school and MHST staff and pupils. The tool itself also encourages the collation of insights from multiple perspectives by suggesting the benefit of gathering evidence from different groups across an educational setting, to ensure all needs are being addressed. This tool was also piloted across a wide geographical range, with seven MHSTs in three regions in England: South, South East and North East and Yorkshire.

On the other hand, this project only includes regions in England and within MHST settings; thus we cannot comment on the acceptability of the tool in schools which are outside of MHST remit or in other devolved nations in the UK. Indeed, the schools that participated in this project were schools that have an associated MHST and therefore may have been further on in the development of their WSCA, and thus the ratings may reflect this. We also did not gather data from a wider range of settings such as colleges, pupil referral units and schools for pupils with special educational needs or disabilities. Thus, key intricacies in how approaches are implemented in these settings have not yet been captured or explored, and these deserve attention in future research.

Finally, considerably more work needs to be done to explore the process of calibrating and moderating the ratings given by different individuals at different times and in different educational settings. As noted by one of the respondents to our feedback survey, the criteria and response options in our self-assessment toolkit are presented in broad terms, and the subjectivity involved in making these assessments at the level of an entire school is inevitable. It will be important to establish a clear structure and process for MHSTs, or other bodies working across multiple schools, to work collaboratively with schools and educational settings to ensure that ratings of both implementation and outcomes (including evidence ratings) are well-calibrated and appropriately justified. This work has the potential to enhance WSCA activity further because of the opportunity to constructively discuss the details of the work being done and the evidence for its impacts in different areas.

Education and service implications

This project presents practical implications on a local, regional and national level. Once a more accessible digital version of the self-assessment toolkit has been created, this has the potential to assist with tracking and assessing the impact of the WSCA and can be completed as often as needed by the schools. Crucially, this tool generates a numerical dataset, with a standardised structure, which can be plotted across multiple time points. On a local scale, this

can allow schools to identify areas of strength and areas for improvement, how this may differ with time and how it can be directly fed into their future plans for the WSCA work. Schools can therefore continually monitor their progress and ensure all needs are being met by their WSCA.

Furthermore, on a regional level, with the further development of a digital platform for the tool, MHSTs will be able to collate impact data relating to their work on WSCA across settings in their area. By doing so, MHSTs can evidence their WSCA work in a comparable way to the delivery of one-to-one interventions, ensuring this valuable work remains equally at the forefront of their service delivery and is recognised as such. Nationally, if this tool is rolled out widely, there is the potential for the collection of a very large dataset speaking to the impact of the WSCA across regions. With this information, there is the potential to inform how schools can be supported in developing this approach by national organisations, such as NHS England or Department for Education, whether they are associated with an MHST or not.

Future directions for research and next steps

This project piloted the tool with a small sample of 26 schools, and further work is therefore needed to investigate the acceptability of this tool in different regions and across a range of educational settings. Future work on implementing this tool must also be rigorous by ensuring the recording of further important information, such as who is allocated to complete the tool in each setting and which evidence is used by educational settings. This work can help to embed what evidence is useful to complete the tool and support consistency across schools. Future research could also investigate this tool at multiple time points, to see how the implementation and impact of school's WSCA develop over time and whether this tool is sensitive to these changes.

Following the feedback from the pilot work reported above, the project team is now developing a digital platform to facilitate the distribution and completion of the outcomes and implementation tool. When complete, this will be made publicly available, at no cost, for all schools and MHSTs. We will also expand on our information and guidance around the tool to support schools in adopting the toolkit.

Acknowledgements

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Appendix A: Items from the WSCA Outcome Self-Assessment Tool

Q1 Early identification mental health difficulties

0. No evidence of early identification strategies for mental health difficulties.
1. Evidence that the school environment supports recognition of distress within pupils.
2. [1] + Evidence that early indicators of distress or mental health difficulties are being effectively and systematically identified at school
3. [2] + Evidence that staff, parents, and pupils across the whole school community are skilled in identifying indicators of pupil distress or mental health difficulties, and know how these can be safely and appropriately communicated in order to get help.

Q2 Effective intervention for mental health difficulties

0. No evidence of intervention or support system in place for mental health difficulties, such that pupils with mental health needs are not accessing appropriate support or intervention.
1. Evidence that there are support systems and intervention approaches in place that are effective in reducing distress or mental health difficulties.
2. [1] + Evidence that targeted interventions for pupils experiencing distress or mental health difficulties are generating meaningful improvements in those pupils' wellbeing.
3. [2] + Evidence that targeted interventions for pupils' mental health difficulties are generating sustained improvements that ensure a healthier school environment for all.

Q3 Pupil help-seeking

0. No evidence that pupils are confident in knowing where to get help for mental health difficulties.
1. Evidence that most pupils are confident about getting help with distress or mental health difficulties from at least one trusted adult.
2. [1] + Evidence that pupils have the skills and confidence to access support in different ways, and know how to get appropriate help when the need arises.
3. [2] + Evidence that pupils are actively and regularly using a range of help-seeking resources and services within the school community.

Q4 Relationships with peers: Social inclusion and belonging

0. Widespread evidence of problems with social acceptance, belonging, and inclusion among pupils
1. Evidence that the majority of pupils generally experience social inclusion at school
2. [1] + Evidence that pupils are confident about strategies to increase social inclusion when facing difficulties
3. [2] + Evidence that school strategies are ensuring that no pupil experiences protracted problems with social inclusion, and that whole-school work to promote equality and inclusion for all in the community is effective.

Q5 Relationships with peers: Bullying

0. Significant and widespread evidence of bullying among pupils.
1. Evidence that there are effective strategies in place to address and respond to individual cases of bullying.
2. [1] + Evidence that overall levels of bullying are being reduced through work across the whole school, systematically drawing upon the engagement of all staff, with support from senior leadership.
3. [2] + No protracted episodes of bullying, with pupils and parents reporting little or no bullying and feeling confident that the school responds effectively and promptly to any incidents that arise.

Q6 Pupil relationships with staff

0. Evidence of widespread problems in the relationships between staff and pupils, with generally little or no experience of trust or support.
1. Evidence that most pupils and most staff report positive relationships with each other.
2. [1] + Evidence that pupils and staff consistently report high levels of trust, support, and care for each other in their relationships.
3. [2] + Evidence that pupils and staff are confident about feeling safe and listened to even when dealing with difficult situations and issues of concern.

Q7 Pupil well-being and mental health: social behaviour

0. Evidence of widespread problems with pupil conduct, with low levels of prosocial and socially adaptive behaviour and/or high levels of socially withdrawn, aggressive, or dysregulated behaviour.
1. Evidence that the majority of pupils are displaying positive, well-regulated, and socially adaptive behaviour most of the time.
2. [1] + Evidence that incidents of socially withdrawn, aggressive, or dysregulated behaviour are minimal and infrequent, and appropriately and rapidly addressed within the school when encountered.
3. [2] + Evidence that all or nearly all pupils, staff, and parents feel confident about social behaviour being positive, well-regulated, and socially adaptive across the whole school community.

Q8 Pupil well-being and mental health: Emotional functioning

0. Evidence of widespread problems with emotional difficulties such as low or depressed mood, anxiety, anger, and distress.
1. Evidence that the majority of pupils are showing positive indicators of emotional wellbeing most of the time.
2. [1] + Evidence that cases of low or depressed mood, anxiety, anger, and distress are minimal and infrequent, and pupils are provided with appropriate and rapid support to reduce such experiences.

3. [2] + Evidence that all or nearly all pupils, staff, and parents feel confident about levels of emotional wellbeing being high across the whole school community.

Q9 Pupil participation and engagement in school community

0. No evidence that pupils are actively engaged in school community decision-making, activities, and initiatives, beyond what they are required to do.
1. Evidence that the system for pupil participation in the school is enabling some consultation with a selected pool of pupils on a limited range of topics.
2. [1] + Evidence that a broad range of pupils are actively engaged with issues that are important to them and are confident about how to influence school initiatives.
3. [2] + All or nearly all pupils are actively engaged in shaping different aspects of the school community life and effectively participate in decision-making about issues that concern them.

Q10 Staff confidence in addressing pupil mental health

0. Evidence of widespread difficulties and low confidence among staff members in addressing pupil mental health.
1. Most members of staff are aware of how they can access professional development/training and support in addressing pupil mental health.
2. [1] + Evidence that staff members are feeling confident about the opportunities for professional development, training, and support for promoting pupil mental health and addressing mental health difficulties.
3. [2] + Evidence that all or nearly all staff have high levels of confidence in using strategies to promote pupils' mental health across the whole school community, identifying signs of mental health difficulties, and working as part of a wider team (in school and beyond where appropriate) to support pupils who are experiencing difficulties.

Q11 Staff well-being

0. Evidence of widespread difficulties with staff wellbeing, and/or minimal understanding or awareness in the school of staff members' own wellbeing needs.
1. Evidence that systems and structures in the setting are providing some support for individual staff members experiencing low levels of wellbeing.
2. [1] + Evidence that difficulties with staff wellbeing are minimal and infrequent, and that staff are provided with appropriate and rapid support to reduce such experiences.
3. [2] + Evidence that all or nearly all staff feel confident about levels of emotional wellbeing being high for themselves and for other staff members, across the whole school community.

Q12 Parent/carer engagement in school wellbeing

0. No or extremely minimal evidence that parents/carers are engaged with school wellbeing activities or initiatives.

1. Evidence that structures, events, and activities are ensuring engagement from a selected pool of parents/carers on a limited range of topics.
2. [1] + Evidence that a broad range of parents/carers are actively engaged in school activities and initiatives concerning issues that are important to them.
3. [2] + All or nearly all parents/carers are actively engaged in shaping different aspects of the school community life and effectively participate in decision-making about issues that concern them.

Evidence Rating (requested for each of the Outcome Ratings above)

1. Only very limited evidence is provided for the outcome rating, such as informal observations and anecdotes
2. Some evidence is provided for the outcome rating, with written documentation in line with an agreed plan for data collection, but the reliability, validity, coverage and/or independence of data collection are limited (e.g., individual case studies based on staff observations)
3. Strong evidence is provided for the outcome rating, with written documentation in line with an agreed plan for data collection, and confidence about the reliability, validity, coverage, and independence of data collection (e.g., whole-school survey with high response rate, systematic programme of independent focus groups with all year groups, clear trends in school metrics)

Appendix B: Items from Feedback Survey

- The Outcomes tool is feasible to complete in the school environment.
- The Outcomes tool and its relevant guidance is easy to understand and apply to my setting.
- The Outcomes tool is an acceptable length.

[1 = strongly disagree to 5 = strongly agree]

- How long did it take you to complete the measure?

[1 = < 10 minutes to 4 = > 30 minutes]

- If you had any problems completing the tool, please state them here.

[open-ended]

- Ratings for the 12 key criteria provide an appropriate way to track the impact of WSA.

[1 = strongly disagree to 5 = strongly agree]

- In relation to this, are there any criteria you believe are confusing or unsuitable?
- Are there any criteria you would like to see in the tool, that are not currently included?

[No or Yes; if Yes, please indicate/elaborate]

- The rating process is easy to understand and feasible to complete.
- The rating descriptors on each level are clear and helpful in the rating process.
- I understand the type of evidence that is needed for each rating.
- I can feasibly provide or gather the evidence needed for this tool, in the school environment.

[1 = strongly disagree to 5 = strongly agree]

- Are there any issues with the tool or anything you would like to change?

[No or Yes; if Yes, please indicate/elaborate]

- Finally, if you have any comments on the tool, please outline them here.

[open-ended]